"DEPRESSION KILLS MORE THAN A SELF":
CONCEPTS OF MENTAL DISTRESS AMONGST PAKISTANIS

R. MALIK

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ABSTRACT

This thesis investigates the role of culture in the experience of distress and depression amongst British Pakistanis.

Part I of the thesis addresses the tensions inherent between psychiatry and anthropology in the field of cross cultural psychiatry. In essence, the opposing epistemological and methodological positions taken by the two disciplines has resurrected the age old universalist/relativist debate. The influence of these positions on the results produced are discussed with reference to the cross cultural study of depression. It is argued that in the field of ethnic minority mental health an integrated approach is required, which is both meaningful to the cultural minority in question and the wider cultural system. This thesis adopts such an approach by using quantitative and qualitative methods to comparatively research the symptom pattern and explanatory models of distress / depression in British, British Pakistani and Pakistani respondents.

Part II of the thesis describes three quantitative studies. These involve the use of a British standardised screening instrument, juxtaposed with a Pakistani standardised screening instrument for measuring the symptoms of distress / depression. In addition a multicultural explanatory model questionnaire was used to investigate cross cultural perceptions of health beliefs. Together these findings statistically suggest some cross cultural variation in symptom patterns and explanatory models. To further investigate the cultural themes that emerged from these studies, a detailed interview study was conducted with half of the Pakistani and British Pakistani respondents. This is described in Part III. This study demonstrates the interconnection between wider cultural themes of meaning and their role in shaping the experience of distress / depression in Pakistanis.
Part IV reviews and draws together the findings of the studies to develop an indicative explanatory model of distress / depression in Pakistanis which highlights the role of culture. The theoretical and methodological implications and applications of this research are discussed.
ACKNOWLEDGEMENTS

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To my friends at SOAS, the last thing that remains to be said is that Brunei Gallery II is yet to be built.....!
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PART I
Psychiatry and the study of mental illness is distinguished by its location at the interface between the physical and social sciences. This uneasy positioning becomes particularly strained in the research of mental illness across cultures, which brings the disciplines of psychiatry and anthropology together. Much debate has subsequently taken place regarding this multidisciplinary field and the approach best taken to it. In essence this has reverberated the universalist/relativist polemical debate. The divides between the two positions are to some extent encapsulated in the contemporary orientations of the, so called, 'transcultural psychiatry' and the 'new cross cultural psychiatry', both of which have generated research that has impacted on the development of the field. This chapter, through a review of the merits and demerits of the research produced by the respective schools of thought, argues for a more integrated approach and the need to demarcate some common ground. This case is argued with particular reference to ethnic minority mental health.

1.1 UNIVERSALISTS AND RELATIVISTS
Skultans (1993) has pointed out that the rubrics of 'transcultural psychiatry' and the contemporary 'new cross cultural psychiatry' are in themselves indicative of the paradigmatic divide and divergence in approaches between the universalists and relativists. Whilst the linguistic innuendo in these terminologies is a subtle one and may seem pedantic, the actual consequences in terms of research and findings are extensive. Skultans (1993) argues that the 'transcultural' aspect of the 'transcultural psychiatrists' alludes to a notion of 'psychiatry' crossing cultures to examine mental disorders. This can be juxtaposed to the 'cross cultural'
aspect of the 'new cross cultural psychiatrists', which alludes to a notion of the crossing of cultures to examine psychiatry / mental disorders. Therefore, although both approaches share the same ultimate goal of investigating the extent to which culture exerts an influence on mental illness and human behaviour both, however, proceed from different premises. The former proceeds with a starting point of 'psychiatry', whilst the latter proceeds with a starting point of 'culture'. This emphasis can be paralleled with the disciplines of psychiatry / psychology and anthropology, respectively. As Fabrega (1992) points out, the repercussions of these premises are, that whilst biology implies 'sameness' in the production of illness and its manifestations, culture implies 'difference' in appearance, interpretation and meaning of psychiatric illness across culture. In effect, this didactic positioning of 'transcultural psychiatry' and the 'new cross cultural psychiatry', re-enacts the quintessential debate between the universalist and relativist paradigms.

To elaborate, the universalists, at their most extreme, believe that psychiatric and psychological diversity, due to its being essentially rooted in underlying biological processes, is more apparent than real. Consequently they focus on homogeneity and paradigmatically apply Western psychiatric diagnostic categories to other cultures in comparative research. The relativists on the other hand, at their most extreme, believe there is no such thing as objective reality and that what we regard as 'objective' is the end-product of the workings of individual perceptions and socio-cultural concepts (Geertz, 1983). In turn they focus on heterogeneity indigenous theories and practices, and paradigmatically question the application of Western psychiatric diagnostic categories (which they regard as cultural constructions) in comparative research. Indeed, at their most radical they completely condemn comparative research. These formulations of universalism and relativism, however, represent the most extreme ends of a continuum along which most cross cultural psychiatric research can be placed. The transcultural psychiatric movement and the new cross cultural psychiatric movement can be placed along this continuum; veering towards (although not necessarily at the extreme of) these respective poles. More pragmatically, these orientations adopt universalist and relativist principles as a premise or approach to the research of mental illness.
across cultures. This divide is, then, further evident in the methodology they adopt, and subsequently much of the debate between the two schools of thought, has been centred around this issue.

In general, transcultural psychiatry, with its origins in medicine, adopts a more etic perspective to research. Whilst the new cross cultural psychiatry, with its origins in anthropology, advocates a more emic perspective to research. The etic / emic methodological dichotomy and the respective concepts they use to guide research, the perspectives they advocate researchers to take and the number of cultures they aim to investigate, all reverberates the universalist / relativist orientations. The essential points of contrast between the etic and emic dichotomies are summarised in the table below.

Table 1.1 - Contrast of essential aspects of the etic and emic approaches to research

<table>
<thead>
<tr>
<th></th>
<th>ETIC</th>
<th>EMIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSPECTIVE TAKEN BY THE RESEARCHER</td>
<td>Behaviour of a culture is studied from the outside, by an outsider who is not familiar with that culture</td>
<td>Behaviour of a culture is studied from within by an insider who is familiar with the culture</td>
</tr>
<tr>
<td>NUMBER OF CULTURES STUDIED</td>
<td>As many as possible - for statistical generalisation purposes</td>
<td>Only one at a time - and generalisations not drawn across culture</td>
</tr>
<tr>
<td>STRUCTURE OF CONCEPTS GUIDING RESEARCH</td>
<td>Constructs / structures created by the researcher and the theoretical perspective he / she adopts, and are imposed onto the system being studied</td>
<td>Constructs / structures are discovered by the researcher, when and if they manifest as important dimensions in one culture</td>
</tr>
</tbody>
</table>

Adapted from Lonner (1979) in Issues in Cross Cultural Psychology. Marsella et al. (ed).
The above summary shows that the etic approach is clearly a more positivist approach to research. This approach, assuming the universality of mental disorders, uses concepts, methodologies and research instruments developed primarily in the West. In line with this the transcultural psychiatric school of thought has used standardised questionnaires and classification systems for researching distribution of symptoms and syndromes in different cultural settings. Therefore, the etic approach has focused on the collation of empirical data. This is in contrast to the emic approach, which is clearly a more anti-positivist approach to research. This approach, stressing relativity, uses more interpretive methods (based on a hermeneutic philosophy), such as participant observation to focus on context. In line with this the new cross cultural psychiatric school of thought has criticised the use of Western standardised questionnaires across cultures and advocated a more ethnographic or ethnomedical (Fabrega, 1982) approach to research, which does not assume disorder categories. Such a methodology is often counter to the scientific rigour the universalists pride themselves on.

The impact of these differential methodological approaches on the type of findings generated and the strengths / shortcomings of both approaches is better illustrated by considering some of the respective research produced by the transcultural psychiatric and the new cross cultural psychiatric schools of thought.

1.2 TRANSCULTURAL PSYCHIATRY
The emergence of so-called ‘transcultural psychiatry’ can be traced back to the turn of the century in the work of Kraepelin (1904). Kraepelin (1904) who had strongly influenced the founding of several psychiatric syndrome categories based on the dysfunctional patterns of German patients, confronted, like many psychiatrists since, the complexities of investigating mental disorders across cultures. Faced with distinct differences in expression and frequency of mental disorders in Java, in comparison to his native Germany, Kraepelin attributed the cultural inconsistencies he observed to the perfunctory impact of diet and climate. In doing
so, he turned to the then popular discourse on 'form' and 'content'. Whilst the 'form' of the disorder was attributed to underlying core biological processes, the 'content' was attributed to the superficial layer of culture. This framework thus conceptualised disorder categories to be pan cultural in their 'form' - in elements such as mood disturbances and hallucinations - and culture specific in their 'content' - by what the disturbances comprised of and the interpretation given to them. The form/content formulation therefore through the assumption, that behaviour can be culturally de-contextualised and the relegation of the meanings of the behavioural content to secondary position, provided a universalist orientation (Fabrega, 1992). This produced a model that depicted a 'thick' biological core to be surrounded by a 'thin' cultural envelope which researchers could attempt to uncover (Littlewood, 1990). Consequently in much subsequent transcultural psychiatric research, non-Western patterns of behaviour were structurally fitted to and identified with Western disorder categories. Those disorders, however, that did not correspond at all to Western psychiatric classification were called 'culture bound' syndromes and forwarded as examples of the 'exotic'; which were left to the realm of the anthropologists.

1.3 MIGRATION AND MENTAL ILLNESS

This relative lack of concern for the 'envelope' of culture and a preoccupation with disorder categories, was further displayed in the large body of research produced in the 1950's to 1970's on migration and mental illness. The period marked a substantial upsurge in the interest in the field of migration and psychiatry, which was largely fuelled by the postwar increase in migration to Britain, the United States of America, and Australia; that is, the subsequent appearance of a new research sample. This research primarily addressed rates of disorders in ethnic minorities in comparison with the indigenous populations. Whilst much of the ensuing research observed clear differences in rates, the explanatory hypotheses accounting for the differences were largely speculative (Furnham & Bochner, 1986). The earlier comparative research on rates, such as that by Odegaard (1932) - comparing indigenous Norwegians, migrant Norwegians and indigenous Americans - ascribed the inflated
rates in mental disorders in ethnic minorities to the selection hypothesis. The selection hypothesis suggested that ethnic minorities imported their disorders and that the kind of person that migrated was more pre-disposed to mental disorder than a person that did not.

Later research, such as that of Malzberg and Lee (1956), however, began moving away from the predomination of the selection hypothesis and started to focus on the social aspect of mental illness and migration. They interpreted their findings of higher mental hospital admission rates in immigrants in their first post-migratory year in New York, in terms of both the selection and stress hypotheses. Sanua (1969) lent further credence to the stress hypothesis, when he found that children of migrants had intermediate rates of mental illness between that of the first generation and the indigenous population. These social aspects and stresses of the migration process were built upon further in the multidimensional demographic studies of Taft (1960) and Krupinski (1967) in Australia. Both Taft and Krupinski identified a range of variables and several predisposing factors that rendered immigrants vulnerable to mental disorder. This early research, whilst focusing primarily on the selection and social aspects of migration and mental illness often drew few distinctions in disorder categories and largely ignored the heterogeneity of the immigrant groups. 'Culture' to this end was not really a consideration, it served merely as a categorisation; synonymous with 'immigrant' or the 'other'.

Relatively more recent research in Britain did, however, begin to delineate between disorder categories and the origins of the minority groups. The majority of this research in the 1960's, focused on the new wave of 'visible' migrants from the New Commonwealth (West Indians, Africans and Asians), thereby introducing the factor of race and racism into the equation (Walvin, 1984). These studies, like their predecessors, also concentrated largely on hospital admission rates and services used by immigrants in comparison to the indigenous population.

(Hemsi, 1961; Bagley, 1971). In general, this research reported particularly high rates of disorders (especially schizophrenia and affective disorders) in West Indians as compared to the indigenous population (Hemsi, 1961). The research also reported higher rates of psychiatric services use by Africans, Indians and Pakistanis, as well as the Irish (Bagley, 1971). These findings, however, were prone to discrepancies and contradictions, as well as methodological problems. For example, Burke (1977) in a comparative study of West Indian and British patients - unlike Hemsi’s (1961) previous study - found no evidence of an association between mental illness and ethnic origin. He found, rather unsurprisingly - in an area that was often paradoxically overlooked with ethnic minorities - an association between non-migratory predisposing factors, such as unhappy childhood or family history and mental illness. Much of this body of research, however, has been subsequently discredited for not considering the numerous confounding factors of sex, age and class, which are known to be related to mental illness in all cultures.

More reliable age and sex standardised data has since been provided by Cochrane (1977) in the largest nation wide study of mental hospital admission rates in the major immigrant groups. Whilst this data provided a more accurate and comprehensive picture of hospital admission rates and particular disorders in specific ethnic groups (refer to Chapters 2 & 3) it still, as is inevitable in such an approach to research, assumed the universality of disorder categories.

Notwithstanding the issue of the validity of disorder categories, this research, however, created a climate in which there was a growing curiosity for explication of the observed differences. Whilst the selection and stress hypotheses attempted to provide some answers, they were little more than speculative. The possibility of a third hypothesis which diminished the findings as artefact could not be dispelled. This stemmed from concerns regarding the shortcomings in the use of hospital admission rates as base rate statistics.

Hospital admission rates, it was argued, could be highly misleading both in terms of, as
indicators and as indices for comparison. The issue of the use of hospital admission rates as indicators of actual level of psychopathology in a community was connected, on the one hand, to the relativists concerns about category validity (refer to section 1.4) and on the other hand differential diagnostic and referral practices of psychiatrists. In the case of ethnic minorities these issues were further compounded by a number of other factors, including differential presentation, the frequent mis-recognition of disorders and availability of resources in addition to the unavoidable issues of racial prejudices (Bhat et al., 1988). Moreover, the use of hospital rates as an index for comparison in minorities were also effected by peripheral problems pertaining to family attitudes and the possibility of lack of use of services due to reliability on family management, or the seeking of alternative healers. This is all not to mention the practical limitations of hospital data, which have frequently been noted to have missed information or failed to record pertinent information. For example the severity of the disorder, which could be vital to the quality of any analysis and the conclusions drawn.

Subsequently, research attention began to shift to the micro level of community studies and symptom presentation (Cochrane & Stopes Roe, 1977; 1981). Aptly this may have coincided with the emergence of the new cross cultural psychiatric school of thought, which focused primarily on the impact of 'culture' on mental disorders. Up until now much transcultural psychiatric research, requisite to universalist assumptions and empirical methodology, had been concerned mainly with 'culture' as an independent variable. This was clearly evident in the case of research on ethnic minority health, where 'culture' merely served as a label.

1.4 NEW CROSS CULTURAL PSYCHIATRY

The 'new cross cultural psychiatry' was heralded by Kleinman's (1977) seminal paper entitled, 'Depression, Somatisation and the New Cross Cultural Psychiatry'. This paper challenged the transcultural psychiatric assumption that depressive reactions were identical across different cultures and thereby criticised the assumption of universality. Kleinman (1977) referred to this as the now well known 'category fallacy'; that assumes that Western psychiatric categories
are culture free entities. Alternatively, Kleinman proposed a fundamental change in theoretical and methodological paradigms and advocated a more anthropological ethnographic approach to research that considered local meanings of behaviour patterns before attempting any comparative work.

A crucial and inextricably linked adjunct to the 'new cross cultural psychiatrists' argument, was, therefore, that it placed Western psychiatry and psychology within the context of the social and cultural. In doing so it viewed Western psychiatric nosology and psychological theory as a historical by product of a Western biomedical society. This argument was grounded in a post empirical philosophy of science, which based on Kuhns theory of 'The Structure of Scientific Revolutions' (1970), maintains there is no certain foundations of any knowledge claims. In such a viewpoint, science cannot be distinguished from other discourses because of its supposed neutral or objective nature. Rather science is considered as a particular set of metaphors alongside others in our attempts at describing the world (Rorty, 1989). The scientific community itself is thus conceived to be subjected to traditions, values and norms; that is, cultural influences, embodied in its very practice (Bernstein, 1983). Littlewood (1990) points out, this position has led to a shift in emphasis of cross cultural psychiatric research and rather than focusing solely on the cross cultural comparison of psychiatric categories, research is now being levelled at examining psychiatric epistemology and clinical practice in all societies. The very issues of meaning and interpretation, which were at one time only considered relevant to human sciences, are consequently becoming central to the natural sciences (Hesse, 1980). In this sense 'culture' refers to a system of learnt meanings that provides people with a distinctive sense of reality and which helps shape behaviour and affective responses (D'Andrade, 1984). The new cross cultural psychiatrists thus view psychiatry and mental disorder as cultural constructions and thereby make the component of 'culture' central to any research and debate. Although they also acknowledge that certain disorders like schizophrenia are likely to have more of a biological base (Littlewood, 1990).
For example, Gaines' (1992) paper on the cultural construction of U.S. psychiatric classification, deconstructs the DSM-III-R nosologies and classificatory process to show how they express an underlying cultural psychology. He suggests that classifications are explorations of culturally meaningful aetiologies, which invoke themes such as notions of the 'idealised self' and self control. The subsequent 'other' in such a system is conversely constructed as biological / natural and beyond culture and serves as a means to create and distance the 'idealised self' from those represented as 'other'. Fabrega (1992), likewise has also discussed Western psychiatry and the modern concept of disease as a cultural and historical product of Western biomedicine. Through tracing the history of mental illness, or 'human behavioural breakdown' as he refers to it\(^2\), from medieval times to the 20th century he demonstrates the social stigma that has come to be associated with psychiatry and madness and more currently problems such as: neuroses, somatisation and personality disorders\(^3\). Both Gaines' and Fabrega's approaches to the analysis of psychiatry represent the kind of 'ethnomedical' approach to research that is advocated by the 'new cross cultural psychiatrists'.

Other techniques utilised by the new cross cultural psychiatrists have employed inferential models (D'Andrade, 1976) which involve an examination of decisions people tend to make in diagnosis and treatment. Procedural models (Bourdieu, 1977) which involve an observation of management of actual episodes of illness and propositional analysis (White, 1982), which involves a repertory grid type analysis. This type of examination, of the structures of popular classificatory systems of other cultures, adopts the disease / illness distinction suggested by Kleinman (1978) to clarify the differential between a biomedical professional view and that of popular culture. In this notion of 'illness', the personal, interpersonal and cultural reaction to disease are thus encapsulated. Such a view and approach, Littlewood (1990) argues, helps to avert the previous assumptions of structural

\(^2\) The relevance of this notion is picked up again in section 1.5.

\(^3\) For a fuller discussion of the history of madness and psychiatry in England, refer to Porter's (1987) seminal work - 'Mind Forg'd Manacles'.

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similarity in folk models of psychiatric illness and Western medical theories of psychiatric illness. By not assuming such a one to one correspondence between disease entity and name and not imposing a structure by asking informants to simply describe the characteristics of a given disorder, the assumption of a clear distinction between; symptoms, syndromes, aetiology and prognosis are not made and much of the contextually rich information can be accessed (Good & Good, 1982). Good & Good's (1982) study on 'heart distress' in Iran provides a good example of this approach and explores, using semantic networks, the full range of meaning associated with local categories of distress before doing an epidemiological study.

Such new meaning centred approaches to research have arguably generated findings higher in explanatory power than that of the transcultural psychiatrists. Furthermore, Bracken (1993) argues that this kind of anti positivist approach to cross cultural psychiatric research provides a unified approach to knowledge and avoids the pitfalls of the natural / social science dichotomy. This contextualisation of cross cultural research, however, in an uncompromising form (ie. in an extreme relativist stance⁴) is limited by its lack of 'comparability component' and its instability (Skultans, 1993). As pointed out by Shweder & Bourne (1991), the view of the extreme relativists; that cultures can only be understood in context, leads some-what to a 'self-contained ideational universe' and provides no grounds for common standards or criticisms. Such a stance therefore backs this approach into an intellectual corner when it comes to explaining changes in cultural ideational systems; an issue which is unavoidable in the globalisation of psychiatry.

1.5 TOWARDS A RESOLUTION; DEMARCATING A COMMON GROUND
Having given an account of the differences between the theoretical orientations of the 'transcultural psychiatrists' and the 'new cross cultural psychiatrists' and their respective

⁴ This is not necessarily the stance of the new cross cultural psychiatrists.
approaches to research, one observes the rather circumlocutory nature of this argument is apparent. As Shweder and Bourne (1991) postulate, inevitably the theoretical orientation of the researcher influences the methodology they adopt and this in turn invariably involves the use of concepts / rules tailored to generate data that rediscover the interpretive model of choice. Despite a common ultimate goal the differential frames of reference all too frequently produce rather polarised results and conclusions. The transcultural psychiatrists by focusing primarily on an empirical methodology, have largely re-established psychiatric principles and the new cross cultural psychiatrists by focusing primarily on an interpretive methodology have largely reestablished the importance of culture. The contribution of both paradigms to the debate on mental illness across cultures, cannot however, be denied and the current 'refusal of closure', as Littlewood (1990) surmises, can be taken as an exciting prospect. Through encouraging dialogue between the two perspectives it may offer the possibility of the development of a demanding alternate method. Although some commentators in the field think that a resolution of the conflict at this stage is still neither feasible nor desirable (Skultans, 1993). In the case of the mental health of ethnic minority groups however, some pragmatic progression is undoubtedly desperately needed.

The case of ethnic minority groups presents a particularly interesting situation that encapsulates the many dilemmas in the field. Here we have a juxtaposition in which a 'subcultural population' with possible / probable variant health beliefs and explanatory models are resident in a differential dominant cultural health care system. The comparatively high or low hospital admission rates observed in Cochrane's (1977) survey (as already discussed) may be a testament to this possibility. The question this then raises is, how can this predicament be investigated in a meaningful way that may facilitate required changes in ethnic minority mental health care; that is, in the context of the highly medicalised culture of Britain in which we live. Achieving this meaningful comparative position will surely require some dialogue between numbers and meaning (Krause, 1994) and the respective orientations.
The revisionist versions of universalism and relativism may prove a means for facilitating such an analysis. In short, as described by Skultans (1993), a revised version of universalism maintains that cultures do overlap in a multitude of ways, but dispenses with the notion of a unique unchanging core of rationality. The common core is instead conceptualised as being a shifting one, which may meet at certain points for a particular group of cultures and at different points for different group of cultures. This can be juxtaposed with the revised version of relativism (Gellner, 1982), which although continues to emphasise the importance and interest of meaning (maintaining a distinction of truth from meaning), focuses analytic attention on it in a manner that offers a universalist and relativist account.

Here, in these revised versions we can begin to demarcate some common ground and attempt to reconcile 'sameness' with 'difference', acknowledging that there are both situations of universality, as well as, relativity. In line with this integration Gellners (1982) in his search for human universals, takes his starting point as the assumption of the existence of one world but not necessarily the corresponding assumption of the existence of 'one kind of man' (Gellner, 1982). Fabrega (1992), in a similar vein, whilst acknowledging variation in the way people; describe, show, recognise and respond to illness in accordance with cultural meaning, argues that, what can be labelled a medical event almost always invariably involves a disturbance in adaptation, usually with a bodily or behavioural focus. In this sense he postulates that:

"....although the concept of illness is subject to cultural variation since it rests on socio-psychological and / or behavioural conventions about behaviour, it refers to phenomena that are also somehow universal and biological" (Fabrega, 1992. p.92)

Such formulations, provide the potential for a possible route forward, towards a more integrated approach. In terms of actual research, instead of using Western nosological categories as starting points, Fabrega (1992) uses the notion of 'Human Behavioural Breakdowns' (HBBs) to achieve this universal starting point and Krause (1989), taking the
lead from Gellner (1982), uses the human body and its organs, in particular the heart as a 'natural reality' and starting point for her study on distress and the 'sinking heart complex' in Punjabis.

This common universal starting point thereby avoids the pitfall of the 'category fallacy' and the issue of validity. Beyond this initiation, however, it is important to address the related issues and methodological sticking points of: normative uncertainty, centicultural bias and the translation and indeterminacy of meaning (Kleinman & Becker, 1991). When conducting research one needs to bear in mind the cultural specificity of what is regarded as normal / abnormal. This includes and is in relation to such things as the duration of symptom pattern required for qualification of psychiatric 'caseness', cut off points and threshold level; issues which are by no means even unanimously agreed upon within Western psychiatry. Moreover, there is the issue of centicultural bias (Wober, 1969), which refers to the fact that many research strategies involve an instrument that has been validated and developed exclusively in one culture and is therefore often limited in its range of symptoms. Although some researchers have attempted to overcome these problems by modifying items in Western questionnaires in a culturally sensitive manner, they still need to take into consideration the larger pool of cross culturally variant symptoms (West, 1985 - Arabic version of the BDI).

Finally, even if one is to modify or attempt to determine the cross cultural applicability of a research approach or instrument, there is the central complex issue of translation and the achieving of literal or conceptual equivalence. Kleinman and Beker (1991) argues, the simple semantic equivalence of a term is not adequate enough, as it assumes the existence of objective and universal referents, which either may not exist in a particular culture or may be represented by differential symbolic forms.

This demarcation of a common approach and a consideration of the central issues in research methodology is beginning to be carried out. As Krause (1994) points out, we have recently begun to see psychiatrists acknowledging cultural variation in symptomatology (Kinzie et al., 1982; West, 1985; Manson et al., 1985; Mumford et al., 1991) and valuing non-Western medical paradigms in research (Good, 1977; Kleinman, 1986), as well as, anthropologists...
applying Western psychological theories to non-Western contexts (Shweder & Bourne, 1984; Obeyesekere, 1990). Furthermore, a uniform approach to research may be guided by models such as that put forward by Littlewood (1990). This model depicts the range of mental disorders along a continuum in relation to their interface between the biological and social. At one end of this spectrum, Littlewood suggests, that disruptive behaviour patterns can be understood as primarily constrained by biology and individual differences (such as psychoses), and at the other end he suggests they can be best interpreted by examining social and individual differences (such as, neuroses or disorders like anorexia). Leff (1990) postulates that such a formulation with an added component of a vertical axis of culture-distance may prove useful in assessing the validity of already existing research. Therefore, using this type of template, studies of the so called more 'social orders', involving a large 'culture distance', would be expected to be approached using an ethnographic type analysis. The over hasty discarding of all previous transcultural research would, however, Leff (1990) thinks be premature and akin to 'throwing out the baby with the bath water'. Such demarcation, as Krause (1991) sums up, is not so much about how one approach is quantified and the other qualified, but rather how the labour can be divided and the two paradigms equally respected to inform one another. After all, what one paradigm can contribute in validity the other can in reliability.

Through this type of cooperation and multi-disciplinary approach we can progress in developing an integrated model that encompasses both paradigmatic frames of reference, and offers greater cross cultural explanatory power. There are already a few cases in point that are worth mentioning and building upon. For example Lonner (1979) discusses the possibility of combining emic and etic perspectives on the basis of theories such as Witkin and Goodenough's (1977) field dependent / field independent cognitive differentiation theory. This, he postulates, may be one way of incorporating psychological theory and anthropological reality and may provide a means for looking at individual and group behaviour, both within and across cultures. Obeyeskere (1981) in his book 'Medusa Hair' looks at this very interface between psychology and anthropology and the relationship
between private and public symbols. He develops the obvious but often dismissed influence of culture on behaviour and in turn, the importance of the socio-cultural for the integration of personality. In contrast, other researchers have presented more structural models facilitating cross cultural comparisons. For example, Carr and Vitaliano (1985) using a Heuristic distress model demarcate the universal aspects of cross cultural disorders (ie., in principals of learning) and the culture specific aspects (ie. in acquisition of cultural: norms, beliefs, expectations and behaviour and goals and coping styles) which are used to assign meaning to events and experiences. Marsella (1980), in a model that can be incorporated with Carr and Vitaliano's (1985) model, at the culture specific level, has speculated on an epistemic orientation continuum, ranging from the objective to the subjective, for understanding and contrasting the cross cultural expression of depression. Finally, Kleinman (1989) on a larger scale has proposed a model which tries to understand health, illness and healing in a society as a cultural system. This model shows how culture\(^5\) mediates between external parameters (political, economic, historical, epidemiological and technological) and internal parameters (psychophysiological and behavioural) of medical systems, determining the content, effects and changes they undergo. Such modelling, thus, makes comparative research more amenable.

To summarise it appears that we are moving more and more towards the possibility of an integrated approach to the cross cultural research of mental illness. A prospect that, it has been argued, is particularly relevant to ethnic minority groups who are in the peculiar position of having to function within another cultural and medical system. Indeed the lacuna between the health beliefs of ethnic minorities and that of the wider medical system, and the essential need for them to be bridged has become more apparent since the realisation of the extent of retention of cultural identity in many of Britain's visible minorities\(^6\), dispelling the widely held

\(^5\) Culture, here is defined as a system of symbolic meanings that shapes both social reality and personal experience.

\(^6\) This particularly applies to first generation migrants.
simplistic assumption that they would assimilate into the wider system. This growing assertion of cultural identity in conjunction with growing consumerism within the NHS\(^7\), has lead to an acknowledgement that ethnic minorities are proportionally under utilising particular health facilities and that local health authorities are not fulfilling their statutory duty to provide their needs. Using the developments in comparative methodological approaches in the research of mental illness across cultures which have been discussed, we may now be able to start generating some meaningful understandings of the discrepancies in health service use. These discrepancies in health service use, in relation to South Asians, are outlined in more detail in Chapters 2 & 3.

\(^7\) The growing consumerism within the NHS is depicted in the recent structural implementations of 'purchasers and providers'.
-CHAPTER 2-

CULTURE AND DEPRESSION

The continuum proposed by Littlewood (1990), in Chapter 1, for understanding cross cultural patterns of symptoms, places neurosis towards the sociological paradigmatic end of the spectrum. This relatively greater influences of 'culture' in neurotic phenomena, that is in comparison to psychotic phenomena, has been widely accepted. Neurosis forms an especially challenging area for cross cultural psychiatric research. Evidence suggesting that the flux in diagnostic systems, particularly in American psychiatry- as set out in DSM III (American Psychiatric Association, 1980)- is moving towards a relatively narrower definition of schizophrenia and a broader category of affective disorders (Leff, 1982). Within this broader categorisation of neurosis, in some sense, is the comparatively contemporary disorder of 'depression'\(^8\), which reportedly, according to Sartorious (1986) is on the increase. This speculated greater shift towards depression is due to several factors. For example, the rapidly changing social environment worldwide (Sartorious, 1986) and the introduction and greater availability of specific anti depressant medication (Hare, 1974). Whatever conclusions drawn are, however, greatly influenced by how one interprets depression, and the approach taken to research. These issues in essence, relate to the dichotomy of the universalist / relativist orientations and the approaches to research of the transcultural psychiatric and the new cross cultural psychiatric schools of thought (refer to Chapter 1). The findings of these two differential approaches to the research of depression across cultures are reviewed. The aim is to demarcate a common ground, and a combined approach to the research of depression, particularly in ethnic minorities.

\(^8\) The disorder category 'depression' can be said to be comparatively contemporary, dating back to the late 19th century and the work of Kraepelin (1904) but its close conceptual predecessor 'melancholia' can be traced back much further in time to the Greek period.
2.1 WESTERN CONCEPTUALISATION OF DEPRESSION

The disorder of depression, a relatively contemporary pathological conception, has been conceptually linked to the ancient notion of 'melancholia'; which is derived from the Greek words 'melan' and 'choler', meaning black bile. 'Melancholy', referred to a sad, thoughtful or gloomy state of mind, which Marsella et al. (1985) point out is made reference to in the Old Testament, and ancient Hindu medical texts. The notion of 'depression', however, as it is known today in psychiatry can be traced to the work of Kraepelin (1904). It has currently become such a familiar term and notion in popular and medical culture in the West that, Seligman (1973) has referred to it as 'common cold of psychopathology' (1973). Whilst it may be a familiar term and notion, one major problem with its use is its multifarious connotations. For example, depression can either represent a state, trait or symptom, which occur as secondary complications in a diversity of physical and mental disorders. Or, it can represent a clinical pathological entity in its own right. In essence, the confusion that has surrounded depression is due to the issue of normative uncertainty and at what point a depressive mood can be considered an illness in its own right. Even within the latter clinical formulation, depression by all accounts, is a rather heterogeneous category (Davison and Neale, 1990). It has been delineated at various times in terms of unipolar, bipolar, exogenous, endogenous, reactive, biological, neurotic and psychotic distinctions. Similarly, its aetiology has been studied from many perspectives and ascribed to several theories.

At the more social end of the spectrum, which is the unipolar, exogenous or reactive depression, sociological models, such as that of Brown and Harris (1978) have been proposed. These focus on the social context of depression and the influence of provoking agents and vulnerability factors, including: life events, socioeconomic status and sex. At the more biological end of the spectrum, which is the bipolar or endogenous depression, physiological models that focus on the central nervous system and neuro-chemical transmitters have been advanced. This perspective has also included genetic studies.
Besides these dichotomous theories there are also a multitude of other more psychologically based theories, including psychoanalytic, cognitive and behavioural theories. The psychoanalytic theories, such as that of Freud's (1956) and Bowlby's (1980) quintessentially emphasise the unconscious conflicts associated with grief and loss in depression. The cognitive theories, such as Beck's (1979) focus on the depressed persons self defeating thought processes. Whilst, the behavioural theories, such as Seligman's (1975) Learned Helplessness Model or Revised Attribution Style Model (1978), contend with the curtailment of activity associated with depression. These theories summarised here represent the more well-known theories of depression and each has been widely critiqued from within, as well as from a cross cultural perspective. Essentially, the plurality of these theories reflects the heterogeneity of the notion of depression and will not be resolved until depression is more conceptually demarcated.

Considering the above complications surrounding the concept of depression within Western cultures, it is therefore, not surprising that the study of depression cross culturally has been plagued with many difficulties and many questions have remained unanswered (Sartorious, 1986). Are the differences in rates of depression reflecting cultural or biological processes? How significant are cross cultural differences in symptomatology? Is depression a disease or a culturally constructed illness? These questions remain central to the cross cultural research on depression. Although answers have been postulated, they have been heavily influenced by the theoretical orientations and methodological focus of the researcher. The findings regarding these issues are discussed again under the rubrics of the transcultural psychiatrists and new cross cultural psychiatrists and their respective frames of reference of symptomatology and meaning.

2.2 TRANSCULTURAL PSYCHIATRY AND DEPRESSION

Kraepelin (1904) in his study in Java concluded that depression was rare in this population of people. He based his observation primarily on a universalist framework and, therefore, the
lack of apparent corresponding depressive symptomatology. Although subsequent research has since acknowledged variation in presentation, primarily concerning the somatic expression of depression, it has still assumed the universality of the disorder category in line with DSM-III and ICD criteria. Consequently, it has ascribed any observed difference to a 'masking effect' of culture. In general, these etic approaches to research, which have involved translated versions of Western standardised questionnaires, or sometimes even the original English versions, have generated a large body of research. Patel (1994) has attributed the dramatic increase in studies of depression in, say Africa, to this, relatively speaking, simple approach to research. Indeed the vast majority of early cross cultural studies on depression fall into this transcultural orientation. These comparative studies, as Marsella et al. (1985) point out, have typically involved epidemiological studies, clinical studies, matched diagnostic group studies, matched sample studies, and international surveys, all of which have their own shortcomings (refer to section 2.3).

Following these approaches, epidemiological studies have generally found the prevalence and incidence figures of depression to vary from culture to culture (Murphy & Leighton, 1965; Silverman, 1968; Carstairs & Kapoor, 1976; Shah et al., 1980; Engelsman, 1980; Murphy, 1982; Singer, 1975). The clinical picture has also suggested some further variance, however, of symptomatology. Many of these studies have reported the dominance of somatic aspects of depression and the reduced frequency of psychological aspects (Sethi & Gupta, 1970; Wraziri, 1973; Rao, 1973), in addition to rarity of attempted suicide (Sartorious, 1986; Farberow, 1980; Rao, 1978; Kiev, 1972) and guilt feelings (Sethi, 1986). Marsella et al. (1985) have concluded that cross cultural reviews of depression have found guilt, suicide, self depreciation and despair to be rare or absent in non-Western societies; but, somatic, sleep disturbances, changes in appetite, energy and body sensations have been found to be more common. In spite some of the differences in cross cultural symptomatology in non-Western cultures, the transcultural psychiatric approach has tended to conclude that there are no, or few, cross cultural differences in depression (Singer, 1975; O’ Daniels, 1988), and where they do exist there are more similarities than differences (Sartorious et al., 1983). The tenets of this body of research, however, have recently been widely criticised.
Weiss et al. (1986) have argued that the assumption that depression is a universal disease irrespective of symptomatology, has resulted in clinicians paradoxically diagnosing depression even when the central cognitive features of the illness are absent and outweighed by somatic presentation. Patel (1994) similarly has underlined the tautological nature of universality assumptions. He argues that universalists by eliminating the need to establish category validity also assume the universality of symptoms that serve as the criteria for diagnoses. Kleinman (1977), contended that the approach of the transcultural psychiatrists has inevitably missed or understated any cultural differences in depression. By the very virtue of their assumptions and approach to research, which focuses primarily on symptomatology. He stresses that the issue of validity is first and foremost central to cross cultural research in depression and is inextricably linked with etiology and symptomatology of the disorder.

2.3 NEW CROSS CULTURAL PSYCHIATRY AND DEPRESSION
Kleinman in his paper on 'Depression, Somatisation and The New Cross Cultural Psychiatry' (1977) proposed that culture shapes the very way we conceive illness and provides the context to disorders like depression. In criticising the transcultural psychiatric approach to research, and in advocating a more emic approach, he made the distinction between illness and disease (refer to Chapter 1). He argued that it is the illness aspect of depression, which the transcultural psychiatrists systematically bypassed. Yet it is in this very aspect, he suggested, that cultural differences would be observed and which would then impact on the conceptual cross cultural validity of the category. This argument, propelled a relatively newer body of ethnographic research, which began to focus on depression as an illness and did not assume its validity as a disease. Most of this research has viewed depression as a cultural construction and through its phenomenological approach has consequently uncovered cultural variations in depression - as a mood, a symptom and disorder.

The quintessential mood element of depression is dysphoria or sadness, which Kleinman (1985) argues, has different meanings and expressions in different societies. The work of
Obeyesekere (1985) on Sinhala Buddhists in Sri Lanka, and the work of Good and Good (1985) on Shi'ite Muslims in Iran, has suggested that dysphoria has a differential meaning in these contexts in comparison to the West. Obeyesekere argued that the generalisation of hopelessness, which is valued and not pathologised in Buddhist cultures; where pleasure from worldly things is considered the basis of all suffering and wilful dysphoria is considered a step towards salvation. Along similar lines, Good and Good (1985) have argued that the association of grief with religious experiences in Shi'ism has led to an appreciation of the individual who can experience grief or dysphoria. In this cultural context, the above are considered markers of a person's depth.

The symptomatic element of depression, as already discussed to some extent, has been found to vary greatly across cultures. Besides somatisation and the under representation of psychological aspects, such as suicide and guilt feelings - depression has also been cross culturally associated with specific bodily complaints. For example, as the sensation of ants crawling in parts of the brain in Nigerians (Ebigbo, 1982), and a sensation of the heart being squeezed in Chinese (Kleinman, 1985), or distressed in Iranians (Good & Good, 1977).

In conjunction, Kleinman (1985) argues that these differences in depressive mood and symptoms across cultures, which serve as criteria for depression, cast aspersions on the very validity of the disorder category and make it difficult to establish whether the illness being studied is the same. Indeed, Schieffelin (1985) and Lutz (1985) have suggested that the very syndrome and structure of depression is related to implicit theories of emotion and personhood. In other words depression is related to the particular cultural structure of the emotional system in which it appears. Therefore, as Lutz (1985) clarifies, whilst how we feel in physiological terms doesn't vary across cultures, what we feel and whether or not we feel 'depressed' is psychologically constructed and may vary cross culturally. To illustrate this subtlety, Schieffelin juxtaposes the emotions of anger and grief in the emotional system of the Kaluli in Papua New Guinea, with depression. Similarly, Carr and Vitaliano (1985) juxtapose
depression and ‘amok’ in Malay culture and argue that they are both culture bound syndromes in the sense they mark a range of possible distress responses to stressful life situations.

This body of research seems to suggest that dysphoric affect is interpreted and socially organised in different ways in many societies and that depression, therefore is a culturally distinct form. This appears to be justified by the observation that other cultures classify depression in different ways, as described in Littlewood’s (1985) study on Tabanka in Trinidad. Indeed some cultures have been reported to have no equivalent term for depression at all (Marsella et al., 1979). These observations inevitably raise questions regarding on what grounds the presence of depression can be assumed in cultures that do not have a name for it (Schiefellin, 1985). Even if the term depression is familiar within a culture Kleinman (1985) questions the extent to which differences in cultural meanings significantly alter the experience of depressed mood and the symptoms of depressive illness. This then raises questions such as, does the somatic experience of depression which has been described in many cultures differ to a psychological experience of depression? Marsella (1980) seems to suggest this may be the case, in his argument that when a psychological dimension such as guilt or self depreciations is added to somatic symptomatology, it exacerbates the cause and outcome of depression. Is depression thus one disorder with several guises or several different disorders with a single name (Schiefelin, 1985)?

2.4 DEPRESSION IN ETHNIC MINORITIES

Whilst more phenomenological descriptions of depression, which address the issue of validity are being produced by the new cross cultural psychiatric approach, they are conspicuously low in comparability component and reliability. Even Kleinman (1977) acknowledges the current lack of systematic cross cultural comparison of depression. This comparative component, whether a positive exercise or a negative one, is fundamental to drawing any conclusions from research and facilitating any pragmatic change in mental health services when it comes to ethnic minority groups. Within Britain, in terms of hospital admission rates,
diagnosed depression is less frequent in West Indian and South Asian minorities (Burke, 1980; Cochrane, 1977). Earlier, this kind of finding was interpreted as suggesting that these minority groups, simply, did not suffer depression. Which Littlewood and Lipsedge (1982) have connected to the implicitly racist assumptions that Africans and Asians were incapable of examining their feelings and psychologising: these afflictions being considered the province of the sensitive and the intellectually aware. Research has since showed, however, that this does not reflect the actual occurrence of depression in the community (Cochrane & Stopes-Roe, 1977; Fenton & Sadiq, 1993). Prince (1968) has argued that black people do get depressed and that with better hospital facilities and less racism they are more likely to seek medical advice and not rely solely on their communities.

In spite of this contradictory and controversial picture, very few comprehensive studies have been conducted on depression in ethnic minorities in Britain. In part, this painfully slow progress has been due to the lack of a suitable approach that, on the one hand, does not impose a Western concept of depression on ethnic minorities and still produces meaningful results. Whilst on the other hand, produces results that are meaningful to a wider medical system, often preoccupied with an empirical approach. Clearly, this requires a combined approach to research and the demarcation of a common ground. Patel (1994), in his review of cross cultural studies on depression, has suggested that an ideal culturally valid assessment method for depression would involve a qualitative starting point. In turn this would elicit the lexicon of idioms of distress and concepts of mental illness from patients, carers, and healers from the culture under investigation, independent of a unified framework (Kleinman, 1977), or in other words, the assumption of a disorder category or structure. Based on this information, Patel then (1994) suggests conducting unstructured and semi-structured interviews to enable an elicitation of emic phenomenology using an etic standardised approach. The symptom profiles thus elicited he argues, can shed light on the presentation of common mental disorders in the community, and can be used to develop a screening instrument, which after validation can be used in epidemiological studies. Such an approach of course involves a somewhat lengthy and complex process, which few studies have
embarked upon. One example of such an endeavour is the Explanatory Models Interview Catalogue (EMIC) designed by Weiss et al. (1996). This aims to provide a standardised approach to the elicitation of explanatory models across cultures. The development of more indigenous screening instruments also offers further opportunities for this kind of meaningful comparative research, which has started to accompany the spread of the psychiatry discipline across the globe, although admittedly rather slowly.

In conclusion, the cross cultural study of depression has been plagued with many difficulties. In a large part this has been due to the nature of the construct and its very close placement to the centre of the biological / sociological spectrum of mental illness. Geerston (1980), has also attested to the somewhat confused construct of depression, which he argues, remains an inaccurate and often conflicting diagnosis with no agreed etiology, despite progress in pharmotherapy and psychotherapy. The contradictory cross cultural findings regarding depression are not surprising given this lack of clarity of the notion of depression, even within the cultural context from which it has arisen. Snaith (1993) has claimed that the measurement of depression in developing countries has often been as confused as the construct itself. The cross cultural study of depression, however, has had and continues to have much to contribute to the understanding of emotional distress in all cultures as well as the broader development of the psychiatry discipline. The questions generated by cross cultural studies have resulted in a fundamental questioning of the aetiology and expression of depression, in fact, the actual clarity of the concept. To therefore produce the kind of valid and reliable findings required to advance this debate it has been argued that a combined qualitative and quantitative approach needs to be pursued. By using a combined approach, which supports one another, we can move away from the basic issues of methodology and progress towards some practically useful findings.
CONCEPTUALISATION OF MENTAL DISTRESS AMONGST PAKISTANIS
AIMS AND PROCEDURE

During the past thirty years, studies on the mental health of South Asian minorities, compared with the indigenous British population⁹, have produced a rather confusing picture. Earlier studies, which predominantly focused on mental hospital admission rates, generally suggested a higher incidence of psychiatric morbidity in all minority groups (Hashmi, 1968; Bagley, 1969; Pinto, 1974). These studies, however, were open to major criticism for through focus on hospital admission rates without recourse to demographic differences in populations. For example, they did not address such factors as: sex ratios, age structure, social class, which are widely known to be associated with mental illness rates. Furthermore, these studies only focused on particular regions of the country, which arguably have different settlement patterns of minority groups and socioeconomic profiles. Indeed, limitation of this research is evident in its lack of delineation between minority groups, let alone within the blanket term of 'Asians'.

Cochrane (1977) and Cochrane and Bal (1989) have provided more reliable statistics since then in their nationwide surveys on mental hospital admission rates in England and Wales, based on 1971 and 1981 censuses. These studies, whilst providing more accurate age and sex standardised data; also attested to the total higher rates of admissions in minority groups. Further analysis, however, revealed the more complex nature of the picture. Cochrane (1977) found that Asians, compared with the Irish and Afro-Caribbeans, had markedly less differential rates to the indigenous population. Further subdivision of 'Asians', by Hitch

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⁹ Most of this research on the mental health of ethnic minorities has been comparative, therefore, when rates are talked about in terms of 'higher' and 'lower' it is relative to the indigenous British population.
For example, whilst Hitch's study in Bradford found higher admission rates in Pakistanis and lower rates in Indians, Giggs study in Nottingham found higher rates in Indians and lower in Pakistanis. In terms of diagnoses, Cochrane found that Asians in line with Afro-Caribbeans, had higher rates of psychosis than the indigenous population, but surprisingly lower rates of neuroses. The paradox of the higher rates of chronic disorders, yet lower rates of acute disorders in minority groups, in addition to regional differences observed by Hitch and Giggs, clearly suggested that something was contradictory. The very use of hospital admission rates as 'absolute' indices of psychiatric morbidity (as argued in Chapter 1) are to some extent responsible for this unsatisfactory account (Bhat et al., 1988). Cochrane (1981) has also affirmed that hospital admission statistics conceal more than they reveal. In doing so, he turned his attention to smaller scale community studies to help clarify the picture.

Despite several such community studies the current picture remains equivocal. Some studies suggest that South Asians are indeed more psychologically healthy than the indigenous British population (Cochrane & Stopes-Roe, 1981; Ineichen, 1990), and others suggest that the 'apparent health' of Asians is a myth and a reflection of a system that is failing minority groups (Beliappa, 1991; Fenton & Sadiq, 1993; Bowes & Domokos, 1993). The need to address this issue, however, is made all the more urgent by the recent reports of alarmingly high suicide rates in Asian women (Raleigh, 1990; 1996). This Chapter then, in an attempt to review the current literature and set a context to this research considers the findings of quantitative (empirical) and qualitative (interpretive) studies on / or relevant to depression in South Asians in more detail.

3.1 NEUROSES AND DEPRESSION IN SOUTH ASIANS

Studies on hospital admission rates for neuroses have been somewhat contradictory. Whilst Cochrane's studies found lower national rates of neuroses in Indians and Pakistanis (see above), Carpenter and Brockington (1980) found higher rates of neuroses in Manchester.
Carpenter and Brockington's findings, however, directly contrast London's (1986) who, in the same city, found no significant difference in rates of depressive neuroses. Dean et al. (1981) in a study in South East England, on the other hand, found the picture to be more varied, with higher rates in Indians and lower rates in Pakistanis. The inconclusive and inconsistent nature of these findings, besides the possibility of differential hospital service use by Asians, made it clear that hospital admission rates were not an accurate reflection of the incidence of neuroses in these populations. Attention, consequently, shifted to the community level.

Cochrane and Stopes-Roe (1981) in a follow-up study to hospital admission rates - conducted a large national community survey of mental health and related adjustment indices of South Asians. They found that Indians and to a lesser extent Pakistanis, experienced substantially fewer mental health problems than the indigenous British. They attributed these findings to positive selective migration and the supportive extended family structure in these communities (Cochrane & Stopes-Roe, 1981). The differences, they attributed, between Indians and Pakistanis was ascribed to the inflexibility of Islam, in comparison to Hinduism. Both religions, however, comparative to a British secular society, appeared to provide a buffering effect against neuroses. The findings of Glover (1990) in Newham, East London seem to support the differences in rates of mental illness as a function of Hindu and Islamic religions. Glover found psychiatric hospital admission rates of 332 per 100,000 in Muslims, in comparison to 215 per 100,000 in Hindus. These differences, in what appear to be religious terms, may although have been more a reflection of socioeconomic status. Indeed Cochrane and Stopes-Roe (1981) acknowledged in their argument that Pakistanis (Muslims) compared with Indians (Hindus) have remained in the same low status occupations as when they entered Britain, and have largely shown little upward mobility.

These findings of Cochrane and Stopes-Roe would thus seem to suggest that Asians due to several intervening factors are less prone to suffer mental disorders like depression. The

10Whilst some studies have addressed neuroses in general, other studies have more specifically addressed depression.
unequivocalness of this postulation has been challenged by another body of research, which has suggested that the issue of neuroses in Asians is a more complicated one. This body of research insinuates that much of neuroses, due to differential presentation, goes undetected in British Asians. For example, Rack (1982) suggested that British Asians are unlikely to exclusively bring psychological problems to health practitioners. He argued that psychological symptoms in Asians were considered largely the province of helpful relatives or other non medical sources. It has been suggested by several researchers, that the lack of psychological presentation to general practitioners (GPs) is compensated by more somatic presentation. Wilson and MacCarthy (1994) found that whilst there were no differences in Asian and indigenous British samples' psychiatric morbidity, as measured by the Self Rating Questionnaire, there were differences in their presentation to GPs. On the one hand, Asians were more likely to report that they were consulting their GP about physical problems. Whilst, and, on the other hand GPs were less likely to identify psychiatric morbidity in Asian patients. This finding is also supported by similar earlier findings of Bal (1987). Together such findings have precipitated the notion of 'somatisation' in Asians, and the poor understanding of psychological causation in Asians (Henley, 1979). They have also lent further credence to the possibility of low levels of detection of psychological disorder by GPs in Asians (Brewin, 1980; Shaik, 1985; Bal, 1987; Wilson & MacCarthy, 1994). Indeed poor detection by GPs may explain why Asians more frequently consult their GP than indigenous British people (Blackmore, 1983; Murray & Williams, 1986; Gillam et al., 1989; Balarajan et al., 1989). Interestingly, when the figures were further analysed, Balarajan et al.'s study found that the high rates of consultation no longer applied in relation to mental illness alone. Together, then, these findings seem to support Bal's (1987) suggestion that GPs find it difficult to recognise psychiatric disorders, perhaps because of predominance of somatic presentation.

Other researchers, however, suggest that this lack of recognition is not the sole responsibility of the health practitioner. Rather, Asian cultures, due to the shame of being associated with mental illness may refrain from bringing mental illness into the open and under the scrutiny
of health services (Rack, 1982). Henley (1979) and Schofield (1987) support this possibility that Asians are more likely to manage mental illness within the family and delay seeking help until the condition is in advanced stage. Indeed Cartwright and Anderson (1981) suggest that even if GP's do recognise symptoms of psychological disorder they may think that it is inappropriate to treat or refer Asian patients to psychiatric services. GP's, therefore, may themselves tacitly or overtly discourage Asian patients from attending to such problems. Ineichen (1990) ascribes this presupposition to the very notion that Asians prefer to manage mental illness in the family.

Whether a consequence of GPs biases or under detection, or Asian patients not wanting medical assistance for mental health problems, the one clear fact is that Asians are less likely to be referred to specialist services (Fernando, 1995). Yet they are more likely to be prescribed drugs by a GP after consultation (Gill et al., 1995). In cases where minorities are referred for further treatment, Littlewood and Cross's study (1980) found that they were more likely to receive physical treatments, like tranquilizers and ECT (electro convulsive therapy) than their British counterparts. Stern et al. (1990) also found that when Bengali children were referred to psychiatric services in East London they represented a narrower range of problems than English children.

From the review of the above results it appears that the more plausible hypothesis for the 'apparently' low level of neuroses in Asians is attributable to the GPs low levels of detection and a lack of health service provision that is aware of their needs. Webb's (1981) finding of the success of a telephone advice service for ethnic minorities, would also seem to support this hypothesis and suggest that, when services are appropriate then Asians do use them. In fact, Webb (1981) noted that many requests that came into the advice service were from women who were in severe life crises. This finding, in addition to the widely reported finding of inhibited contact of Asian women with GP's (Murray & William, 1986; Gillam et al., 1989 and Balarajan et al., 1989), seem to suggest a particular mental health need in this subgroup, which is currently not being met. The recent findings of high suicide rates in young Asian
women suggests the urgency of this need to be addressed (Raleigh, 1996). Although the findings regarding high suicide rates have not been as inflated in Pakistani Muslim women (Raleigh, 1996), other more qualitative studies have also attested to an unmet need. Beliappa (1991), in an interview study commissioned by the Confederation of Indian Organisations on the mental health needs of Asians, challenged many previous findings and beliefs held about Asians 'mental health'. Beliappa (1991) argued against the notions that Asians have few mental health problems: that they do not recognise the link between physical and psychological problems and have strong familial and community ties. Similarly, Fenton and Sadiq (1993) in a study commissioned by the Commission for Racial Equality (CARE) further challenged the 'myths' that Asians do not suffer from depression and that 'they look after their own'. They conducted extensive interviews with six, Asian women in Bristol, four of which were Muslim, about their depression. The women in this study frequently called this depression 'soochne ke bimaari' / 'thought sickness'. Fenton and Sadiq similarly concluded that health services were failing ethnic minorities in Britain. Furthermore, Bowes & Domokos (1993) study on concepts of health in Pakistani women in Glasgow, again using an interview method, found that these women were not receiving their full health care entitlement. They concluded that this was due more to the features of the health care system rather than 'Asian culture'. Finally Currer's (1986) study on Pathan women in Britain concluded, slightly counter in emphasis to Bowes and Domokos, that the concepts of health and illness in Pathan women were at variance with the British biomedical system. She argued that dominant British cultural notions of individual separateness did not apply in the same way to these women. Moreover, their illness behaviour and health concepts could only be understood in their own terms. For example, by making recourse to their cultural beliefs, their structural position within Pathan migrant society and as immigrants within wider British society. Concerning these issues, she further questioned the appropriateness of the methodology in this kind of research, especially regarding the use of psychological screening tests. Qualitative

11 The accuracy of this data on suicide rates has, however, been open to debate.
studies, however, are also on the other hand open to criticisms for their small sample sizes and lack of representativeness. In general, from this review of studies it can be seen that whilst quantitative approaches tended to conclude differential rates, qualitative studies tended to conclude a more complex picture (this issue of methodology is further discussed in section 3.2).

In brief, a good argument can be made for the inaccuracy of the low levels of neuroses detected in Asians; as measured by hospital admission rates. Rather, it seems that the low level of diagnosis of neuroses in Asians are attributable to several factors. These, on the one hand, include the culturally mediated effects of presentation and health beliefs in Asians and, on the other hand, include the low levels of detection by health practitioners, due to unawareness or stereotyping of Asians mental health needs. There is therefore, a need to develop an understanding of the way in which wider cultural beliefs shape presentation and illness behaviour of Asians. such an understanding is vital if we are to attempt to achieve effective changes in Asian patient and practitioner communication, as well as develop large scale integral changes in the health service, to recognise and provide for the needs of minority groups. The first hurdle, however, in this endeavour, which none of these studies incidentally (apart from Fenton and Sadiq to some extent) attempted, is to establish the validity of the current construct of depression in British Asians. This, in itself, may shed invaluable light on whether neurosis and what kind of neuroses exist in Asians. Central to the issue of validity of disorder categories (as argued in Chapter 1 and 2) is methodology.

3.2 METHODOLOGY AND APPROACH TO RESEARCH

Previous studies, adopting a more etic perspective have measured psychiatric morbidity in terms of hospital admission rates or screening instruments. The screening instruments used in British Asian populations have included, the Self Rating Questionnaire (Wilson & McCarthy, 1994), Langner-22 (Cochrane & Stopes-Roe, 1981; Bal, 1987), and the General Health Questionnaire (Currer, 1986; Krause et al., 1990). The construct validity of these
questionnaires has, however, not been a major concern of most of this research; Currer (1986) and Krause et al. (1990) although do take some issue with it and caution against drawing definitive conclusions on the basis of these empirical results alone. Any conclusions of disorder categories, therefore, drawn from these studies are open to a 'category fallacy' (Kleinman, 1977) of sorts, until construct validity can be demonstrated. Indeed such instruments also do little to advance the issue of recognition of neurosis by health practitioners. Whilst they may indicate what pre-defined symptoms minorities respond to, or do not respond to, they do little to excavate cultural idioms or expressions of distress. In other words, they are prone to a centicultural bias (Wober, 1969).

Despite the various findings that have suggested poor communication between Asian patient and health practitioners, few attempts, apart from the work of Currer (1986) Krause (1989) and Fenton & Sadiq (1993) have been made to research the differences in British and Asian cultural beliefs about causes of neuroses. Clearly, this would also explicate the issue of presentation. Bal (1987), in his research, which in some ways instigated the 'somatisation' notion in British Asians, has briefly speculated on this. Recognising that culturally appropriate expressions of distress involve symptoms that have symbolic meaning within a given cultural context, he asserted the need for clinicians to elicit the patients' ethno-cultural ideas or explanatory models about illness for effective treatment. This to a large extent has gone unaddressed.

The aim of this research, therefore, was to address the uncertain rates of depression in British Pakistanis, through an investigation of presentation and explanatory models of depression in this minority group. In doing so, it was also essential to address the central issue of methodology in this field. Having argued for the demarcation of a common ground in Chapter 1, and for a more integrated systematic approach to research on depression in Chapter 2, this research takes a combined quantitative and qualitative approach. This approach was further justified by the acknowledgment that the mental distress of British
Pakistanis, in practical terms resides in the context of a wider British biomedical system. To produce any meaningful results in this context requires an integrated approach, which portrays British Pakistanis' experience of distress / depression and yet speaks to the wider system. By thus using an empirical and interpretive methodology, both the symptomatic and meaning centred frames of reference are addressed. In addition, the extent of assimilation to British medical beliefs and the retention of indigenous Pakistani medical beliefs was ascertained through the juxtaposition of the British Pakistani sample with an indigenous British sample and an indigenous Pakistani sample.

Addressing the issue of conceptual validity of 'depression' was integral before conducting any research. Whilst some British Pakistanis are familiar with the term, others may not be. Even in those British Pakistanis that use the term, a conceptual equivalence to the Western notion of depression could not be assumed. Given that the validity of the concept of depression has not been unequivocally established in British Pakistanis a more universal starting point was necessitated. Taking the lead from Fabrega (1992) and Gellner's (1982) arguments on human universals (as discussed in Chapter 1), a premise of 'distress' was decided upon. Distress, it was reasoned, could arguably be called a universal phenomena, of which depression is but one (Western defined) response. Carr and Vitaliano (1985), in drawing a parallel between amok in Malay culture and depression, also argued that both concepts are two of a range of possible distress responses that people to averse life events. Consequently, this research, only utilised the term depression if respondents identified it of their own volition. Regarding terminology, then, throughout this thesis the words 'distress / depression' are used synonymously; as no assumptions were drawn about the meaning of depression to British Pakistanis until the conclusion of the research.

In line with the recommendations of Kleinman (1977) and Patel (1994), a qualitative pilot phase of open-ended interviews were conducted with twenty, first generation British
Pakistanis living in North London. These interviews on average lasted two hours and were tape recorded. They centred around the informants experiences on having migrated to this country. Any conversations around distress were picked up on and listened to carefully for phenomenological description. Twelve out of twenty informants during these conversations and their descriptions of distress used the word 'depression' of their own accord. These particular phenomenological descriptions were listened to again and content analysed. Based on these actual phrases the respondent used, a vignette was constructed describing a man / woman suffering depression. At no point did the vignette explicitly use the term 'depression'.

This vignette formed the beginning of the 'Pakistani Explanatory Models Schedule' [refer to appendix 3.8], which was constructed in Urdu to help elicit detailed British Pakistanis explanatory models of distress / depression. The schedule followed Kleinman, Eisenberg and Good's (1978) explanatory model framework but was guided by a theme list based on these particular open-ended interviews. In following this procedure, care was taken that a conceptual structure and diagnostic category, was not imposed on the British Pakistani informants explanatory models. Prompts were also incorporated into the schedule to avoid the assumption that the mentioning of particular descriptions by respondents precluded others. This schedule was used together with other etic instruments measuring symptomatology and explanatory models.

The symptomatic paradigm was addressed through a Western standardised instrument - the General Health Questionnaire (GHQ) [refer to appendix 3.1]. The GHQ has been widely used to measure psychiatric morbidity and depression in cross cultural community studies and its validity has been the subject of much debate and investigation. Furthermore, it has been used with some success in Asians samples in Britain (Cochrane, 1977; Currer, 1986 and Krause et al, 1990). It was, therefore, deemed a more 'adequate' instrument, out of a whole

12 First generation British Pakistanis were chosen for the purposes of this research, as the influence of Pakistani culture would be expected to be greater in this generation, in comparison to second generation.
range, for the detection of distress or depression in British Pakistanis.\(^{13}\)

Juxtaposed to the GHQ, a screening instrument indigenous to Pakistan was used to address the issue of centicultural bias. The Aga Khan University Anxiety and Depression Scale (AKUADS) (Ali et al., 1993) [see appendix 3.4] was designed to detect depression and anxiety in community and clinical samples. The AKUADS recent development provided a rare opportunity to reverse the translational process from a non-Western cultural context to a Western cultural context.

The explanatory model paradigm was addressed through both empirical and interpretive approaches. Empirically it was addressed using the Mental Distress Explanatory Models Questionnaire (MDEMQ) (Eisenbruch, 1990) [see appendix 3.5]. The MDEMQ is a multicultural instrument designed to elicit a range of Western and non-Western, personalistic and naturalistic causes of mental distress in community samples.

Using an interpretive approach, more detailed explanatory models were elicited through the Pakistani Explanatory Models Schedule (the construction of which is described above).

All four of the instruments were subjected to a translation and back translation procedure before Urdu versions could be used in the Pakistani samples and English versions could be used with the British sample. The GHQ and MDEMQ were translated into Urdu, by a first generation Urdu speaker proficient in English. They were then back translated into English and the differences between the two versions were assessed and negotiated before drafting a final version. The AKUADS and The Pakistani Explanatory Models Schedule were subjected to the same translation and back translation procedure before drafting a final English version. (Specific translation problems in each instrument are described in more detail

\(^{13}\) Other instruments that were considered were the BDI and Zung Depression inventory. These were not chosen for the purposes of this study, as they focused heavily on psychological symptoms alone.
in the relevant chapters. [Refer to: appendix 3.2 for an Urdu translation of the GHQ, appendix 3.3 for an English translation of the AKUADS, appendix 3.6 for an Urdu translation of the MDEMQ and 3.7 for an English translation of the Pakistani Explanatory Models Schedule]. Respondents were also administered a short demographic questionnaire [refer to appendix 3.9] to elicit socio-demographic information.

3.3 SAMPLING FRAME

In order to investigate the role of culture in presentation and explanatory models of distress / depression, this study focused on three samples, indigenous Pakistanis, first generation British Pakistanis and an indigenous British sample. The factors of sex and socio-economic status were also taken into account. Each cultural sample consisted of one hundred and twenty respondents, including sixty males and sixty females. Thirty of each sex group were from a middle class background and thirty from a working class background. The age range of the sample spanned between 25 and 60 years, and every effort was made to obtain a representative sample of age's within this range.¹⁴

The determination and cross cultural matching of socio-economic status (SES), age and education was particularly difficult in these three sample. The difficulties encountered in this highlight the kinds of paradoxes that cross cultural research has to contend with. Within the British Pakistani and British samples SES was determined largely according to occupation. In the indigenous Pakistani sample assessment of SES could not be made on the basis of occupation alone. This was because the meaning of 'occupation' or 'employment' in Pakistan is dissimilar from that in Britain. In Pakistan it is not uncommon for both middle class and working class men to be employed, as well as hold interest in a family business. These family

¹⁴ The range of 25-60 was pre chosen, in a sense, by the decision to focus this study on first generation British Pakistanis. First generation either tend to be those that arrived in the 1960's and 1970's or those that more recently have arrived through marriage to second generation British Pakistanis.
businesses can range from large export companies to street vending. Consequently, lack of employment or a low income job are not always an absolute indicator of greater poverty. Furthermore many families reside together within the joint family network, which may comprise of several breadwinners. Most of all, it has to be remembered that, what would be termed as 'working class' in Pakistan is not comparable to the standard of living in the British working class. Comparatively working class Pakistanis are living in adjunct poverty. SES, for the purposes of this study, was thus decided on the basis of an assessment of the area of residence of the respondents and the apparent standard of living of the respondents.

In a similar way age and education were also difficult to translate across cultural divides. Example of this are, the fact that in Pakistan the average age of marriage is considerably lower (especially in women) than in Britain, and life expectancy is also substantially lower. In terms of education, there is no practised compulsory state education policy, which is evident in the high rates of illiteracy. Bearing in mind these high rates of illiteracy, it was decided to adopt an interviewer administration procedure in this study for both Pakistanis and British Pakistanis.

A brief description of each of the sample and how they were recruited for the study is given below. The recruiting procedures for all three sample varied according to the context.

3.3.1 British Pakistanis

The British Pakistani sample was the main focus of this research, and therefore their background and current situation needs to given more detailed consideration. Migration of the Pakistani community began in the 1950's and early 60's, in response to Britain's search for cheap labour. Most of these early migrants were men of small or middle peasant background, and were primarily economic motivated migrants. They arrived on the basis of what has been frequently described as a 'chain migration' (Anwar, 1979). One result of this has been that Pakistanis have formed small tight knit communities in particular cities on the basis of commonalities of religion, area of origin, 'biradri' and kinship (Ballard, 1982).
Although many of the early migrants intended to return to Pakistan, they have since become permanent settlers. The gradual process of settlement essentially began with the arrival of women and children in the early 1960's. This rush of entry came with the passing of the Commonwealth Immigration Act, which imposed tighter controls on immigration. A recent estimate of the size of the Pakistani community in Britain, according to the 1991 census, was 449,646, that is, 3.04% of the population (Ballard, 1994). Some forty years later, Shaw (1994) argues, the 'myth of return' (Anwar, 1979) that many Pakistanis held, has almost ceased to be a central feature of their perceptions and ideologies.

The process of settlement has, however, been some-what counter to the expectations of assimilation held by British society. Pakistanis have to a large extent begun to assert their cultural identity. As Ballard (1994) suggests British Pakistanis, like many other of the new minorities, have been strongly committed to cultural and religious reconstruction. They have, over a number of generations now, continued to draw inspiration from their own cultural, religious and linguistic traditions. This maintenance of cultural and religious beliefs has led to many Pakistani communities drawing a clear boundary between themselves and their white neighbours, whose values they see as being antithetical to their own.

On the basis of this it should not be assumed that they have not undergone any change. Ballard (1982) describes some of the radical changes that family and family organisation has undergone as a consequence of migration. This has included a change in the structure of the household, with many conjugal households containing only a single married couple, as opposed to an extended network. As a consequence of this many women have gained independence at an earlier age than they would have done in the extended network in Pakistan. Although with this independence has also come greater responsibility and isolation. This has, in turn, has lead to a closer and in some senses a more dependent relationship between husband and wife and children. Such changes have therefore required British Pakistanis to devise adaptive strategies as a means of coping with their new environment. One of these strategies has inevitably had to be that of how to deal with health.
More recent analysis by the policy studies institute (1996) has indicated that Pakistanis since migration have shown relatively less upward mobility than Indians. Pakistanis along with Bangladeshis are found to have jobless rates five times as high as the indigenous 'white' population, and are likely to have considerably lower income rates. In terms of health 35% of Pakistani women and 35% of Pakistani men, aged 45-64, in comparison to 18% and 13% of 'white' females and males respectively reported consulting their General Practitioner in the two weeks before the interview. Both Pakistani men and women thus appear to visit their general health practitioner considerably more frequently than indigenous British people. What is particularly surprising is that only 15% of Pakistan women in the age range of 50-74 and 42% in the age range 30-49 reported the ability to speak English.

The British Pakistani sample used in this study were drawn from the areas of Brent and Harrow in North West London, where they make up 3% of the population. Although they conformed in many ways to the general description above, they did not form the same kind of stereotypical tight knit structure that is evident in areas like Bradford and Slough. This community was somewhat more dispersed in these areas, but still closely connected through the infra-structure of community centres and mosques. Another aspect in which they differed from the larger Pakistani communities was in their ethnic origin. Whilst the larger population of Pakistanis are predominantly from the Mir Pur area of Pakistan, these respondents were from Punjab and Karachi. More specifically they were of the ethnic groups known as Punjabis and Muhajirs.

The respondents in this study were approached primarily through two community centres with the help of community leaders over a period of four months. After initial contact in person or on the telephone, a meeting was arranged in the respondents home.

3.3.2 Pakistanis

The indigenous Pakistani sample used in this study were drawn from the north region of the city of Karachi during a four month field trip. Karachi is the largest cosmopolitan city in
Pakistan, with an accompanying large migrant population. It, in many ways provided a good match to the British Pakistani sample, in terms of its heterogeneity and the fact that it contained large numbers of Punjabi and Muhajir residents. The middle class sub-section of this sample were drawn from the 'middle class' area of Gulshan, and the working class sub-section were drawn from the neighbouring 'working class' katchi abadis - (urban squatter settlements) of Esa Nagri and Sabzi Mandi. Respondents in the Gulshan area were approached through a random door to door strategy, and in the areas of Esa Nagri and Sabzi Mandi the help of two local residents was enlisted for introductions.

3.3.3 British

The British sample used in this study was also drawn from the Brent and Harrow areas of North West London. Some-what ironically, of the three samples, they posed the greatest difficulty in accessing. This was due to a number of reasons. Firstly, there was the problem of identifying 'indigenous British' respondents, as a large sector of the 'white' population is not indigenous. Secondly, they were difficult to recruit using the same strategies as adopted in the British Pakistani and Pakistani samples. This was because on the one hand there was a lack of representative community meetings which did not reflect a particular group interest, and on the other hand a door to door strategy was considered unsafe. As a consequence the British sample were randomly approached through a dentists surgery and asked to self administer the questionnaires.

3.4 PROCEDURE

Respondents were asked, in Urdu or English, to participate in a study looking at their beliefs about mental distress. Out of a total of three hundred and seventy eight people approached twelve people (3%) declined, and a further six (1.5%) had to be discluded because of incompletion. The GHQ, AKUADS, MDEMQ and a demographic questionnaire were administered to all the respondents. The order of administration was such that, the GHQ was followed by the MDEMQ, the demographic questionnaire and finally the AKUADS, or vice
versa. This was done to avoid an ordering effect, as it may be argued that the GHQ and AKUADS measure the same construct. Responses to one may, therefore, have effected responses to the other, had this not been pre-empted. This procedure on average lasted 30-45 minutes. Half of the Pakistani and British Pakistani samples were asked to further participate in a more detailed interview - The Pakistani Explanatory Models Schedule, the administration of which lasted on average an hour. This part of the research was tape recorded with the respondents permission. The total time to conduct the study in this part of the sample to approximately two hours. Throughout the procedure respondents were invited to ask any questions or offer any comments.

In the case of the British sample, respondents were asked to self administer the questionnaires. Self administration took considerably less time than interviewer administration, although this was probably also due to the British sample being more familiar with filling in questionnaires. The confounding effects of self administration as opposed to interviewer administration was controlled for by conducting a small pilot study, in which the results of an self administered sample were compared with the results of an interviewer administered sample. No significant difference in results was found.

The results of the questionnaire studies were subjected to a statistical analyses and are reported in Part II of the thesis. The interview study was subjected to an ethnographic content analysis and is described in Part III of the thesis.
CHAPTER 4

THE GENERAL HEALTH QUESTIONNAIRE - GHQ

4.1 INTRODUCTION

The General Health Questionnaire (GHQ) is a relatively well established screening instrument that was developed by D. Goldberg in the 1960s and 70s for the detection of psychiatric morbidity. The developments of the GHQ was stimulated by a shift in psychiatric epidemiological research, from the secondary care level (hospitals) to the primary care level (community) (Williams et al., 1980). This new body of research consistently indicated that a considerable amount of mental morbidity remained undetected or uncommunicated at the primary care level. Goldberg and Blackwell (1970) estimated that as much as one third of total morbidity at the primary care level was undetected. Subsequent, studies looking at reported rates of psychiatric illness found an alarmingly large inter-practitioner variation. In certain instances, these variations were reported to be as high as nine fold (Shepherd et al., 1966). Factors that have been implicated as underlying these variations included: patient presentation factors (Ormel et al., 1991), socio-demographic factors and general practitioner’s attitudes (Shepherd et al., 1966). In an attempt to eradicate these subjective elements more standardised approaches were developed leading to a wide range of screening instruments and standardised interviews, such as the GHQ.

Since then, the validity and utility of psychometric tests to assess pathology in epidemiological or clinical settings, as well as the methodology of self reporting have become the subject of debate. The controversy, needless to say, is further exacerbated when instruments standardised in particular cultures (predominantly Western) are applied cross-culturally (refer to Chapter 1). In spite of these concerns, screening instruments have been used cross culturally to assess pathology in epidemiological studies, some more effectively than others. The GHQ has been particularly widely used in cross cultural studies and the
issue of validation has been of central importance in a number of these studies.

This chapter reviews the development of the GHQ, studies which have addressed its validity and sociodemographic correlates and the growing number of cross cultural studies that it has been employed in. The cross cultural applicability and comparability of the GHQ, and the issues involved in cross cultural translation form Western to non-Western cultural contexts are illustrated and discussed with reference to Pakistani culture in particular.

4.1.1 Construction of the GHQ

The GHQ (Goldberg, 1972) was designed as a self administered screening instrument for the detection of minor psychiatric morbidity, especially anxiety and depressive neurosis. Although it was intended for use in general practice it has been used in a variety of settings, covering hospital, general practice, community and student samples. The GHQ has, thus, been used as both an epidemiological tool and a screening instrument, as well as an index of psychiatric morbidity against which a number of other variables have been correlated. The original version of the GHQ consisted of sixty items looking at psychological distress and change in established behaviour patterns; that is, on each item, subjects are asked to compare their recent state with their usual state. Symptoms which are experienced "more than usual" are considered a sign of pathology. The GHQ, therefore, focuses on breaks in normal functioning rather than lifelong traits.

The construction of the GHQ, like most psychiatric screening instruments, was based on symptoms observed by psychiatrists and clinical researchers. The construction process involved the collation of a large item pool, which, in conjunction with psychiatrists opinions, was used to generate four areas on which the subsequent search focused. These included items to do with: (i) depression and unhappiness (ii) anxiety and felt psychological disturbance (iii) objectively observable behaviour ie. social impairment and social inadequacy and (iv) hypochondriasis ie. superficially organic items. Using these four areas as a template an extensive search was made for appropriate items from a range of pre-existing instruments.
These included: The Cornell Medical Index, The Minesota Multiphasic Personality Inventory, Taylors Manifest Anxiety Scale and Eysenks Maudsley Personality Inventory', as well as, Veroff et al.'s (1962) study on the views of 542 non-hospitalised Americans about aspects of adjustment and "felt distress".

The selected items were subjected to a calibration study, an item analysis and a principal component analysis, before the final 60 item version was drafted. A number of shorter versions of the GHQ have also been drafted from the original 60 item format. Formats in common use include the 30, 28 and 12 item versions, all of which have been subjected to a barrage of validity studies. A range of these results are reviewed below.

4.1.2 Validity and Reliability of the GHQ

Vieweg and Hedland (1983), in one of the most comprehensive and recent reviews\(^\text{15}\) of psychometric properties of the various version of the GHQ, found the internal consistency (an estimate of the reliability of the GHQ) to typically range between 0.78 and 0.95. The index of test-retest estimates, however, were found to be some-what lower at 0.51 and 0.90. The concurrent validity coefficient of the GHQ, which has been based primarily on criterion measures of standardised psychiatric research interviews, such as the PSE (Present State Examination) and CIS (Clinical Interview Schedule), was found to range between 0.55 and 0.83.

The construct validity and content validity, which are central to any cross cultural research, have been demonstrated as a by product through properties inherent in the GHQ and its findings. The construct validity has been assessed by the repeated observation that the GHQ, in addition to detecting more differentiated psychotic and neurotic syndromes, also picks out

\(^{15}\) There have been no recent reviews of the psychometric properties of the GHQ since Vieweg and Hedland's (1983). A current review and validation studies are being conducted by a group in Sheffield, which will be published later in 1997.
patients who have less differentiated levels of psychiatric illness. This is identified by the emergence of a general factor in rotated principle component analysis. In the case of content validity, it has been argued that validity is ensured by the construction of the questionnaire itself; that is the questionnaire having been based on items that through principal component and item analysis have been chosen precisely because of their ability to discriminate between psychiatric patients and normal controls. These lines of argument, it should be pointed out, can only hold true for the cultural population the instrument was constructed in, unless they can be established otherwise. The sensitivity and specificity indices, also crucial to cross cultural work, have been estimated between 42% and 95%, and 68% and 99%, respectively. Finally, as a screening instrument used in conjunction with other similar criterion measures, the GHQ misclassification rates have been found to be relatively low, ranging between 7% - 22%.

Apart from validity indices, Vieweg & Hedland (1983) also reviewed studies looking at the exploratory factor analytic structure of the GHQ. Studies on the GHQ-60 tended to find six to eight factor solutions. The most common factors identified were: depression, sleep disturbance and general somatic illness. In addition, two more variable factors were also identified, which tended to include: social dysfunction and anxiety items. Similar studies on the GHQ-30 have also typically produced depression and sleep disturbance factors. The anxiety and social dysfunction items were once again found to be more factorially complex.

For the purposes of this study, however, the GHQ-28 was of primary interest. The GHQ-28 was developed by Goldberg and Hillier (1979) on the basis of a principal component analysis of the 60 item version. It has been validated by a number of studies (Medina-Mara, 1983; Lobo et al., 1986; Romans-Clarkson et al, 1990), and has been shown to have a relatively stable factor structure across time and a number of samples (Patton & Waring, 1984; Weyer et al., 1986). The GHQ-28 has become popular for research due to its ability to generate four

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16 These normally include cases with a mix of anxiety and depression.
distinct sub-scale measures of somatic, anxiety, social dysfunction and depression symptoms. It, thus, has capacity to identify distinct disorder categories. In particular, it has been found by a number of studies to be a good measure of depressive neurosis (Rand, 1988; Shek, 1991; Clarke et al., 1993), and indeed, in several studies, it has been adopted as the measure of depression (McNabb, 1983; Melville et al., 1985; Clarke et al., 1991). The inference of depressive neurosis, however, on the basis of GHQ scores alone is still open to some debate. Parkes (1982) and Briscoe et al. (1985) have argued that the inference of 'depression' cannot be made from the GHQ without a closer examination of the factor structure. They have further related the extent to which different aspects of psychoneurotic disturbance are differentiated in the factor structure of the GHQ to cognitive style i.e. field dependence / independence.\textsuperscript{17}

4.1.3 Socio-demographic Correlates of the GHQ

Large scale surveys on general populations in the 1970s and 1980s have enabled the effects of major demographic variables on GHQ scores to be examined. Very few large scale surveys have been conducted since then, but a summary of those findings and more recent smaller demographic studies are presented in table 4.1.

In short, studies show that whilst some variables have a consistent relationship with the GHQ (in particular sex) others are more complex, with, for example, the pattern of association varying between men and women. More subtle associations between the GHQ and demographic factors, however may have also been overlooked. It is argued that, when considering risk groups or cross cultural samples, differences may lie not so much in absolute terms and high scores, but rather in the symptom profile of the different groups. Indeed, Huppert and Garcia (1991) have found qualitatively distinct psychiatric symptom patterns in unemployed men, single mothers with young children and elderly people in poor health.

\textsuperscript{17} Field dependence/independence has also been discussed as a potential for investigating individual and group differences in cognitive style across cultures (refer to section 1.5).
These findings of few repeated associations between psychiatric morbidity and demographic variables are, interestingly, not corroborated in the clinical setting. Several studies have indicated that general practitioners hold their own socio-demographic patient stereotypes that alert them to the possibility of psychiatric illness and make them prone to typecasting (Marks et al., 1979; Boardman, 1987).

Table 4.1 Socio-demographic correlates of the GHQ

| SEX - Most studies have indicated higher GHQ rates in women, especially in random community samples as opposed to general practice samples (Finlay-Jones & Burvill, 1977; Williams et al., 1986; Cox et al., 1987). Higher rates in women have been observed in a number of cross cultural studies also (Sicillian et al., 1985; Vasques Barquero et al., 1986). However it has been suggested that the GHQ may be an instrument that is more applicable to women than men (Hobbs et al., 1983). Supporting this argument Tarnopolsky et al (1979) found the rates of misclassification, sensitivity and specificity of the GHQ to be lower in men than women. |
| SOCIO-ECONOMIC STATUS - This has generally not been found to exert a strong effect on the GHQ, although some studies have indicated a greater rate in lower class samples (D'Arcy, 1982). Other related indices, for example: education level or school leaving age may be better correlated with the GHQ (Boardman, 1987). |
| AGE - This has not appeared to exert a strong clear effect on the GHQ. However some studies do indicate a mediating sex effect. For example female GHQ scores have been found to decrease with age, whilst male scores either show no age effect, or rise until middle age and then decrease (D'Arcy, 1982). |
| MARITAL STATUS - Most studies have indicated that individuals who have been married, but are now divorced / widowed from their spouses have higher rates than single or married individuals (Goldberg et al., 1970; Cox et al., 1987; Stansfield, 1991). Finlay-Jones & Burvill (1977) and Williams et al. (1986) on the other hand claimed that the effect of marital status is applicable only to women and not men. Similarly, studies looking at the quality of marital relationships and family support have also reported high correlations between poor marital relationships, lack of support and psychological distress (Patton & Waring, 1984; Ballinger et al., 1985), especially in women (Patton & Waring, 1984; Radhika & Prakash, 1987; Cramer, 1991). |
EMPLOYMENT STATUS - Many studies have demonstrated increased GHQ rates amongst unemployed individuals (Huppert & Garcia, 1991). However Finlay-Jones and Burvill (1977) and Hodiamont et al. (1988) argue that the effect of unemployment is significant for men only and not women, Stansfield (1991).

RACE & CULTURE - Goldberg et al. (1970) reported higher rates in 'blacks' in Philadelphia, compared to 'whites'. Finlay-Jones and Burvill (1977) on the other hand, have reported no significant effect of country of birth on GHQ rates in their sample. Other smaller scale comparative studies, looking at Asian minority groups in Britain, have also tended to report no significant effect of ethnicity on rates of morbidity, (Cochrane et al., 1977; Krause et al., 1990). Distinct demographic profile for these groups, however, have been reported in some studies. Variables including social support / interpersonal relationships, SES, life events, post migratory stressors, acculturation etc., have been found to be more clearly associated with psychiatric morbidity in these samples (Pan & Goldberg, 1990; Cheung & Spears, 1994).

Boardman (1987) found these to include women, middle aged patients, housewives, separated / widowed patients, patients with a minimum education, Irish patients and patients with elderly dependants. Although he has argued that, on the whole the construction of these stereotypes is justified by the actual high prevalence in these groups in the clinical setting, the obverse effect is that these groups become in danger of 'over diagnosis'. This is in contrast to those groups that appear to constitute a negative stereotype, who are conversely in danger of 'under diagnosis'. Sub-populations that have been consistently found to be under diagnosed include males, young age groups, those in full time employment and those of African or Indian origin. Indeed Shapiro et al., (1987) found an increased rate of detection of psychiatric morbidity in 'blacks', men and the elderly by general practitioners when GHQ feedback was used as an interventive measure.

4.1.4 Cross Cultural Studies Using the GHQ

Though the GHQ was not designed to be a cross culturally sensitive instrument, it has been used in many different cultural settings, as well as, (although to a lesser extent) in comparative

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18 This is not to say that there are no unequivocal differences in psychiatric morbidity between different ethnic groups, rather these are results as measured by the GHQ alone.
studies looking at cultural or racial minority groups. In the growing field of international psychiatric epidemiology the GHQ appears to be one of the most popular tools for measuring psychiatric morbidity and depression notwithstanding the issues of validity, normative uncertainty, centicultural bias and translation (discussed in Chapter 1). Chan (1993), similarly argues that psychological tests developed in a specific setting, cultural context and language may suffer problems of generality, psychometric properties, idiomatic expression of the items and interpretation when applied to a different cultural context. Although there is also some evidence to suggest that the GHQ translates well into their languages (Shek, 1993)

In total, the GHQ has now been translated into approximately thirty six languages, and over fifty validation studies have been conducted on it. The majority of studies confirming its validity have, however, been conducted in Western, particularly European, cultural settings (Lobo et al., 1986; Vazques-Barquero et al., 1986; 1988). Studies conducted in non-Western cultures, such as Nigeria (Oduwole & Ogunyemi, 1989) and Brazil (Mari & Williams, 1985) have typically been more cautious on issues concerning validity and the influence of language on translated versions of the GHQ. Whilst Oduwole and Ogunyemi (1989) concluded the GHQ to have high misclassification rates and low sensitivity / specificity in a Nigerian setting, Mari and Williams (1985) concluded the GHQ to be ‘acceptably’ valid for use in Brazil.

The relativist school of thought have claimed that many of the validity studies conducted on the GHQ have themselves been prone to a "category fallacy" (Kleinman, 1977). They have argued that validation of the GHQ against research interviews such as the PSE and CIS, which are also rooted in the same Western cultural framework, has simply produced validity coefficients which are artefact to the methodology adopted, and reflect the assumption of construct universality. Indeed this was the validation method used by Mari and Williams (1985)

Goldberg (1988), however, in his retort to the relativists has argued that at the cross cultural level, at the very least, the GHQ can usefully measure undifferentiated psychological distress,
if not specific aspects of distress. To back his argument, Goldberg cited a study by Kleinman & Kleinman (1985), in which diagnoses based on structured American research interviews were found to significantly match those of indigenous Chinese physicians. Although diagnoses in this study, overlapped more in terms of case identification than actual diagnostic categories it demonstrated, Goldberg argues, that psychological distress at the undifferentiated level has many common features across cultures.

However, even if the GHQ is taken as a measure of generalised psychological distress across cultures, its effectiveness as a screening instrument is still questionable on the basis of centicultural bias. The GHQ by virtue of its design does not take into account cross culturally specific ways of expressing distress. To overcome this limitation, several cross cultural studies have modified the GHQ to include culturally relevant symptoms (Chan, 1985; Ohaeri & Odejide, 1994). In effect, this has frequently involved the inclusion of significantly more somatic items.

The most extensive research on the cross cultural applicability of the GHQ has been conducted in Chinese cultures. Although initial studies using the GHQ in Chinese settings demonstrated its validity and indicated a stable factor structure, recent studies have sought to modify and improve the GHQ for use in this cultural setting. Recent studies, for example, have taken a closer look at the effects of translation and the inclusion of culturally salient items. Chan (1993) validated the GHQ 30 in China against the CIS, and, on the basis of the information generated, added an additional 30 (mainly somatic) items to the GHQ reflecting common expressions of psychiatric morbidity in China. This new sixty item version improved the validity coefficients significantly. Furthermore, in a micro level investigation of the effect of language in a Chinese translated GHQ, Chan (1985) found that although language did not exert an effect at the macro-factor level, it did make a difference at the item level. Resulting

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19 The GHQ was designed to measure the construct of psychiatric / psychological morbidity. Although more recent versions, such as the GHQ 28 claim to detect more distinctive constructs of neurotic disorders, such as depression.

66
modifications have invariably improved the validity, reliability and discriminatory power of the Chinese version of the GHQ.

The GHQ therefore appears to be a potentially useful tool for detecting distress, at least at an undifferentiated level, across cultures. Studies using the GHQ in South Asian populations are discussed in section 4.1.5.

4.1.5 Aim and Hypotheses

In this study the GHQ-28 was used in the context of Pakistani culture, amongst indigenous Pakistanis and first generation British Pakistanis. Although very few studies using the GHQ have been carried out in the Pakistani context, a lead can be taken from studies conducted in India, given that these cultures share heritage and similar languages.

Previous research using the GHQ in India has found the GHQ to be a valid screening instrument (Gautam et al., 1987; Bandyopadhyay et al., 1988). In order to improve validation indices, however, these researchers have recommended the use of higher cut-off scores for identifying cases in this setting. In terms of the effects of language, Sriram et al. (1989), like Chan (1985), found discrepancies between the English and Hindi versions of the GHQ at the item level but not at the structural level. Sriram et al. (1989) concluded that these discrepancies could be ascribed to semantic and technical problems in translating and finding conceptual equivalents for phrases in the GHQ, such as ‘tasks’, ‘out of sorts’, and ‘strung up’. In both the Hindi and Chinese studies, thus, although translation appeared to exert an effect on the GHQ at the item level, these effects did not seem to have repercussions on validity levels.

The only known GHQ study in Pakistan was conducted by Mumford (1989). This study, however, was not concerned primarily with validity issues and did not use an Urdu version of the GHQ. Rather, it administered the English version of the GHQ in conjunction with the Bradford Somatic Inventory to second year Pakistani medical students to ascertain the relationship between somatic symptoms and psychological distress.

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The GHQ has also been used in British Asian migrants (Cochrane et al., 1977; Currer, 1986; Krause et al., 1990). Cochrane et al (1977) using a modified version of the GHQ on a British Asian sample concluded, on the basis of a criteria group method, that the GHQ and the Langner-22 was a valid measure of psychological distress. Interestingly, they found no significant difference in GHQ score between British and Asian respondents. Krause et al. (1990), in a more recent study, compared the GHQ with a devised Punjabi Health Questionnaire (PHQ) in Bedford. They also found little significant difference in British and Punjabi responses. The authors of this study, however, did express some unease about drawing definitive conclusions on Punjabis mental health on the basis of these results alone. They stressed the need to relate the findings to wider Punjabi cultural themes and concepts.

To summarise, on the basis of these studies, the GHQ appears to be a potentially valid instrument for measuring mental distress in Pakistanis. Although the construct issue (that is, whether or not it can detect depression) and the effects of language and translation on the GHQ, do not appear to be as clear cut.

Bearing in mind the previous research, the aim of this GHQ - 28 study was two fold:

I. To investigate the effects of language and translation on the internal structure of an Urdu version of the GHQ. Enabling, thus, an establishment of the degree of congruence between both Urdu and English language versions and the construct they are measuring.

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2 The 28 item version of the GHQ was chosen for this study due to its sub-scale structure. The GHQ-28, through the depression sub-scale, offered an opportunity to investigate whether 'depression' can be measured on the basis of this instrument. It also, through the somatic sub-scale, offered the opportunity to investigating the 'somatisation' notion in Asians (Katon et al. 1982; Bal 1987; Leff 1988; Goldberg & Bridges 1988; Mumford 1989).
II. To measure symptom levels and psychiatric morbidity in the three cultural samples, and
to investigate demographic correlates of morbidity, with particular reference to sex and class
differences, in order to identify vulnerable groups

The GHQ-28 was translated into Urdu and back translated to ensure a valid conceptual
translation, before being administered to: an indigenous Pakistani (P) sample in Karachi, a
sample of British Pakistani (BP) migrants in London and an indigenous British (B) control
sample (who, of course, were administered the original English version).

Hypotheses predicted that:

I. There would be more similarities at the structural level ie. in terms of response styles
between P and first generation BP samples than the B sample (as determined by reliability
statistics, item endorsement patterns and factor analysis), given the strong retention of culture
of origin in BPs (Ballard, 1994). In the case of the British sample, the GHQ structure was
predicted to be in line with Goldberg’s predicated sub-scales.

IIa. There would be differential cultural endorsements and scores at the item and sub-scale
level, due to translational and other socio-cultural factors. This is on the basis of Sriram
(1989) and Chan's (1985) findings.

IIb. P and BP samples would score higher on and endorse more somatic items than the B
sample, on the basis of somatisation findings of Kakar (1982); Rack (1982); Bavington and
Majid (1986); Bal (1987) and Leff (1989).

III. Indigenous Ps would score higher than BPs and B respondents, given the higher rates
found in indigenous Indian samples by Prema (1978) and Bandyopadhyay (1988). The
direction of greater psychiatric morbidity in BPs and B respondents was left open given the
existence of only a small number of inconclusive findings. Studies on mental hospital
admission rates (Cochrane, 1977; Cochrane & Bal, 1989) and community studies (Cochrane & Stopes-Roe, 1977, 1981) have indicated markedly less affective disorders in Asian migrants; whereas anecdotal evidence and smaller studies have suggested that Asian migrants suffer more distress than their British counterparts due to stressful life situations (Rack, 1982; Mahmud, 1987) and low levels of diagnosis of disorders in Asians by health professionals (Brewin, 1980; Shaikh, 1985; Bal, 1987) (refer to Chapter 3). Studies that have used the GHQ in Asian samples have found no significant difference in Asian migrant and British psychiatric morbidity rates (Cochrane & Stopes-Roe, 1977; Murray & Williams, 1986; Krause, 1990).

IV. At the demographic level, women would score higher than men, and working class respondents would score higher than middle class respondents given the evidence of previous GHQ studies (Finlay-Jones & Burvill, 1977; D'Arcy, 1982; Cox et al., 1987).

4.2 METHOD

4.2.1 Sample and Procedure
The sampling frame and procedure of the overall study has been described in detail in Chapter 3.

4.2.2 Translation of the GHQ
The GHQ [appendix 3.1] was translated into Urdu by a proficient Urdu and English speaker. Emphasis was placed on conceptual equivalence rather than literal translation. The translated Urdu version was then subjected to an independent back translation into English. Any differences between the two versions were assessed and negotiated before a final version was drafted [appendix 3.2].

Several problems with translation and interpretation of the Urdu version arose. Colloquial
phrases posed particular difficulty due to a lack of semantic equivalents. Relying on conceptual translation, phrases such as "Been feeling run down and out of sorts" read more as "Do you feel tired and exhausted"; "Found everything getting on top of you" read more as "Have you felt as if everything in life has become a difficulty for you"; "Been feeling nervous and strung up" read more as "Do you stay worried and restless all the time" and "Been satisfied with the way you have carried out your tasks" read more as "Are you satisfied with your usefulness".

The translation of the general term 'things', which recurringly features in the social dysfunction sub-scale, also proved difficult to translate. The appropriate translation was deemed to be 'kam', which re-translates as 'work'. The use of this term was unavoidable in items: 15, 16, 17 and 21.

Conceptual problems, were identified by respondents, in items 21, 22 and 24:

Item 21 - "Been able to enjoy your normal day to day activities" was met with some puzzlement as it involved the term 'kam' / 'work' in translation. Work for many of these respondents was not considered a source of pleasure or enjoyment, but a duty to be carried out. Item 22 - "Been thinking of yourself as a worthless person" in translation involved the term 'nakabil' for 'worthless', which can be re-translated as 'unworthy'. The religious connotations that this evoked led some respondents to take offence. Item 24 - "Felt that life isn't worth living" in re-translation read more as "Have you ever thought, what am I going to do by living". This was frequently mis-interpreted by respondents and many responded with "yes - there were many things to be done".
4.3 RESULTS

4.3.1 Internal Consistency

Alpha coefficients of internal reliability were calculated for each of the three cultural groups; testing the internal consistency of the GHQ sub-scales and the total scale (refer to table 4.2).

Table 4.2  Alpha reliabilities of GHQ sub-scales and total scale for P, BP and B samples

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOM</td>
<td>.87</td>
<td>.85</td>
<td>.76</td>
</tr>
<tr>
<td>ANX</td>
<td>.86</td>
<td>.85</td>
<td>.86</td>
</tr>
<tr>
<td>SOC</td>
<td>.76</td>
<td>.81</td>
<td>.70</td>
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<tr>
<td>DEP</td>
<td>.80</td>
<td>.69</td>
<td>.88</td>
</tr>
<tr>
<td>TOT</td>
<td>.93</td>
<td>.90</td>
<td>.88</td>
</tr>
</tbody>
</table>

As can be seen from table 4.2 the GHQ total scale had high levels of internal consistency for both Urdu and English language versions, and for all three samples. The GHQ-28 sub-scales also showed significantly high internal consistency. Although, in the sub-scales there was some variability in internal consistency of the somatic, social dysfunction and depression sub-scales across the three cultural groups. The anxiety sub-scale showing the highest and most comparable level of internal consistency across the three group

4.3.2 Intercorrelation of Sub-scale and Total Scores

Correlations between GHQ sub-scale and total scores, and Intercorrelation between sub-scales for the three samples are presented in table 4.3.

Table 4.3 indicated that all sub-scale scores were significantly correlated with the total scores, for all three samples. However, there were some subtle but interesting differences in
intercorrelation patterns between the three samples.

Table 4.3 Intercorrelation matrices of GHQ sub-scales and total scale for P, BP and B samples

<table>
<thead>
<tr>
<th></th>
<th>SOM</th>
<th>ANX</th>
<th>SOC</th>
<th>DEP</th>
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<tbody>
<tr>
<td>P</td>
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<tr>
<td>ANX</td>
<td>.70***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC</td>
<td>.46***</td>
<td>.47***</td>
<td></td>
<td></td>
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<tr>
<td>DEP</td>
<td>.61***</td>
<td>.66***</td>
<td>.38***</td>
<td></td>
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<tr>
<td>TOT</td>
<td>.89***</td>
<td>.88***</td>
<td>.65***</td>
<td>.79***</td>
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</table>

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<tr>
<th></th>
<th>SOM</th>
<th>ANX</th>
<th>SOC</th>
<th>DEP</th>
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<tbody>
<tr>
<td>BP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANX</td>
<td>.67***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC</td>
<td>.33***</td>
<td>.30**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP</td>
<td>.61***</td>
<td>.44***</td>
<td>.28**</td>
<td></td>
</tr>
<tr>
<td>TOT</td>
<td>.90***</td>
<td>.86***</td>
<td>.46***</td>
<td>.69***</td>
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<table>
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<tr>
<th></th>
<th>SOM</th>
<th>ANX</th>
<th>SOC</th>
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<tbody>
<tr>
<td>P</td>
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<td></td>
</tr>
<tr>
<td>ANX</td>
<td>.50***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOC</td>
<td>.13</td>
<td>.41***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEP</td>
<td>.11</td>
<td>.44***</td>
<td>.47***</td>
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</tr>
<tr>
<td>TOT</td>
<td>.65***</td>
<td>.88***</td>
<td>.63***</td>
<td>.67***</td>
</tr>
</tbody>
</table>

Sig levels ***p<.001 **p<.01 *p<.05

In the case of the P and BP samples the somatic and anxiety sub-scales intercorrelated the most with the other sub-scales and with the total score, followed by the depression and finally the social dysfunction sub-scales. The social dysfunction sub-scale in fact, was proportionally speaking, less correlated with the somatic, anxiety and depression sub-scales. The somatic and anxiety sub-scales, thus, appeared to be the best predictors of the total score for the P and BP samples. Furthermore they were highly intercorrelated with one another.

In the case of the B sample the anxiety sub-scale correlated the most with the total score, followed equally well by the depression, somatic and social dysfunction sub-scales. In
comparison to the P and BP samples then, the B samples somatic sub-scale was proportionally less intercorrelated with the other sub-scales and the total score. The most notable finding was the non-significant intercorrelation of the somatic sub-scale with the social dysfunction and depression sub scales in the B sample. The greater intercorrelation observed in the P and BP samples is explained further in the discussion.

### 4.3.3 Factor Analysis

Exploratory and confirmatory factor analyses was conducted to further investigate the structure of the GHQ. The aim was to investigate if the P, BP and B samples data adequately fitted the theoretical GHQ sub-scales, namely: somatic, anxiety, social dysfunction and depression, and thereby followed a distinct syndrome model.

A principal component analysis with VARIAMX rotation was performed separately for each of the three samples. Accepting all components with an eigenvalue of greater than one produced: seven factors for all three samples. In the P sample it accounted for 71% of the variance, in the BP sample it accounted for 71.2% of the variance and finally in the B sample it accounted for 67.4% of the variance. To avoid over factoring, however, and taking into consideration interpretability of the factors a confirmatory factor analysis, restricting the number of factors to four was performed on each sample. A cut-off of 0.3 was used to identify components on which items loaded. Highest item loadings were used to determine which factor the items loaded onto. These components were labelled on the basis of predominant pattern of item loadings, following those adopted by Goldberg.

**Pakistanis**

Confirmatory factor analysis accounted for 58.4% of the variance. A breakdown of the twenty eight item factor loadings are presented in table 4.4

Factor I - accounted for 34.7% of the variance, and could be interpreted as a general factor, comprising of all somatic items (except item 1), all anxiety items and item 23 - "Felt that life is entirely hopeless" and 26 - "Found at times you couldn't do anything because your nerves
Factor II - accounted for 11% of the variance, and could be interpreted as a suicide factor; containing all four items referring to suicide. Factor III - accounted for 7.2% of the variance, and consisted of five of the social dysfunction items in addition to item 1- "Been feeling perfectly well and in good health". It is interesting to note here, that four of the five social dysfunction items that loaded onto this factor involved use of the term 'kam' / 'work'. This term, which as noted in section 4.2.2, was found to pose particular difficulties in translation during the construction of the Urdu version. This literal and conceptual unequivalence in translation, thus, appeared to have had some repercussions, which are discussed later in relation to the socio-cultural factors (refer to section 4.4.2). Factor IV - accounted for 5.4% of the variance and could be interpreted as a self dysfunction factor. It contained two of the social dysfunction items: item 19- "Felt that you are playing a useful part in things" and item 20 - "Felt capable of making decisions about things", both of which, notably, did not involve the term 'kam' / 'work' in translation. These items, thus, referred to concepts relating to self perception as opposed to social roles. Factor IV also contained item 22- "Been thinking of yourself as a worthless person."

British Pakistanis

Confirmatory factor analysis accounted for 58.5% of the variance. A breakdown of the twenty eight item factor loadings are presented in table 4.4.

Factors I, II, III and IV corresponded very closely to the four factors that emerged for the Pakistani sample: the general Factor- I accounted for 29.7% of the variance, the suicide Factor- II accounted for 12.4% of the variance, the social dysfunction Factor- III accounted for 9.7% of the variance, and the final self dysfunction Factor -IV accounted for 6.7% of the variance.
Table 4.4  Confirmatory factor analysis structure and loadings of P and BP samples

<table>
<thead>
<tr>
<th>GHQ ITEMS</th>
<th>P</th>
<th>BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been feeling perfectly well and in good health</td>
<td>FI 0.58</td>
<td>FI 0.56</td>
</tr>
<tr>
<td>2. Been feeling in need of a good tonic</td>
<td>FI 0.48</td>
<td>FI 0.39</td>
</tr>
<tr>
<td>3. Been feeling run down and out of sorts</td>
<td>FI 0.67</td>
<td>FI 0.72</td>
</tr>
<tr>
<td>4. Felt that you are ill</td>
<td>FI 0.65</td>
<td>FI 0.62</td>
</tr>
<tr>
<td>5. Been getting any pains in your head</td>
<td>FI 0.71</td>
<td>FI 0.63</td>
</tr>
<tr>
<td>6. Been getting a feeling of tightness or pressure in your head</td>
<td>FI 0.74</td>
<td>FI 0.63</td>
</tr>
<tr>
<td>7. Been having hot or cold spells</td>
<td>FI 0.68</td>
<td>FI 0.61</td>
</tr>
<tr>
<td>8. Lost much sleep over worry</td>
<td>FI 0.73</td>
<td>FI 0.74</td>
</tr>
<tr>
<td>9. Had difficulty in staying asleep once you are off</td>
<td>FI 0.64</td>
<td>FI 0.52</td>
</tr>
<tr>
<td>10. Felt constantly under strain</td>
<td>FI 0.64</td>
<td>FI 0.64</td>
</tr>
<tr>
<td>11. Been getting edgy and bad tempered</td>
<td>FI 0.63</td>
<td>FI 0.66</td>
</tr>
<tr>
<td>12. Been getting scared or panicky for no good reason</td>
<td>FI 0.62</td>
<td>FI 0.61</td>
</tr>
<tr>
<td>13. Found everything getting on top of you</td>
<td>FI 0.65</td>
<td>FI 0.78</td>
</tr>
<tr>
<td>14. Been feeling nervous and strung up all of the time.</td>
<td>FI 0.60</td>
<td>FI 0.79</td>
</tr>
<tr>
<td>15. Been managing to keep yourself busy and occupied</td>
<td>FI 0.57</td>
<td>FI 0.62</td>
</tr>
<tr>
<td>16. Been taking longer over the things you do</td>
<td>FI 0.60</td>
<td>FI 0.62</td>
</tr>
<tr>
<td>17. Felt that on the whole you are doing things well</td>
<td>FI 0.59</td>
<td>FI 0.84</td>
</tr>
<tr>
<td>18. Been satisfied with the way you have carried out your tasks</td>
<td>FI 0.46</td>
<td>FI 0.81</td>
</tr>
<tr>
<td>19. Felt that you are playing a useful part in things</td>
<td>FIV 0.73</td>
<td>FIV 0.73</td>
</tr>
<tr>
<td>20. Felt capable of making decisions about things</td>
<td>FIV 0.81</td>
<td>FIV 0.68</td>
</tr>
<tr>
<td>21. Been able to enjoy your normal day to day activities</td>
<td>FIV 0.59</td>
<td>FIV 0.74</td>
</tr>
<tr>
<td>22. Been thinking of yourself as a worthless person</td>
<td>FIV 0.59</td>
<td>FIV 0.72</td>
</tr>
<tr>
<td>23. Felt that life is entirely hopeless</td>
<td>FI 0.52</td>
<td>FI 0.53</td>
</tr>
<tr>
<td>24. Felt that life isn’t worth living</td>
<td>FI 0.58</td>
<td>FI 0.79</td>
</tr>
<tr>
<td>25. Thought of the possibility that you might make away with yourself</td>
<td>FI 0.92</td>
<td>FI 0.86</td>
</tr>
<tr>
<td>26. Found you could not do anything because your nerves were too bad</td>
<td>FI 0.40</td>
<td>FI 0.58</td>
</tr>
<tr>
<td>27. Found yourself wishing you were dead and away from it all</td>
<td>FI 0.92</td>
<td>FI 0.96</td>
</tr>
<tr>
<td>28. Found that the idea of taking your own life kept coming into your head</td>
<td>FI 0.93</td>
<td>FI 0.96</td>
</tr>
</tbody>
</table>
Thus the factor structure of the GHQ for the P and BP samples did not appear to closely correspond with the sub-scales proposed by Goldberg. This is partly attributed, in the discussion, to translational problems and the cultural inappropriateness of certain items. What, however, is clearly evident in both samples is the emergence of a large general factor consisting of somatic and anxiety items, which accounted for proportionally most of the variance. This factor for both samples is, in turn, followed respectively by a suicide factor, a social dysfunction factor and a self dysfunction factor.

**British**

Confirmatory factor analysis accounted for 53.8% of the variance. A breakdown of the twenty eight items factor loadings are presented in table 4.5.

Factor I accounted for 26.6% of the variance, and corresponded closely to Goldberg's anxiety sub-scale. It contained all of the seven anxiety items in addition to item 7 - "Been having hot or cold spells" and item 16 - "Been taking longer over the things you do", however this item had a relatively low factor loading of .33.

Factor II accounted for 13.4% of the variance, and corresponded completely with Goldberg's severe depression sub-scale.

Factor III accounted for 7.2% of the variance, and corresponded closely to Goldberg's somatic sub-scale. Containing six of the original somatic items.

Factor IV accounted for 6.6% of the variance, and consisted of five of the original social dysfunction items.

The factor structure of the British sample, thus, corresponded very closely with the GHQ sub-scales reported by Goldberg. The anxiety factor was found to account for most of the variance in this sample, followed by: the severe depression factor, the somatic factor and finally the social dysfunction factor. It is worth stressing here that in the case of the B sample the depression factor accounted for more variance than the somatic factor, in comparison with the P and BP samples, where the somatic and anxiety - general factor accounted for most of the variance.
Table 4.5  Confirmatory factor analysis structure and loadings of B and whole samples

<table>
<thead>
<tr>
<th>GHQ ITEMS</th>
<th>B</th>
<th>WHOLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been feeling perfectly well and in good health</td>
<td>FIII .64</td>
<td>FII .73</td>
</tr>
<tr>
<td>2. Been feeling in need of a good tonic</td>
<td>FIII .60</td>
<td>FII .40</td>
</tr>
<tr>
<td>3. Been feeling run down and out of sorts</td>
<td>FIII .70</td>
<td>FII .72</td>
</tr>
<tr>
<td>4. Felt that you are ill</td>
<td>FIII .67</td>
<td>FII .76</td>
</tr>
<tr>
<td>5. Been getting any pains in your head</td>
<td>FIII .53</td>
<td>FII .61</td>
</tr>
<tr>
<td>6. Been getting a feeling of tightness or pressure in your head</td>
<td>FIII .46</td>
<td>FII .65</td>
</tr>
<tr>
<td>7. Been having hot or cold spells</td>
<td>FI .65</td>
<td>FII .62</td>
</tr>
<tr>
<td>8. Lost much sleep over worry</td>
<td>FI .71</td>
<td>FII .71</td>
</tr>
<tr>
<td>9. Had difficulty in staying asleep once you are off</td>
<td>FI .61</td>
<td>FII .68</td>
</tr>
<tr>
<td>10. Felt constantly under strain</td>
<td>FI .61</td>
<td>FII .67</td>
</tr>
<tr>
<td>11. Been getting edgy and bad tempered</td>
<td>FI .58</td>
<td>FII .58</td>
</tr>
<tr>
<td>12. Been getting scared or panicky for no good reason</td>
<td>FI .78</td>
<td>FII .60</td>
</tr>
<tr>
<td>13. Found everything getting on top of you</td>
<td>FI .75</td>
<td>FII .66</td>
</tr>
<tr>
<td>14. Been feeling nervous and strung up all of the time.</td>
<td>FI .76</td>
<td>FII .61</td>
</tr>
<tr>
<td>15. Been managing to keep yourself busy and occupied</td>
<td>FIII .49</td>
<td>FIV .36</td>
</tr>
<tr>
<td>16. Been taking longer over the things you do</td>
<td>FI .33</td>
<td>FIV .39</td>
</tr>
<tr>
<td>17. Felt that on the whole you are doing things well</td>
<td>FIV .75</td>
<td>FIV .75</td>
</tr>
<tr>
<td>18. Been satisfied with the way you have carried out your tasks</td>
<td>FIV .66</td>
<td>FIV .67</td>
</tr>
<tr>
<td>19. Felt that you are playing a useful part in things</td>
<td>FIV .48</td>
<td>FIV .66</td>
</tr>
<tr>
<td>20. Felt capable of making decisions about things</td>
<td>FIV .57</td>
<td>FIV .58</td>
</tr>
<tr>
<td>21. Been able to enjoy your normal day to day activities</td>
<td>FIV .68</td>
<td>FIV .66</td>
</tr>
<tr>
<td>22. Been thinking of yourself as a worthless person</td>
<td>FIII .66</td>
<td>FI .58</td>
</tr>
<tr>
<td>23. Felt that life is entirely hopeless</td>
<td>FIII .73</td>
<td>FIII .52</td>
</tr>
<tr>
<td>24. Felt that life isn’t worth living</td>
<td>FIII .84</td>
<td>FIII .69</td>
</tr>
<tr>
<td>25. Thought of the possibility that you might make away with yourself</td>
<td>FIII .77</td>
<td>FIII .86</td>
</tr>
<tr>
<td>26. Found you could not do anything because your nerves were too bad</td>
<td>FII .37</td>
<td>FII .46</td>
</tr>
<tr>
<td>27. Found yourself wishing you were dead and away from it all</td>
<td>FII .85</td>
<td>FIII .90</td>
</tr>
<tr>
<td>28. Found that the idea of taking your own life kept coming into your head</td>
<td>FII .83</td>
<td>FIII .91</td>
</tr>
</tbody>
</table>
Whole Sample
A joint confirmatory factor analysis was performed on all three samples, in order to ascertain a factor structure that would enable cross cultural, sex and SES comparisons to be conducted across the three samples. The factors and factor loadings are presented in table 4.5.

The emerging factor structure corresponded closely to Goldberg's original sub-scales. Factor I accounted for 31.9% of the variance, and corresponded closely to Goldberg's anxiety sub-scales. It consisted of all seven anxiety items in addition to item 2 - "Been feeling in need of a good tonic" and 22 - "Been thinking of yourself as a worthless person". The loading on item 2, however, was relatively low - at 0.40.

Factor II accounted for 10.1% of the variance and corresponded closely to Goldberg's somatic sub-scale. It consisted of six of the original somatic items, in addition to item 26 - "Found at times you couldn't do anything because your nerves were too bad".

Factor III accounted for 7.4% of the variance, and corresponded closely to Goldberg's severe depression factor. It consisted of five of the original depression items.

Factor IV accounted for 4.9% of the variance, and corresponded exactly with Goldberg's social dysfunction factor.

4.3.4 Item Analysis
An item analysis was conducted in order to further ascertain variations in cultural patterns and responses to particular items; thereby helping to indicate which items may be more or less salient to which cultural group. Endorsement frequency percentages; that is, proportion of respondents endorsing an item in the pathological direction were computed for all three samples. Item responses were thus re-coded by the 'simple scoring method' of 0-0-1-1 to indicate pathology (refer to table 4.6).

The range of endorsement frequencies for the three sample were: 1.7-33.3% for the P sample, 0-8-20.0% for the BP sample and 1.7-18.3% for the B sample.

Generally, higher endorsement frequencies were found for the P sample, followed by the B
sample and finally the BP sample (in line with mean scores - refer to table 4.8). There were, however, some differences in endorsement patterns on particular sub-scales or items, which in correspondence to the factor analytic findings raised issues regarding translation and broader socio-cultural factors.

**Somatic Items** - P (18.3-30.8%) and BP (2.0-20%) respondents tended to endorse somatic items (apart from item 2) in the pathological direction more than did B (4.2-16.7%) respondents. This thereby suggested that P and BPs are more likely to express mental distress in pathological somatic terms on the GHQ.

**Anxiety Items** - Generally P respondents endorsed anxiety items more in a pathological direction, followed by B respondents and finally BP respondents. This was, however, apart from on items: 8 - "lost much sleep over worry" and 12 - "been getting scared or panicky for no good reason" which were endorsed more by BP respondents than B respondents, although there appears to be no obvious explanation as to why.

**Social Dysfunction Items** - Half of the social dysfunction items followed the pattern of being pathologically endorsed by more P followed by Bs followed by BPs. Items: 16 - "Been taking longer over the things you do", 17 - "Felt on the whole you are doing things well' and 21- "been able to enjoy your normal day-to-day activities", however, were endorsed by more B respondents than P and BPs. Bearing in mind the comparatively low endorsement ranges on the social dysfunction items (Ps: 7.5-20.0%, BPs: 0.8-4.2% and B: 9.2-18.3%) it appears that these items are not readily used by Ps and BPs to express mental distress. It was these items that also posed the greatest difficulties in translation.

---

These results are discussed in terms of percentages rather than statistical significance, as chi square tests would have otherwise been significant for each item, considering the highly differential base rates of P, BP and B samples. The data also could not have been normalised to facilitate statistical testing, as it was ordinal and not continuous.
<table>
<thead>
<tr>
<th>GHQ ITEMS</th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Been feeling perfectly well and in good health</td>
<td>30.8</td>
<td>20.0</td>
<td>11.7</td>
</tr>
<tr>
<td>2. Been feeling in need of a good tonic</td>
<td>18.3</td>
<td>5.0</td>
<td>16.7</td>
</tr>
<tr>
<td>3. Been feeling run down and out of sorts</td>
<td>31.7</td>
<td>20.0</td>
<td>15.8</td>
</tr>
<tr>
<td>4. Felt that you are ill</td>
<td>20.8</td>
<td>16.7</td>
<td>4.2</td>
</tr>
<tr>
<td>5. Been getting any pains in your head</td>
<td>22.5</td>
<td>12.5</td>
<td>8.3</td>
</tr>
<tr>
<td>6. Been getting a feeling of tightness or pressure in your head</td>
<td>20.0</td>
<td>12.5</td>
<td>4.2</td>
</tr>
<tr>
<td>7. Been having hot or cold spells</td>
<td>23.3</td>
<td>7.5</td>
<td>6.7</td>
</tr>
<tr>
<td>8. Lost much sleep over worry</td>
<td>33.3</td>
<td>11.7</td>
<td>9.2</td>
</tr>
<tr>
<td>9. Had difficulty in staying asleep once you are off</td>
<td>31.7</td>
<td>3.3</td>
<td>13.3</td>
</tr>
<tr>
<td>10. Felt constantly under strain</td>
<td>23.3</td>
<td>8.3</td>
<td>15.0</td>
</tr>
<tr>
<td>11. Been getting edgy and bad tempered</td>
<td>20.8</td>
<td>8.3</td>
<td>15.8</td>
</tr>
<tr>
<td>12. Been getting scared or panicky for no good reason</td>
<td>14.2</td>
<td>7.5</td>
<td>4.2</td>
</tr>
<tr>
<td>13. Found everything getting on top of you</td>
<td>18.3</td>
<td>10.0</td>
<td>14.2</td>
</tr>
<tr>
<td>14. Been feeling nervous and strung - up all the time</td>
<td>19.2</td>
<td>6.7</td>
<td>10.0</td>
</tr>
<tr>
<td>15. Been keeping yourself busy and occupied all of the time</td>
<td>10.8</td>
<td>4.2</td>
<td>9.2</td>
</tr>
<tr>
<td>16. Been taking longer over the things you do</td>
<td>12.5</td>
<td>1.7</td>
<td>18.3</td>
</tr>
<tr>
<td>17. Felt on the whole you are doing things well</td>
<td>7.5</td>
<td>4.2</td>
<td>12.5</td>
</tr>
<tr>
<td>18. Been satisfied with the way you have carried out your tasks</td>
<td>18.3</td>
<td>3.3</td>
<td>10.1</td>
</tr>
<tr>
<td>19. Felt that you are playing a useful part in things</td>
<td>20.0</td>
<td>3.3</td>
<td>12.5</td>
</tr>
<tr>
<td>20. Felt capable of making decisions about things</td>
<td>15.8</td>
<td>5.8</td>
<td>9.2</td>
</tr>
<tr>
<td>21. Been able to enjoy your normal day to day activities</td>
<td>13.3</td>
<td>0.8</td>
<td>18.3</td>
</tr>
<tr>
<td>22. Been thinking of yourself as a worthless person</td>
<td>7.5</td>
<td>0.8</td>
<td>4.2</td>
</tr>
<tr>
<td>23. Felt that life is entirely hopeless</td>
<td>10.0</td>
<td>7.5</td>
<td>3.3</td>
</tr>
<tr>
<td>24. Felt that life isn't worth living</td>
<td>6.7</td>
<td>0.8</td>
<td>1.7</td>
</tr>
<tr>
<td>25. Thought of the possibility that you might make away with yourself</td>
<td>1.7</td>
<td>0.8</td>
<td>2.5</td>
</tr>
<tr>
<td>26. Couldn't do anything because your nerves were too bad</td>
<td>17.5</td>
<td>8.3</td>
<td>3.3</td>
</tr>
<tr>
<td>27. Wishing you were dead and away from it all</td>
<td>1.7</td>
<td>0.8</td>
<td>2.5</td>
</tr>
<tr>
<td>28. Idea of taking your own life kept coming into your mind</td>
<td>1.7</td>
<td>0.8</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Depression Items - Endorsement percentages for these items were distinctively the lowest for all three groups (Ps: 1.7-17.5%, BPs:0.8-7.5%, B:17-4.2%). Items 22, 24 and 26 followed the normal endorsement pattern of P>B>BP. However items 25 - "Thought of the possibility that you might make away with yourself", 27 - "Found yourself wishing you were dead and away from it all" and 28 - "Found that the idea of taking your own life kept coming into your head"; that is, the 'suicide items' were endorsed in a pathological direction by more B respondents than Ps and BPs. (refer to section 4.4.2). Conversely, Item 24 "Felt that life isn't worth living", which also makes reference to suicide had a, surprisingly, higher endorsement rate by P respondents. This item as already identified (refer to section 4.2.2) was frequently mis-interpreted by respondents.

4.3.5 Effect of Culture Sex and SES on Sub-Scale Scores

A multivariate analysis of variance was performed in order to test for differences in sub-scale scores across a) cultural samples b) male and female sub-groups and c) middle class and working class subgroups. A 3x2x2 MANOVA was conducted on the four dependant variables or factor sub-scale scores that emerged from the joint confirmatory factor analysis. These factors, as can be seen from the confirmatory factor analysis results on the whole sample in table 4.6, corresponded very closely to Goldberg's sub-scales. For practical purposes they can, thus, be conceptualised as: somatic, anxiety, depression and social dysfunction factors. Using these factor scores that resulted from orthogonal VARIMAX rotation instead of original sub-scale scores avoided the problem of highly intercorrelated sub-scales and thereby avoided violation of the MANOVA test assumption of; independence of dependant variables. Prior to conducting any statistical tests the normality of data and homogeneity of variance test assumptions were also verified.

The results of the multivariate analysis of variance: including the multivariate pillais trace and univariate F tests are presented in table 4.7.

From table 4.7, using Pillais criteria it can be seen that the combined DVs were significantly
affected by: culture, with $F(2, 347) = 7.78 \ p < .001$, class, with $F(1, 347) = 4.75 \ p < .001$ and sex, with $F(1, 347) = 15.51 \ p < .001$. There was also a significant interaction between culture and class, with $F(2, 347) = 2.51 \ p < .01$, culture and sex, with $F(2, 347) = 4.87 \ p < .001$. To further investigate the impact of each main and interactive effect a series of univariate F tests were performed, refer to table 4.7. Significance levels of the F tests were adjusted to .0125, using Bonferroni contrasts to account for type I (multiple testing) error.

Table 4.7 Multivariate and univariate analysis of variance of GHQ sub-scales by culture, class and sex

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>PILLAIS</th>
<th>ANX</th>
<th>SOM</th>
<th>DEP</th>
<th>SOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>CULTURE</td>
<td>p = .00</td>
<td>$F(2, 348) = 20.46$</td>
<td>$F(2, 348) = 7.28$</td>
<td>$F(2, 348) = 2.35$</td>
<td>$F(2, 348) = .24$</td>
</tr>
<tr>
<td>CLASS</td>
<td>P = .00</td>
<td>$F(1, 348) = 2.21$</td>
<td>$F(1, 348) = 1.31$</td>
<td>$F(1, 348) = 13.10$</td>
<td>$F(1, 348) = .69$</td>
</tr>
<tr>
<td>SEX</td>
<td>P = .00</td>
<td>$F(1, 348) = 2.22$</td>
<td>$F(1, 348) = 57.37$</td>
<td>$F(1, 348) = .12$</td>
<td>$F(1, 348) = .52$</td>
</tr>
<tr>
<td>CULTURE x CLASS</td>
<td>P = .01</td>
<td>$F(2, 348) = 4.80$</td>
<td>$F(2, 348) = .00$</td>
<td>$F(2, 348) = 4.37$</td>
<td>$F(2, 348) = .30$</td>
</tr>
<tr>
<td>CULTURE x SEX</td>
<td>P = .00</td>
<td>$F(2, 348) = .00$</td>
<td>$F(2, 348) = 19.18$</td>
<td>$F(2, 348) = .74$</td>
<td>$F(2, 348) = .22$</td>
</tr>
<tr>
<td>CLASS x SEX</td>
<td>P = .34</td>
<td>$F(1, 348) = .17$</td>
<td>$F(1, 348) = 1.35$</td>
<td>$F(1, 348) = .01$</td>
<td>$F(1, 348) = 3.11$</td>
</tr>
<tr>
<td>CUL x CLASS x SEX</td>
<td>P = .11</td>
<td>$F(2, 348) = .51$</td>
<td>$F(2, 348) = 2.20$</td>
<td>$F(2, 348) = .47$</td>
<td>$F(2, 348) = 3.20$</td>
</tr>
</tbody>
</table>

Sig levels ***p < .001  **p < .01  *p < .025

Effect of culture

The main effect of culture was due to a significant difference in variance of the three samples on the anxiety, $F(2, 347) = 20.46 \ p < .001$ and somatic, $F(2, 347) = 7.28 \ p < .001$ sub-scales. In the case of the anxiety sub-scale, marginal means in table 4.8 indicated that it is P respondents
that scored higher than B respondents, who in turn scored higher than BP respondents. However in the case of the somatic sub-scale, once again P subjects score the highest, but this time followed by BP respondents and then B respondents. The association between culture and anxiety scores was \( \eta = .11 \), and the association between culture and somatic scores was \( \eta = .04 \).

Table 4.8 Marginal means for GHQ sub-scale and total scale scores

<table>
<thead>
<tr>
<th></th>
<th>CULTURE</th>
<th>CLASS</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>BP</td>
<td>B</td>
</tr>
<tr>
<td>SOM</td>
<td>5.73</td>
<td>3.75</td>
<td>3.88</td>
</tr>
<tr>
<td>ANX</td>
<td>5.17</td>
<td>2.21</td>
<td>3.79</td>
</tr>
<tr>
<td>SOC</td>
<td>7.33</td>
<td>7.22</td>
<td>7.24</td>
</tr>
<tr>
<td>DEP</td>
<td>1.84</td>
<td>0.54</td>
<td>1.08</td>
</tr>
<tr>
<td>TOT</td>
<td>20.18</td>
<td>13.38</td>
<td>15.98</td>
</tr>
</tbody>
</table>

**Effect of class**

The main effect of class was due to a significant difference in variance between middle class and working class respondents on the depression sub-scale, \( F(1, 347) = 13.10 \) \( p<.001 \). Marginal means indicated that it was working class respondents that scored higher than middle class respondents. The association between class and depression scores was \( \eta = .04 \).

**Effect of sex**

The main effect of sex was due to a significant difference in variance between men and women on the somatic sub-scale \( F(1, 347) = 57.37 \) \( p<.001 \). Marginal means indicated that it was women that scored higher than men. The association between sex and somatic scores was \( \eta = .14 \).
Table 4.9  Cell means for GHQ sub-scale and total scale score

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th></th>
<th>B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC</td>
<td>MC</td>
<td>WC</td>
<td>WC</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>SOM</td>
<td>3.06</td>
<td>6.70</td>
<td>3.30</td>
<td>9.87</td>
</tr>
<tr>
<td>ANX</td>
<td>3.33</td>
<td>4.83</td>
<td>4.36</td>
<td>8.13</td>
</tr>
<tr>
<td>SOC</td>
<td>7.53</td>
<td>6.76</td>
<td>7.07</td>
<td>7.97</td>
</tr>
<tr>
<td>DEP</td>
<td>0.43</td>
<td>1.63</td>
<td>1.73</td>
<td>3.57</td>
</tr>
</tbody>
</table>

Effect of culture and class

The interaction of culture and class was due to a significant difference in middle class and working class P, BP and B respondents scores on the anxiety, $F(2, 347) = 4.80$ $p<.01$, and depression sub- scales, $F(2, 347) = 4.37$ $p<.01$.

Cell means of the anxiety scores (refer to table 4.9) indicated that P working class respondents scored substantially higher than P middle class respondents. Followed by B respondents, in whom there was very little difference in middle class and working class respondents scores. In BP respondents, conversely, middle class respondents actually scored slightly higher than working class respondents.

Cell means of the depression scores indicated that again P working class respondents scored substantially higher than P middle class respondents. In BP and B samples working class respondents also scored higher than middle class respondents but with a less pronounced difference. The association between culture x class and anxiety and depression scores was $\eta = .027$ and $\eta = .25$, respectively.

Effect of culture and sex

The interactive effect of culture and sex was due to a significant difference in male and female P, BP and B respondents scores on the somatic sub-scale, $F(2, 347) = 19.18$ $p<.001$. Cell means of the somatic scores indicated that female Ps and BPs scored significantly higher than B female respondents and, in turn, all scored higher than their
male counterparts. However the difference between male and female Ps was much more pronounced than the difference between male and female BPs and Bs. The difference between male and female Bs was the smallest. The strength of the association between culture and sex and somatic scores was \( \eta = .10 \).

**Effect of culture sex and SES on total scores**

In order to ensure normality of data GHQ total scores for the P and BP sample were transformed, using square root and log transformations respectively. The total scores for the B sample were found to normally distributed and did not require transformation.

A univariate 3x2x2 factor analysis was performed on the total scores to test for cultural, class and sex differences in scores. A significant main effect was found for: culture, \( F(2, 348) = 18.57 \ p < .001 \); class, \( F(1, 348) = 5.95 \ p < .05 \) and sex \( F(1, 348) = 26.14 \ p < .001 \). A significant interactive effect was found between: culture x class, \( F(2, 348) = 3.30 \ p < .05 \); culture x sex, \( F(2, 348) = 6.69 \ p < .01 \) and culture x class x sex, \( F(2, 348) = 3.35 \ p < .05 \).

Means (refer to table 4.8) indicated that the main effects of culture were due to: Ps scoring the highest, followed by Bs and finally by BPs (the relative difference between B and BP scores, however, was small). The main effect of sex was due to women scoring higher than men, and the main effect of SES was due to working class respondents scoring higher than middle class respondents. Cell mean scores (refer to table 4.9) indicated that the interactive effects were repeatedly due to a large difference in P sub-groups scores, comparative to BP and B sub-groups, with women and working class respondents scoring considerably higher than male and middle class respondents. In the case of the culture x class interaction there was no difference between middle class and working class BP respondents scores, and the difference between middle class and working class B respondents scores was small.

In the case of the culture x sex interaction the difference between male and female BP scores was greater than the difference between B male and female respondents scores. The three way interaction was probably due to the exceedingly high scores in working
class P females, in comparison to the other sub-groups.

4.3.6 Caseness

On the basis of the recommended cut-off score of 5 in community samples (Goldberg, 1972), 84 (23%) of cases were identified.

A breakdown of the 'probable case' profiles (refer to table 4.10) revealed that, according to this criteria the vast majority of cases were Ps, especially working class females - 10 B respondents were found to be the next highest qualifiers of 'probable cases', with 25 followed by BPs, with 18 probable cases. In the case of the B and BP samples there was no clear sub group 'case' pattern. However in all three samples middle class men were notably found to have the lowest number of 'probable cases'.

Table 4.10 Breakdown of 'probable cases' identified by the GHQ

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC</td>
<td>WC</td>
<td>MC</td>
</tr>
<tr>
<td>M</td>
<td>6</td>
<td>12</td>
<td>M</td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>6</td>
<td>F</td>
</tr>
<tr>
<td>M</td>
<td>3</td>
<td>9</td>
<td>M</td>
</tr>
</tbody>
</table>

A chi square test revealed that the difference in number of 'probable cases' across the three cultural groups was statistically significant, Chi (df, 2) = 102.40; p<.001, indicating that there are significantly more P 'probable cases, followed by B 'probable case' and finally BP 'probable cases'.

4.3.7 Demographics

Having looked at the effects of culture, class and sex, correlations and standard multiple linear regression analyses were conducted to investigate if any other demographic

23 NB. Pearson correlations were used for the continuous variables of age, marital age, no. children. Kendals tau was used for ordinal variables: education, religious degree. Point Biserial correlations were used for nominal / categorical variables: class, sex, unemployment.
variables were further predictors of GHQ scores in each sample. This enabled an investigation into the cross cultural generality and comparability of the construct the GHQ is measuring (refer to tables 4.11, 4.12 and 4.13). The demographic variables for this analysis were chosen on the basis of previous research correlates identified with psychiatric morbidity. a number of other variables, such as age at marriage and extent of religious beliefs were also included, as they were considered particularly relevant to Pakistani cultural groups. The independent variables (IVs) for this analysis thus were: sex, class, age, marital age, number of children, separation, unemployment, social support, employment status in women and extent of religious beliefs.

From table 4.11 it can be seen that the overall multiple regression was significant for the P sample, F(11,108) = 5.04 p<.001. R square was found to be 0.34 and adjusted R square was 0.27. 34% of the variance in the P sample GHQ scores were therefore accounted for by the combined effect of the IVs. Although correlations indicated a significant association between GHQ scores and sex, r= .38 p<.001; class, r= .23 p<.01; education, r= -.22 p<.01; marital age, r= -.37 p<.001 and separation, r= .28 p<.01, the regression analysis indicated that only sex, marital age and separation remained significant predictors of GHQ scores once the effects of the other variables were partialled out. Sex, T= 3.85 p<.01 was found to account for 6.5% of the variance in GHQ scores. Marital age, T= -2.38 p<.05 was found to account for 3.6% of the variance in GHQ scores. Separation, T= 1.96 p<.05 was found to account for 2.4% of the variance in GHQ scores. The direction of correlation indicated that it was women, respondents who married at a young age and respondents who were divorced/widowed that scored higher on the GHQ. All of the respondents that fell into the supernatural category were women who were widowed as opposed to divorced.

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24 This is taking absence of relatives and family living nearby (within the same district) as an indicator of lack of social support. This variable was very much delineated and chosen with Pakistani culture and the importance of family in mind.

25 Extent of religious beliefs was gauged in the demographic questionnaire by a direct question asking for rating of extent of religious beliefs, as well as, an indirect question about religious activity.
Table 4.11 Demographic correlations and multiple regression analysis of GHQ scores in P sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beeta</th>
<th>T sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.38***</td>
<td>8.87</td>
<td>0.36</td>
<td>3.85***</td>
</tr>
<tr>
<td>Class</td>
<td>0.23**</td>
<td>3.46</td>
<td>0.14</td>
<td>1.21</td>
</tr>
<tr>
<td>Education</td>
<td>-0.22**</td>
<td>-0.73</td>
<td>-0.10</td>
<td>-0.80</td>
</tr>
<tr>
<td>Age</td>
<td>0.08</td>
<td>0.20</td>
<td>0.18</td>
<td>1.49</td>
</tr>
<tr>
<td>Marital age</td>
<td>-0.37***</td>
<td>-0.37</td>
<td>-0.22</td>
<td>-2.38*</td>
</tr>
<tr>
<td>No of children</td>
<td>-0.08</td>
<td>-0.56</td>
<td>-0.12</td>
<td>-1.05</td>
</tr>
<tr>
<td>Separated</td>
<td>0.28**</td>
<td>9.18</td>
<td>0.17</td>
<td>1.96*</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0.11</td>
<td>0.85</td>
<td>0.03</td>
<td>0.34</td>
</tr>
<tr>
<td>Social support</td>
<td>0.08</td>
<td>-3.56</td>
<td>-0.10</td>
<td>-1.26</td>
</tr>
<tr>
<td>Working women</td>
<td>-0.08</td>
<td>1.73</td>
<td>0.12</td>
<td>1.42</td>
</tr>
<tr>
<td>Religious extent</td>
<td>0.02</td>
<td>2.07</td>
<td></td>
<td>0.19</td>
</tr>
</tbody>
</table>

F(11, 108) = 5.04
R Square = 0.34
Adjusted R Square = 0.27

Sig level ***p<.001 **p<.01 *p<.05

From table 4.12 it can be seen that the overall multiple regression was not found to be significant at the 5% level in the case of the BP sample. Although correlations indicated a significant association between GHQ scores and sex, r = .23 p<.01 and employment status of women, r = -.22 p<.01, the regression analysis indicated that only employment status of women remained a significant predictor of GHQ scores once the effects of the other variables were partialled out. Employment status, T= 2.13 p<.05 was found to account for 2.1% of the variance in the GHQ scores. The direction of correlation indicated that women who were not employed and stayed at home were likely to score higher on the GHQ than women who worked.
Table 4.12  Demographic correlations and multiple regression analysis of GHQ scores in BP sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beta</th>
<th>T sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.23**</td>
<td>3.00</td>
<td>0.21</td>
<td>1.68</td>
</tr>
<tr>
<td>Class</td>
<td>0.05</td>
<td>0.64</td>
<td>0.04</td>
<td>0.34</td>
</tr>
<tr>
<td>Education</td>
<td>0.09</td>
<td>0.62</td>
<td>0.12</td>
<td>0.88</td>
</tr>
<tr>
<td>Age</td>
<td>0.06</td>
<td>0.01</td>
<td>0.02</td>
<td>0.14</td>
</tr>
<tr>
<td>Marital age</td>
<td>-0.013</td>
<td>-0.08</td>
<td>-0.05</td>
<td>-0.43</td>
</tr>
<tr>
<td>No of children</td>
<td>-0.01</td>
<td>-0.07</td>
<td>-0.02</td>
<td>-0.13</td>
</tr>
<tr>
<td>Separated</td>
<td>-0.02</td>
<td>-0.55</td>
<td>-0.02</td>
<td>-0.18</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0.10</td>
<td>1.77</td>
<td>0.10</td>
<td>1.02</td>
</tr>
<tr>
<td>Social support</td>
<td>-0.08</td>
<td>-1.80</td>
<td>-0.10</td>
<td>-1.05</td>
</tr>
<tr>
<td>Working women</td>
<td>-0.22**</td>
<td>-3.39</td>
<td>-0.21</td>
<td>-2.13*</td>
</tr>
<tr>
<td>Religious extent</td>
<td>-0.03</td>
<td>-1.42</td>
<td>-0.01</td>
<td>-0.11</td>
</tr>
<tr>
<td>(Constant)</td>
<td></td>
<td>9.36</td>
<td></td>
<td>0.86</td>
</tr>
</tbody>
</table>

$F(11, 108) = 1.26$

R Square = 0.11

Adjusted R Square = 0.02

Sig level  ***p<.001  **p<.01  *p<.05

From table 4.13 it can be seen that the overall multiple regression was not found to be significant at the 5% level in the case of the B sample. Correlations indicated a significant association between GHQ scores and number of children, $r = .22$ p<.01 and unemployment, $r = .20$ p<.05. The regression analysis indicated that both appeared to remain significant predictors of GHQ scores when the effects of the other variables were partialled out. Number of children, $T = 2.78$ p<.01 was found to account for 1.5% of the variance of the GHQ score. Unemployment, $T = 2.19$ p<.05 was found to account for 1.48% of the variance in GHQ scores. The direction of correlation indicated that respondents with more children and unemployed respondents scored higher on the GHQ.
Table 4.13  Demographic correlations and multiple regression analysis of GHQ scores in B sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beeta</th>
<th>Tsig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.07</td>
<td>0.90</td>
<td>0.06</td>
<td>0.63</td>
</tr>
<tr>
<td>Class</td>
<td>0.07</td>
<td>0.86</td>
<td>0.05</td>
<td>0.42</td>
</tr>
<tr>
<td>Education</td>
<td>-0.06</td>
<td>-0.43</td>
<td>-0.06</td>
<td>-0.44</td>
</tr>
<tr>
<td>Age</td>
<td>-0.14</td>
<td>-0.02</td>
<td>-0.05</td>
<td>-0.40</td>
</tr>
<tr>
<td>Marital age</td>
<td>0.06</td>
<td>0.10</td>
<td>0.12</td>
<td>1.14</td>
</tr>
<tr>
<td>No of children</td>
<td>0.22*</td>
<td>1.98</td>
<td>0.31</td>
<td>2.78**</td>
</tr>
<tr>
<td>Separated</td>
<td>0.08</td>
<td>0.10</td>
<td>0.06</td>
<td>0.68</td>
</tr>
<tr>
<td>Unemployed</td>
<td>0.20*</td>
<td>6.27</td>
<td>0.21</td>
<td>2.19*</td>
</tr>
<tr>
<td>Social support</td>
<td>-0.08</td>
<td>-1.16</td>
<td>-0.07</td>
<td>-0.75</td>
</tr>
<tr>
<td>Working women</td>
<td>0.03</td>
<td>1.08</td>
<td>0.06</td>
<td>0.68</td>
</tr>
<tr>
<td>Religious extent</td>
<td>-0.02</td>
<td>-0.08</td>
<td>-0.01</td>
<td>-0.09</td>
</tr>
<tr>
<td>(Constant)</td>
<td></td>
<td>16.32</td>
<td></td>
<td>1.96</td>
</tr>
</tbody>
</table>

\[ F(11, 108) = 1.83 \]

\[ R\text{ square} = 0.16 \]

\[ \text{Adjusted R Square} = 0.07 \]

Sig level  \[ ***p<.001 \]  \[ **p<.01 \]  \[ *p<.05 \]

No single demographic variable was therefore found to significantly predict GHQ scores in all three samples. Rather variables that appeared to be particular to each cultural group were: sex, age at marriage and separation for the P sample; employment status of women for the BP sample and number of children and unemployment for the B sample.

### 4.4 DISCUSSION

The reliability, intercorrelation and factor analyses results indicated greater congruence between P and BP samples. The internal structure of the B sample, on the other hand, was found to be more congruent with Goldberg's GHQ-28 structure, thereby confirming hypothesis I. The emergence of differential factor structures in the P, BP, and B samples suggested that the GHQ was measuring differential underlying constructs. This raises the broader question, already briefly discussed in section 4.1.4, of whether the GHQ-28 can
detect more specific disorder categories, such as depression or is simply an index of a
general form of distress.

Item analysis, concomitant with hypothesis IIa, shed further light on the structural findings
of hypothesis I, and indicated that language and socio-cultural desirability factors led to
the differential responses of Ps and BPs, as compared with the B sample. In particular,
it is argued that the social dysfunction and depression sub-scales are culturally the most
in-appropriate for the P and BP samples. The somatic sub-scale, in contrast, and in line
with hypothesis IIb, was found to yield higher sub-scale scores in both P and BP samples.

Multivariate and univariate analysis of variance, as predicted in hypothesis III and IV,
revealed that P respondents scored significantly higher on the total scale and sub-scales
than the BP and B samples. B respondents, in turn, were found to score slightly higher
than BP respondents. The general trend, thus, was P>B>BP. Significant sex and class
effects were also found, with women and working class sub-groups, especially Ps, scoring
higher than men and middle class sub-groups in all three samples. The effects of other
demographic variables were, however, not found to be consistent across all three samples
and are subsequently discussed in relation to each cultural sample.

4.4.1 Hypothesis I - Structural Level
The internal reliability, intercorrelation matrices, standard deviations and mean sub scale
scores suggested that the somatic and anxiety sub-scales held the greatest differentiating
capacity for P and BP samples. In comparison, the alpha reliabilities, intercorrelations,
standard deviations and means for the social dysfunction and depression sub-scales were
relatively low. The subsequent concerns regarding the validity of the social dysfunction
and depression sub-scales for the P and BP samples were further corroborated by the
factor analytic findings.

The emerging factor structure for P and BP samples was striking on two accounts. First,
in terms of the similarity between the two samples and, secondly in terms of the
divergence with the B sample and Goldberg’s preicated sub-scales. This suggested a
distinct cultural difference in response style.

In general, the anxiety and somatic items in both P and BP samples were found to load onto a large general Factor - I, which accounted for the largest percentage of variance; followed by a distinct suicide Factor - II, and two lower ranking social / self dysfunction Factors - III and - IV. This markedly differential response style and factor structure were analysed further in relation to hypothesis IIa and translational issues (refer to section 4.4.2).

The finding of a large general factor in P and BP samples can be more clearly understood in relation to Parkes' (1982) study on cognitive style (this also connects to the cross cultural differences in modes of thought discussed by Lonner (1979) in Chapter 1). Parkes (1982) investigated the influence of cognitive style, namely field dependence / independence, on the reporting of psychological distress / depression, or in other words, the extent to which different aspects of psychoneurotic disturbance are differentiated by the sub-scales in the GHQ. The relevance of field dependence / independence to symptom differentiation, Parkes reasoned, lay in the capacity of field dependent measures to assess the ability of individuals to perceive and categorise elements of their environment, whether internal or external, as discrete and separate from their contextual background. According to this formulation field independent individuals due to socialisation practices tend to be perceptually analytical and discriminating, whilst field dependent individuals tend to have a more holistic and global mode of perception (Whitkin et al., 1974; 1977). Parkes found, as would be predicted by Whitkin et al.'s (1974) theory, that respondents classified as field independent showed greater differentiation in their GHQ factor structure and respondents classified as field dependent showed less differentiation in GHQ factor structure. To elaborate, the response profiles of field independent respondents revealed a general factor which only accounted for a small percentage of variance; factor loadings which corresponded closely to the GHQ -28 sub-scales; and inter-scale correlations which were significantly lower than in field dependant respondents. The response profiles of field dependent respondents, on the other hand, revealed a large general factor which accounted for a large proportion of the variance; factor loadings that did not correspond
closely with GHQ - 28 sub-scales; and higher intercorrelations of sub-scales than in field independent respondents.

At a glance, a parallel can be seen between Parkes' (1982) findings and the samples in this study, that is, between field dependent respondents and P and BP samples (who produced a large general factor, factor loadings that did not correspond with Goldberg's and highly intercorrelated sub-scales), and field independent respondents and the B sample (who produced factor loadings which corresponded with Goldberg's and lower intercorrelations on sub-scales). This distinction in cognitive style, in line with Lonner's (1979) postulation, may be an interesting way of integrating and investigating cognitive and affective aspects of behaviour across culture.

Indeed, Parkes, elaborating on the implications of these field dependent / independent factor profiles, posited that field dependant respondents (in this case P and BPs) are more likely to conform to unitary / mixed state models of minor anxiety and depressive disorders, as exemplified by a large general factor. This can be contrasted to field independent respondents (in this case the B sample) who are more likely to conform to distinct syndrome models, as exemplified by distinctive factors and a small general factor.

In fact the observation of a large general factor and a more unitary form of distress in the P and BP samples is confirmed by other researchers who also report more mixed states of anxiety and depressive neurosis in Indian patients (Derarsari & Shah, 1988). Moreover, casting these differences in terms of field dependence and cognitive style corresponds with anecdotal evidence of context specific thinking in non-Western cultures (Shweder & Bourne, 1991).

The implications of this finding in relation to constructs in the P / BP and B samples are addressed later, in relation to hypothesis III. It is sufficient to say at this stage that a hypothesis linking cultural cognitive style to affect warrants further investigation.
4.4.2 Hypothesis IIa - Linguistic Level

Item analysis enabled a closer look at the influence of translation, language and inter-related cultural concepts on sample responses. This level of analysis helped clarify the emerging factor structure, as well as, the more specific differential cultural endorsements and sub-scale scores in the P and BP samples. The greatest translational problems in terms of Goldberg's structure, were found in factors II, III and IV, which comprised mainly of depression and social dysfunction items.

Item analysis indicated that counter to the general trend of P>B>BP, social dysfunction items 16, 17 and 21, and suicide items 25, 27 and 28, were found to be endorsed (in a pathological direction) by more B respondents than P and BP respondents. In terms of the social dysfunction items, the translated term 'kam' / 'work', in the place of the more general English term 'things' was a common feature of these items. This type of translation problem from the abstract to the specific has also been noted by several other researchers (Sriram, 1989; Currer, 1989; Krause et al., 1990). In particular Currer (1989) and Krause et al., (1990) also found their respondents to question the notion of 'work' in these items in the GHQ. To the respondents in these studies, as well as in this GHQ study, 'work' was regarded as ever present and to be done; a duty rather than a desirable state of affairs. Consequently items 25, 27 and 28 were met with confusion and were seldom endorsed by P and BP respondents. This translation problem thus appeared to evoke far reaching conceptual consequences rooted in salient Pakistani cultural notions. It provides a good example of how language and translation can highlight some of the cultural assumptions on which certain items are based. Chan (1985) has argued that no matter how closely items are translated, they are still subject to cultural interpretation and appraisal, and thereby influences such as social desirability. He suggests certain phrases in particular languages may evoke a different set of evaluative biases than they do in the original version. The term 'kam' in Urdu appears to be an example of this.

Another key term or notion which raised problems was the culturally proscribed idea of suicide, as depicted in items: 24, 25, 27 and 28. These items scored notably low endorsement in the P and BP samples. Reflecting the strong cultural and religious taboos
associated with suicide. Again, P and BP respondents responses to these items were notably defensive.\textsuperscript{26} This strong dismissal of suicidal thought is consistent with the findings of very low suicide rates in Karachi by Ahmed and Zubberi (1981) and Fareberow's (1975) discussion of Islam's condemnation of suicide. Low suicide rates have also been reported in depressed Indian patients by Venkoba Rao (1978; 1984), Prakash (1979) and Sethi (1986)\textsuperscript{27}. It is not clear, however from these studies whether low reporting is due to the complete absence of suicidal thought in these populations, or a reflection of social constraints of open discussion of suicide. Either way, the appropriateness and effectiveness of suicide related questions for this cultural population is questionable.\textsuperscript{28}

The effects of social desirability and defensiveness on responses to the GHQ have also been attested to by Parkes (1980). Using a number of personality measures in conjunction with the GHQ-28, she found significant correlation between social desirability and social dysfunction items and between defensiveness and reported psychological distress. Thus, the social dysfunction and depression sub-scale in the GHQ, irrespective of culture, appear to be particularly prone to social desirability and defensive factors. In this study this was been found (through endorsement percentages and factor analysis) to be further highlighted in the P and BP samples due to socio-cultural factors (already discussed).

4.4.3 Hypothesis IIb - Somatisation

Interestingly the one sub-scale that Parkes (1980), found to be not influenced by defensiveness was the somatic sub-scale. Item analysis indicated that counter to the general trend of P>B>BP, both P and BPs endorsed more somatic items in a pathological direction than B respondents. This notably greater endorsement of the somatic sub-scale

\textsuperscript{26} Suicide, of course, is also taboo amongst British subjects, but less so since the progressive secularisation of society.

\textsuperscript{27} B.B Sethi (1986) in a review of epidemiological studies of depression in India covers the issue of low rates of suicide.

\textsuperscript{28} It is interesting to juxtapose this finding with Raleigh (1990; 1996), who reported high suicide rates in Asian women. These statistics ave indicated predominantly higher rates in Indian women as opposed to Pakistani women.
confirmed hypothesis IIa.

The relatively greater somatic sub-scale scores in the P and BP samples were consistent with the findings of several researchers (Rack, 1982; Bavington & Majid 1986; Bal 1987), who have stressed the importance of somatic symptomology and expression in Asians. Somatisation would thus appear to be a culturally salient way of Ps and BPs expressing psychological distress. Indeed, Kleinman (1987) argues that somatic symptoms are universally a more acceptable and common form of expressing distress / depression in many non-Western cultures. Rather than drawing any definitive conclusions at this stage, however, the issue of somatisation is discussed further in Chapter 5 in light of the findings of the AKUADS study.

To summarise, in structural terms (ie. Hypothesis I and II), the results indicated a distinctive response style in both P and BP samples. These responses, in particular the low endorsement of social dysfunction and depression sub-scales and the high endorsement of somatic sub-scales, it is argued, reflect language and cultural conceptual issues.

In contrast, and in line with predictions, the emerging structure of the GHQ for the B sample was highly comparable to Goldberg's findings. This was not surprising given that the GHQ was developed in English and in a British cultural context. For the B sample, the anxiety sub-scale was found to have the greatest discriminatory power and accounted for the largest percentage of variance. This was followed, respectively, by the depression sub-scale, the somatic sub-scale and finally the social dysfunction sub-scale. Most notably, then, the somatic sub-scale in the B sample did not appear to be as important a vehicle for expressing distress as in the P and BP samples.

4.4.4 Hypothesis III - Cultural Demographic Level

A breakdown and analysis of GHQ total and sub-scale scores revealed distinct cultural and sub-group patterns. P respondents tended to score higher than BP and B respondents on all GHQ sub-scales and the total score. The B respondents, in turn, were found to score
slightly higher than BP respondents on all the sub-scales, apart from on the somatic sub-scale. In line with this finding, the case identification criteria also implicated a proportionally greater number of P 'probable cases', followed by B and finally BP cases. However, whether these findings on total scores and 'probable cases' can be taken as a definitive index of greater psychiatric morbidity in Pakistan is somewhat debatable. There are a number of issues that need to be considered before such a conclusion can be drawn.

The issue of cut-off points and normative uncertainty, which relates to the specificity and sensitivity of the GHQ measure in these cultures needs to be considered. Kleinman and Becker (1991) have pointed out that even within Western psychiatric cultures there is no agreed cut-off point between normal dysphoria and depression, and dysthymia and depression. The cultural variation between Western and South Asian populations with regard to this issue, are indicated by Bandyopadyay et al.'s. (1988) suggestion of using higher cut-off scores in these samples in order to reduce the number of false positives.

The possibility of false positives in the P and BP samples cannot easily be dismissed, as false positives have frequently been associated with somatic symptoms and misclassification in the GHQ (Finlay-Jones & Murphy, 1979). This clearly has repercussions for the P and BP samples, who in hypothesis IIb were found to score particularly high on somatic items. Bearing this in mind the morbidity scores in the P and BP samples need to be re-considered. The possibility that the GHQ in these samples is detecting physical illness as opposed to psychological distress can thus not be ruled out. Finlay-Jones and Murphy, in fact, suggest that somatically presenting individuals or 'false positives' may be using the GHQ to register a more diverse distress, originating in physical symptoms, recent adverse life events or loneliness, as opposed to psychiatric morbidity. Shapiro et al (1987) argued that if this is the case, the benefits to patients of diagnosing and treating non-specific somatic symptoms as mental morbidity must be questioned. This argument, clearly warrants further investigation as it may undermine the value of diagnosing disorders like depression in Pakistani patients who present somatically. In short, the specificity and sensitivity of the GHQ in P and BP populations needs to be established before absolute cultural differences in levels of distress can be concluded in
this study.

Furthermore, to ascertain the cross cultural differential levels of distress in the three samples, the comparability of the GHQ construct needs to be first established. Factor analysis results (as discussed in section 4.4.1) suggested that, in the P and BP samples, the GHQ measured a more unitary form of distress,\(^29\) than in the B sample. In contrast the GHQ factor structure in the B sample appeared to detect distinct aspects of psychiatric morbidity. This thus implies that the GHQ is measuring differential constructs in the P / BP and B samples. Given this limited incomparability in the GHQ construct, caution is urged in concluding greater morbidity in indigenous Ps. This caution is also supported by Corser & Phillip (1978) who, on the basis of their investigation of newly registered GP patients, stress the importance of not taking the GHQ results as definitive evidence of psychiatric disorder. They echo Kessels (1965) comment that "distress is not the exclusive province of the mentally ill". Indeed it can be argued that in a developing city such as Karachi, torn apart by political strife, a high base level of distress is only to be expected and may not necessarily indicate a greater morbidity. Clearly, the context the study was conducted in cannot be divorced from the findings, especially when the context of Pakistan and Britain vary so much.

Indeed, it has already been seen that socio cultural factors, such as social desirability and defensiveness, in response to the GHQ are likely to be effected by the setting in which the assessment is carried out and the subjects appraisal of it (Parkes, 1980). The setting in this study did vary to some extent across all three samples. The P sample, especially working class, were not accustomed to health surveys and questionnaires, and often anticipated medical assistance despite repeated clarification. This may have led them to more readily report or exaggerate subjective distress. It is therefore possible that there may be a considerable number of false positive's in this sample.

\(^{29}\) This is in line with findings reported in other non-Western cultures. For example, Shek (1993) also, on the basis of confirmatory factor analysis using LISREL, reports a higher order factor model, consisting of a general order factor, as well as, five more distinct factors.
The BP sample, on the other hand, were members of a relatively small minority community and related to the interviewer as a community member. Their responses, in contrast to the P sample, appeared somewhat more defensive. It is tentatively suggested that this over caution and defensiveness in symptom reporting may have resulted in a considerable number of false negatives in this sample.

The B sample, were the only group which self administered the GHQ (in line with the mode of administration it was originally designed for), which inevitably reduced the interviewer effect on the study.\textsuperscript{30} The GHQ results of the B sample were in this sense probably the most accurate, as they were less prone to socio-cultural desirability issues and interviewer effect.

On the basis of the above considerations (cut off points, false positive's, construct comparability, context of administration and subject appraisal), it cannot be safely concluded that the greater scores of the P sample, followed by the B and BP samples, reflect absolute cultural differences in psychological distress levels. These confounding issues are to some extent inevitable difficulties which arise from the differential contexts of cross cultural research.

4.4.5 Hypothesis IV - Socio-demographic Level

No one demographic variable was found to exert a significant effect on GHQ score consistently across all three samples. Therefore a common risk group could not be identified across all three cultures, though significant correlations did point to salient social factors in each culture.\textsuperscript{31}

Variables of marital age and effects of separation on women were found to be the most significant predictors of the P samples GHQ scores. These variables were particularly significant indicators of distress in Pakistan where, it has been argued that young

\textsuperscript{30} Statistical tests on a pilot B sample, however, did not indicate a significant effect of self report or interviewer administration on GHQ responses.

\textsuperscript{31} The factors of sex and class are dealt with later.
marriages are common and are a vulnerability factor for psychological morbidity in women (Naeem, 1990), and where divorce or separation are not only considered a social taboo but are a financial impracticality for most women.

In contrast the only variable significantly found to predict GHQ scores in the BP sample was employment status in women. This factor can be understood by considering not only the financial opportunity, but also the escape from isolation which employment offers many migrant women. It is suggested that employment may have, thus, contributed to working BP women scoring significantly lower on the GHQ than their counterparts who stayed at home.

Finally, in the B sample, the number of children, and unemployment were found to be significant predictors of GHQ score. This again can be seen in the context of a culture, where small families are the norm and where lack of work has been frequently linked with psychiatric morbidity. Indeed, there is an argument to say, occupation largely defines identity in many modern individual-based cultures (as opposed to social role orientated cultures). Lack of work in this context then is particularly likely to lead to greater levels of distress.

In sum, the generality of construct of distress / depression across the three cultural samples, in terms of associated demographic variables also appears to be somewhat questionable. The variables that did indicate vulnerability seemed to reflect differential practices and values of particular cultures, and thereby cultural context. Apart from these variables, sex and class differences in GHQ scores were analysed more extensively due to their frequent implication in mental health.

Sex, as predicted, was found to exert a significant effect on GHQ scores, but mainly in relation to somatic scores. In all three cultural samples in this study women were found to score higher than men on the somatic sub-scale. In particular P and BP women were found to score considerably higher than their male counterparts. Briscoe et al.'s (1989) study on the relationship between gender and symptomatology patterns also explored the
link of cognitive style. They found that women had more field dependant characteristics than men and were more likely to suffer vague symptoms, which they suggested proved difficult for general practitioners to diagnose. Interestingly, similar descriptions have also been attributed to the poor recognition of psychological distress in Asian minorities in Britain, who are also frequently described as presenting vague somatic symptoms. The presentation of generalised somatic distress therefore, may, not only be confined to other cultures.

Class was also found to exert a significant effect, but mainly in relation to the severe depression sub-scale, with working class respondents scoring higher than middle class respondents. However, once again, the difference between sub-groups in the P sample was much more pronounced than in the B and BP samples. Indeed, working class and female Ps scored higher than middle class and male Ps on all sub-scales, an effect not as evident in the B and BP samples.

The lack of corresponding differences in the B and BP samples is none-the-less interesting as it indicated that the BP socio-demographic profile is closer to the B samples (despite their response profiles having closely matched the P samples). This similarity in B and BP socio-demographic profile probably reflects the fact that both samples reside in the same country and share a comparable standard of living. This contrasts with Pakistan where there is a greater difference in lifestyle between men and women, and standard of living between the middle and working classes.

In sum, it seems that working class and female Ps score higher than middle class and male Ps on all sub-scales, an effect which is not evident to the same extent in B and BP samples. It is this effect which accounts for most of the observed statistical interactions. Possible reasons for higher rates of mental distress in women and working class respondents are discussed in Chapter 7.

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32 As indicated by the culture, class and sex interactions in the ANOVA results.
4.5 CONCLUSION

To conclude, using the GHQ in a Pakistani sample has raised important issues regarding communication and measurement of distress. In particular, translation issues at the linguistic and conceptual level have been raised in the Urdu version of the GHQ. These have particularly concerned social dysfunction and depression sub-scales, which have been subsequently questioned in terms of their appropriateness. These issues apply to indigenous Ps as well as to first generation BPs, as is borne out by a highly congruent GHQ internal structure in these samples. Whether this similarity in symptom presentation is a reflection of the extent to which BPs have retained their culture of origin or a consequence of language (both P and BPs having been given an Urdu version of the GHQ) is largely immaterial, as the two are inextricably linked. The GHQ results of the British sample, on the other hand, closely matched Goldberg's findings.

Whilst the GHQ has thus helped illustrate the cultural and language issues that need to be considered in any translation process, it has not been able to unequivocally determine definitive levels of psychiatric morbidity in the three samples. At least, not on the basis of these results alone. The major effects of construct comparability, normative uncertainty and cut-off scores, as well as, context comparability need to be taken into consideration before conclusions are drawn. Indeed, the emergence of a large factor and the low scoring on the depression sub-scale suggested that the GHQ was measuring a more unitary form of distress in the P and BP samples. This is as opposed to more distinct disorder categories, such as depression in the B sample, which was found to be factorially differentiated. The possible link of cognitive style with reporting of affect may provide some explanation for these results. It at least appears to be a hypothesis that warrants further investigation.

Apart from these issues which have been raised through translating a Western standardised instrument, across cultures there still remain a number of unresolved issues in using screening instruments cross culturally. The GHQ, by the very nature of its design and standardisation in a British cultural context, does not include items which may be relevant to distress in Pakistani culture. In other words the issue of centicultural bias (Wober, 1969) has to be considered.
THE AGA KHAN ANXIETY AND DEPRESSION SCALE - AKUADS

5.1 INTRODUCTION

The previous chapter questioned the effectiveness of the GHQ in detecting depression in the Pakistani samples. It was, however, argued that the instrument may have utility on detecting a more generalized form of distress in these populations. Although modifications would be required, especially with regards to the social dysfunction and depression subscales. The translation and cultural conceptual problems that these items were prone to highlighted the cultural assumptions that items were based on and the difficulties that conceptually arise in translating them cross culturally. The unmodified version of the GHQ thus only permitted a comparison within the confines of Western defined premises and symptoms (Wober, 1969). The extent of these constraints and centricultural bias (Wober, 1969) can be more clearly seen by juxtaposing a Western standardized instrument with a non-Western standardized instrument. The recent development of indigenous screening instruments has, therefore, afforded the opportunity to broaden the base of comparability and re-address the one sidedness of most translational studies. With this advancement a more complete picture of the communication of distress cross culturally may be developed. Moreover, distress may be more accurately measured.

The Aga Khan University Anxiety and Depression Scale (AKUADS) (Ali et al., 1993a) is a screening instrument indigenous to Pakistan. It was developed in an attempt to overcome some of the issues plaguing the use of Western standardized instruments, as well as, endeavored to improve the identification and diagnosis of depression in Pakistanis.

This chapter reviews the development and construction of the AKUADS and investigates the issues involved in the reverse translation (as juxtaposed to Chapter 4) of a non-Western instrument into a Western cultural context.
5.1.1 Background to the Development of the AKUADS

Ali et al. (1993a) undertook an investigation of the prevalence of psychiatric morbidity and risk factors in patients attending the Community Health Centre (CHC) of the Aga Khan University Hospital (AKU), after having observed that general practitioners at the CHC were spending a considerable amount of their time dealing with problems which were primarily of a psychiatric nature. These problems were reaching the CHC of a tertiary level hospital\(^{33}\), as they were going largely undiagnosed by primary care general practitioners.\(^{34}\) In Pakistan, prior to this, pre-existing epidemiological data on psychiatric morbidity was rather insubstantial. The few studies that had been conducted reported a comparably high rate of psychiatric morbidity, to that found by Goldberg in Britain. Mumford et al. (1991b), on the basis of results from a validated\(^{35}\) Urdu version of the Hospital and Anxiety Depression Scale (HAD), reported an average 30% prevalence rate of depression in general hospital settings. This statistic, in fact, appeared to reflect a growing trend. Ahmed (1989) reported an increase in the rates of diagnosis of depression in new patients attending the psychiatric out-patient department of Jinnah Postgraduate Medical College, Karachi; from 29.3% in 1980 to 44.1% in 1989. However, the accuracy of these diagnoses and subsequent statistics, in terms of inter psychiatric reliability and their reflection of the wider population in Pakistan was open to question. This issue, which is essentially an issue of standardisation, can in part be attributed to the absence of a valid and reliable indigenous screening instrument.

Various Western standardised screening instruments have been translated into Urdu and have been used by researchers in the investigation of depression and anxiety in Pakistan. These have included Urdu translations of: The Hospital Anxiety and Depression Scale - HAD (Mumford et al., 1991b), the Becks Depression Inventory - BDI (Naeem, 1990)

\(^{33}\) It should be noted that the medical system within Pakistan is considerably different to the national health service in Britain, and is composed of a variety of medical and healing approaches.

\(^{34}\) It was this kind of observation that also instigated the development of the GHQ in Britain (Goldberg & Bridges, 1987).

\(^{35}\) The HADS has been validated in terms of linguistic, conceptual and scalar equivalence.
and Self Rating questionnaire - SRQ (Naeem, 1990). Additionally, there are English versions of: The Attribution Style Questionnaires and the Zung depression inventory (Siddiqui, 1992) have also been used. The Urdu translation of the HADS, however, is the only instrument that has been subjected to a systematic (linguistic, conceptual and scaler) evaluative study (Mumford et al., 1991a). Apart from these translated versions of Western standardised questionnaires (and prior to the construction of the AKUADS), the Bradford Somatic Inventory - BSI (Mumford et al., 1991b) was the sole screening instrument that could be said to be indigenous to Pakistan.

The BSI addressed some of the issues involved in producing a multi ethnic screening tool and adopted a methodology, which involved a simultaneous construction in both Urdu and English. In order to do this it focused exclusively on somatic symptoms, which have been argued to be more translatable across cultures than psychological symptoms (Kleinman, 1986) and have been widely reported in patients of Indian and Pakistani origin (Rack, 1982; Bavington & Majid, 1986; Bal, 1987). Somatic symptoms, however, have also been associated with mis-classifications and the identification of false positives in screening instruments (Finlay-Jones & Murphy, 1979) (refer to Chapter 4). This confounding effect, in addition to the complete exclusion of psychological symptoms, renders the BSI open to the debate on whether somatic symptoms alone can be used to diagnose depression as it is known in the West (a predominantly psychological disorder). For the purposes of this study the BSI was thus not considered to provide an appropriate juxtaposition for comparability with the GHQ.

The researchers involved in the development of the AKUADS also felt a similar unease at the dis-inclusion of psychological items in the BSI. They observed in their clinical practice that, if prompted, Pakistani patients did present psychological symptoms. Indeed, Bavington and Majid (1986) and Rao (1986) have argued that most Pakistani and Indian patients when questioned in their mother tongue are able to describe the psychological symptoms of mood disturbance. Consequently, the AKUADS was constructed on the basis of both psychological and somatic symptoms, and was thereby able to overcome the drawbacks of exclusive orientation on somatic symptoms, as in the BSI. Likewise it was
able to overcome the exclusive orientation on psychological symptoms, as in the HAD. The AKUADS was thus the first indigenous screening instrument for anxiety and depression in Pakistan, importantly ground in a local ethnographic context and consisting of both psychological and somatic symptoms.

5.1.2 Construction, Validity and Socio-demographic Correlates of the AKUADS

The AKUADS was based on the complaints of anxious and depressed patients who presented at the Community Health Centre (CHC) of the Aga Khan Hospital over a period of eighteen months. Symptoms reported by at least ten patients, who fulfilled the inclusion criteria, were used to develop a thirty six item questionnaire. The inclusion criteria used for these purposes were: i) a score of greater than eleven on the Urdu validated version of the HAD scale ii) age range of 16-60 years and iii) no presence of physical illness or medication. On the basis of these criteria 64/167 patients at the CHC screened positive for psychiatric morbidity, producing a prevalence rate of 38.4%. Out of these patients, 19.2% were diagnosed as anxious, 4.2% as depressed, and 15% as both anxious and depressed. Further analysis revealed that in this sample psychiatric morbidity was correlated significantly with age, sex, marital status and occupation. People over thirty five years, women, married people and housewives were found to be more prone to suffer from anxiety and depression.

The resulting first draft of the questionnaire was pilot tested on fifty randomly selected patients at the CHC. After an extensive review of this data, eleven items were removed because of similarities in content and patients responses. The subsequent final 25 item questionnaire, consisting of 13 psychological and 12 somatic items, was validated (against psychiatric interviews and diagnoses) in both a clinical and a community setting. In the psychiatric clinic the AKUADS was found to yield a sensitivity of 59% and a specificity of 79%. In contrast the community sample yielded a higher sensitivity of 74% and a specificity of 81%, with a recommended cut-off score of 19 for 'caseness'.

The AKUADS is, however, (unlike the GHQ) still very much in the early stages of its development and needs to undergo more extensive validation and psychometric tests, as
well as discriminant analysis to enable the identification of items which can differentiate between anxiety and depression. There are therefore few validation and socio-demographic studies using this instrument to report.

In spite of it's incomplete development, the AKUADS was chosen for the purposes of this study. This was primarily because of its partial overlap with well established Western screening instruments, as well as its ability to discriminate between 'cases' and 'non cases'. These two aspects rendered it a good point of comparison with the GHQ. Another advantage of the AKUADS was that it was particularly easy to administer in a society, such as Pakistan, which is not familiar with completing written questionnaires. The devisors of the AKUADS saw this as a prime consideration from the outset in the construction of the questionnaire.

5.1.3 Aim and Hypotheses

The aim of this AKUADS study, as in the previous GHQ study, was therefore two-fold:

I. To investigate the effects of language and translation on the internal structure of an English versions of the AKUADS. Enabling thus an establishment of the degree of congruence in both Urdu and English language versions and the construct that they are measuring.

II. To measure symptom levels and psychiatric morbidity in the three cultural samples, and to investigate demographic correlates of morbidity, with particular reference to sex and class differences, in order to identify vulnerable groups.

The AKUADS was administered to an indigenous Pakistani (P) sample in Karachi, a sample of British Pakistani (BP) migrants in London and an indigenous British (B) sample in London. The British sample were administered an English translated version of the AKUADS.

36 Although this has not yet been fully established by Ali et al (1993)
Hypotheses predicted that:

I. There would be more similarities at the structural level, i.e., in terms of response styles between P and first generation BP samples than the B sample (as determined by reliability statistics, item endorsement patterns and factor analysis), given the strong retention of culture of origin in BPs (Ballard, 1994). Furthermore, these similarities would be more in line with the predicted structure of the AKUADS, considering that it is indigenous to Pakistan.

IIa. There would be differential cultural endorsements and scores at the item and sub-scale level, due to translational and other socio-cultural factors, on the basis of Chan (1985) and Siriram's (1989) findings.

IIb. P and BP samples would score higher on, and endorse more, somatic items than the 'B' sample, on the basis of somatisation findings of Kakar (1975); Rack (1982); Bavington and Majid (1986); Bal (1987) and Leff (1989).

III Indigenous Ps would score higher than BP and B respondents given the higher rates found in indigenous Indian samples by Bandyopadhyay (1988) and Prema (1978). The direction of greater psychiatric morbidity in BP and B respondents was not predicted given the existence of only a small number of inconclusive findings (for a more detailed description of these findings refer to hypotheses III in Chapter 4).

IV At the demographic level women would score higher than men and working class respondents would score higher than middle class respondents (Ali et al., 1993a).
5.2  METHOD

5.2.1  Sample and Procedure
The sample and procedure of the overall study has been described in detail in Chapter 3.

5.2.2  Translation of the AKUADS
The AKUADS [appendix 3.4] was translated into English by a proficient Urdu and English speaker. Once again, emphasis was placed on conceptual equivalenc rather than on literal translation of items. The translated English version was then subjected to an independent back translation into Urdu. Any differences between the two versions were assessed and negotiated, before a final version was drafted [appendix 3.3].

Several problems with translation and interpretation of the English version arose, although these were markedly fewer than in the case of the GHQ.

The term 'gabrahat' in item 4 could either have been translated as 'anxious' or 'palpitations'. After careful consideration and discussion with the authors of the AKUADS, the 'anxious' version was chosen on conceptual grounds. It was decided that 'gabrahat' referred to more than just a physical sensation. The term 'mauosee' in item 9 was translated as 'hopeless' but more literally refers to a 'despondency' aspect of hopelessness. The term 'seenai mai jalan' was translated as 'heartburn', rather than the more literal translation of 'burning sensation in the chest'.

5.3  RESULTS

5.3.1  Internal Consistency
Alpha coefficients of internal reliability were calculated for each of the three cultural groups in order to test the internal consistency of the AKUADS sub-scales and total scale. The psychological sub-scale consisted of the first thirteen items, and the somatic sub-scale consisted of the remaining twelve items (refer to table 5.1).
From table 5.1 it can be seen that the AKUADS total scale, as well as psychological and somatic sub-scales had very high levels of internal consistency for both Urdu and English language versions, and for all three samples.

Table 5.1 Alpha reliabilities of AKUADS sub-scales and total scale for P, BP, and B samples

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSY</td>
<td>.92</td>
<td>.86</td>
<td>.88</td>
</tr>
<tr>
<td>SOM</td>
<td>.87</td>
<td>.84</td>
<td>.87</td>
</tr>
<tr>
<td>TOT</td>
<td>.93</td>
<td>.91</td>
<td>.91</td>
</tr>
</tbody>
</table>

5.3.2 Intercorrelation of Sub-scale and Total Scores

Correlations between AKUADS sub-scale and total scores, and intercorrelations between sub-scales for the three samples are presented in table 5.2.

Table 5.2 Intercorrelation matrices of AKUADS sub-scales and total scale for P, BP, and B sample

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>SOM</th>
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<tbody>
<tr>
<td>PSY</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>SOM</td>
<td>.68***</td>
<td>1.00</td>
</tr>
<tr>
<td>TOT</td>
<td>.92***</td>
<td>.88***</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th></th>
<th>BP</th>
<th>SOM</th>
</tr>
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<tbody>
<tr>
<td>PSY</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>SOM</td>
<td>.70***</td>
<td>1.00</td>
</tr>
<tr>
<td>TOT</td>
<td>.94***</td>
<td>.90***</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th></th>
<th>B</th>
<th>SOM</th>
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<tbody>
<tr>
<td>PSY</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>SOM</td>
<td>.55***</td>
<td>1.00</td>
</tr>
<tr>
<td>TOT</td>
<td>.91***</td>
<td>.86***</td>
</tr>
</tbody>
</table>

Sig levels ***p<.001 **p<.01 *p<.05

Both psychological and somatic sub-scales correlated significantly with the total score for all three samples. The intercorrelations between the psychological and somatic sub-scales were also found to be significant for all three samples, although they were found to be
higher for the P and BP samples than the B sample. The greater intercorrelations observed in the P and Bp samples are explained further in the discussion.

5.3.3 Factor Analysis

Exploratory factor analyses was initially conducted to investigate the underlying factor structure of items for all three samples. Principal component analysis with VARIMAX rotation; accepting all components with an eigenvalue of greater than one produced: five factors for the P sample, which accounted for 63.8% of the variance, eight factors for the BP sample, which accounted for 69.8% of the variance and six factors for the B sample, which accounted for 64.5% of the variance.

To avoid over factoring and in order to verify if the data fitted the theoretical psychological and somatic sub-scales, a confirmatory factor analysis restricting the number of factors to two was performed. A cut-off of 0.3 was used to identify components on which items loaded. Highest item loadings were used to determine which factor the items loaded on. The results of the confirmatory factor analysis for all three samples and the whole sample are presented in table 5.3.

From the factor loadings in table 3 it can be seen that at the structural level the AKUADS appears to be pan cultural. For all three samples and the whole sample, all the psychological items loaded onto Factor I and all the somatic items loaded onto Factor II. The psychological factor - FI was found to account for the largest percentage of variance: 39.7% in the P sample, 31.2% in the BP sample and 32.7% in the B sample.

The somatic factor - FII accounted for relatively less variance: 8.6% in the B sample, 8.5% in the BP sample and 10.4% in the B sample.

However on closer inspection there were some items in the P and BP samples that loaded onto counter intuitive factors: item 7 - "Have you wanted to be by yourself" in the P sample and item 13 - "Have you thought about suicide" in the BP sample loaded onto Factor II (the somatic sub-scale). Although, in both cases the factor loadings resulting from a confirmatory factor analysis on the individual samples and on the whole sample were relatively low - 0.4; thereby indicating that these items or responses to these items
Table 5.3  Confirmatory factor analysis structure and loadings pf P, BP, B and whole sample

<table>
<thead>
<tr>
<th>AKUADS ITEMS</th>
<th>P</th>
<th>BP</th>
<th>B</th>
<th>P / BP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you lost sleep</td>
<td>FI .70</td>
<td>FI .43</td>
<td>FI .47</td>
<td>FI .56</td>
</tr>
<tr>
<td>2. Has your interest in your everyday activities declined</td>
<td>FI .71</td>
<td>FI .64</td>
<td>FI .66</td>
<td>FI .68</td>
</tr>
<tr>
<td>3. Has your interest in you hobbies declined</td>
<td>FI .72</td>
<td>FI .69</td>
<td>FI .76</td>
<td>FI .71</td>
</tr>
<tr>
<td>4. Have you felt anxious</td>
<td>FI .75</td>
<td>FI .71</td>
<td>FI .70</td>
<td>FI .72</td>
</tr>
<tr>
<td>5. Have you felt afraid that something bad is about to happen</td>
<td>FI .78</td>
<td>FI .59</td>
<td>FI .63</td>
<td>FI .68</td>
</tr>
<tr>
<td>6. Have you had difficulty in thinking</td>
<td>FI .68</td>
<td>FI .60</td>
<td>FI .61</td>
<td>FI .67</td>
</tr>
<tr>
<td>7. Have you wanted to be by yourself</td>
<td>FI .30</td>
<td>FI .35</td>
<td>FI .39</td>
<td>FI .40</td>
</tr>
<tr>
<td>8. Have you felt lonely</td>
<td>FI .76</td>
<td>FI .64</td>
<td>FI .62</td>
<td>FI .71</td>
</tr>
<tr>
<td>9. Have you felt hopeless</td>
<td>FI .71</td>
<td>FI .72</td>
<td>FI .72</td>
<td>FI .71</td>
</tr>
<tr>
<td>10. Have you felt helpless</td>
<td>FI .72</td>
<td>FI .69</td>
<td>FI .71</td>
<td>FI .73</td>
</tr>
<tr>
<td>11. Have you been worried</td>
<td>FI .78</td>
<td>FI .55</td>
<td>FI .44</td>
<td>FI .66</td>
</tr>
<tr>
<td>12. Have you cried</td>
<td>FI .58</td>
<td>FI .63</td>
<td>FI .68</td>
<td>FI .61</td>
</tr>
<tr>
<td>13. Have you thought about suicide</td>
<td>FI .31</td>
<td>FI .51</td>
<td>FI .43</td>
<td>FI .40</td>
</tr>
<tr>
<td>14. Has you appetite decreased</td>
<td>FI .56</td>
<td>FI .42</td>
<td>FI .40</td>
<td>FI .48</td>
</tr>
<tr>
<td>15. Have you had heartburn</td>
<td>FI .74</td>
<td>FI .57</td>
<td>FI .73</td>
<td>FI .73</td>
</tr>
<tr>
<td>16. Have you had indigestion</td>
<td>FI .57</td>
<td>FI .65</td>
<td>FI .72</td>
<td>FI .67</td>
</tr>
<tr>
<td>17. Have you had nausea</td>
<td>FI .48</td>
<td>FI .82</td>
<td>FI .71</td>
<td>FI .65</td>
</tr>
<tr>
<td>18. Have you had constipation</td>
<td>FI .35</td>
<td>FI .48</td>
<td>FI .52</td>
<td>FI .48</td>
</tr>
<tr>
<td>19. Have you had difficulty in breathing</td>
<td>FI .63</td>
<td>FI .45</td>
<td>FI .69</td>
<td>FI .60</td>
</tr>
<tr>
<td>20. Have your hands, feet or body kept shaking</td>
<td>FI .75</td>
<td>FI .60</td>
<td>FI .78</td>
<td>FI .70</td>
</tr>
<tr>
<td>21. Have your hands or feet gone numb</td>
<td>FI .64</td>
<td>FI .57</td>
<td>FI .63</td>
<td>FI .62</td>
</tr>
<tr>
<td>22. Have you had tension in your neck or shoulders</td>
<td>FI .72</td>
<td>FI .47</td>
<td>FI .53</td>
<td>FI .60</td>
</tr>
<tr>
<td>23. Have you had headaches</td>
<td>FI .62</td>
<td>FI .43</td>
<td>FI .46</td>
<td>FI .56</td>
</tr>
<tr>
<td>24. Has your body ached</td>
<td>FI .74</td>
<td>FI .48</td>
<td>FI .58</td>
<td>FI .66</td>
</tr>
<tr>
<td>25. Have you had to urinate again and again</td>
<td>FI .34</td>
<td>FI .58</td>
<td>FI .62</td>
<td>FI .50</td>
</tr>
</tbody>
</table>
do not correspond as closely to other items on the AKUADS. Possible translational and socio cultural reasons for these discrepancies are examined more fully in section 5.4.

5.3.4 Item Analysis

An item analysis was conducted in order to further ascertain variations in cultural patterns and responses to particular items; thereby helping to indicate which items may be more or less salient to which cultural group. Endorsement frequencies; that is, proportion of respondents endorsing an item in the pathological direction were computed for all three samples. A score of '1, 2 or 3' indicating pathology were re-scored as '1' and percentage endorsement frequencies were calculated for each item (refer to table 5.4).

The endorsement frequencies ranged from 15.8 - 73.3% for the P sample, from 0.8 - 55% for the BP sample and 0.8 - 79.2% for the B sample. Generally higher endorsement frequencies were found for the P sample followed by the B sample and finally the BP sample on each item (in line with the mean AKUADS scores - refer to table 5.6). These results, as in the GHQ study are discussed in terms of percentages rather than statistical significance (refer to Chapter 4).

All three samples showed highest endorsement frequencies on item 11 - "Have you been worried" and lowest endorsement frequencies on item 13 - "Have you thought about suicide"; 'worry' being the most vague symptom and 'suicide' the most extreme.

However on closer inspection this predominant pattern was found to vary on certain, notably psychological. In the case of six out of thirteen psychological items: 1, 2, 4, 6, 7 and 11, B respondents were found to have higher endorsement frequencies than P respondents. These are discussed further in section 5.4.2.

Apart from these deviations from the general trend (P>B>BP) in the direction of the B sample (B>P>BP), there were a few further deviations in terms of both P and BP samples endorsing somatic items: 8, 9, 15, 21 and 25 more frequently (P>BP>B). It is suggested that this may be a reflection of these items being more culturally salient to Pakistanis (refer
Table 5.4  Endorsement percentages of AKUADS items by P, BP and B samples

<table>
<thead>
<tr>
<th>AKUADS ITEMS</th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you lost sleep</td>
<td>43.3</td>
<td>13.3</td>
<td>67.5</td>
</tr>
<tr>
<td>2. Has your interest in your everyday activities declined</td>
<td>44.2</td>
<td>17.5</td>
<td>47.5</td>
</tr>
<tr>
<td>3. Has your interest in your hobbies declined</td>
<td>43.3</td>
<td>14.2</td>
<td>35.8</td>
</tr>
<tr>
<td>4. Have you felt anxious</td>
<td>47.5</td>
<td>32.5</td>
<td>63.3</td>
</tr>
<tr>
<td>5. Have you felt afraid that something bad is about to happen</td>
<td>39.2</td>
<td>18.3</td>
<td>34.2</td>
</tr>
<tr>
<td>6. Have you had difficulty in thinking</td>
<td>40.0</td>
<td>16.7</td>
<td>48.3</td>
</tr>
<tr>
<td>7. Have you wanted to be by yourself</td>
<td>39.2</td>
<td>22.5</td>
<td>59.2</td>
</tr>
<tr>
<td>8. Have you felt lonely</td>
<td>55.0</td>
<td>39.2</td>
<td>35.8</td>
</tr>
<tr>
<td>9. Have you felt hopeless</td>
<td>43.3</td>
<td>34.2</td>
<td>21.7</td>
</tr>
<tr>
<td>10. Have you felt helpless</td>
<td>42.5</td>
<td>25.8</td>
<td>26.7</td>
</tr>
<tr>
<td>11. Have you been worried</td>
<td>73.3</td>
<td>55.0</td>
<td>79.2</td>
</tr>
<tr>
<td>12. Have you cried</td>
<td>45.0</td>
<td>23.3</td>
<td>30.0</td>
</tr>
<tr>
<td>13. Have you thought about suicide</td>
<td>15.8</td>
<td>0.8</td>
<td>13.3</td>
</tr>
<tr>
<td>14. Has your appetite decreased</td>
<td>43.3</td>
<td>15.0</td>
<td>27.5</td>
</tr>
<tr>
<td>15. Have you had heartburn</td>
<td>32.5</td>
<td>29.2</td>
<td>27.5</td>
</tr>
<tr>
<td>16. Have you had indigestion</td>
<td>40.8</td>
<td>15.8</td>
<td>35.8</td>
</tr>
<tr>
<td>17. Have you had nausea</td>
<td>20.0</td>
<td>9.2</td>
<td>20.0</td>
</tr>
<tr>
<td>18. Have you had constipation</td>
<td>40.0</td>
<td>10.0</td>
<td>20.8</td>
</tr>
<tr>
<td>19. Have you had difficulty in breathing</td>
<td>20.8</td>
<td>15.0</td>
<td>16.7</td>
</tr>
<tr>
<td>20. Have your hands, feet or body kept shaking</td>
<td>29.2</td>
<td>10.8</td>
<td>10.8</td>
</tr>
<tr>
<td>21. Have your hands or feet gone numb</td>
<td>50.0</td>
<td>19.2</td>
<td>15.0</td>
</tr>
<tr>
<td>22. Have you had tension in your neck or shoulders</td>
<td>54.2</td>
<td>35.8</td>
<td>54.2</td>
</tr>
<tr>
<td>23. Have you had headaches</td>
<td>60.8</td>
<td>42.5</td>
<td>50.8</td>
</tr>
<tr>
<td>24. Has your body ached</td>
<td>54.2</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>25. Have you had to urinate again and again</td>
<td>25.0</td>
<td>13.3</td>
<td>0.8</td>
</tr>
</tbody>
</table>
5.3.5 Effect of Culture, Sex and SES on Sub-scale Scores

A multivariate 3x2x2 analysis of variance was performed on the psychological and somatic sub-scales and a separate univariate ANOVA on the total scale, in order to test for differences in scores across a) cultural samples b) male and female sub-groups and c) middle class and working class sub-groups.

Using factor scores that resulted from orthogonal VARIMAX rotation instead of sub-scale scores avoided the problem of highly correlated sub-scales and thereby avoided violation of the MANOVA test assumption of; independence of dependant variables. Prior to conducting any statistical tests normality of data and homogeneity of variance test assumptions were addressed by transforming the data for all three samples using square root functions for the psychological and somatic sub-scales, as well as, the total scale.

The results of the multivariate analysis of variance and univariate F tests for the sub-scales and total scale are presented in table 5.5.

From table 5.5, using Pilais criteria it can be seen that the combined DVs are significantly affected by: culture, with F(2, 348) = 12.45 p < .001, class, with F(1,348) = 8.61 p < .001 and sex, with F (1, 348) = 19.24 p < .01. there was also a significant interaction between culture and class, with F(2,348) = 5.02 p<.001, and culture and sex, with F(2,348) = 3.70 p <.01. To further investigate the impact of each main effect and interactive effect a series of univariate F tests were performed on the sub-scale scores, and a separate univariate ANOVA on the total scores (refer to table 5.5). Where appropriate significance levels of the F test were adjusted to .025, using Bonferroni contrasts to account for type I (multiple testing) error.

Effect of culture

The main effect of culture was due to a significant difference in variance in P, BP and B respondents scores on the total scale: F(2, 348) =23.46, p< .001 , the psychological sub-scale, F(2, 348) = 13.02 p< .001 and the somatic sub-scale, F(2, 348) = 10.06 p< .001. Marginal means in table 5.6 indicated that it was P respondents who scored higher than
B respondents, who in turn scored higher than BP respondents. The strength of the relationship between culture, and psychological scores was $\eta = .10$ and culture and somatic scores was $\eta = .11$, and culture and total score was $\eta = .12$.

Table 5.5  Multivariate and univariate analysis of variance of AKUADS sub-scales by culture, class and sex

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>PILLAI'S TRACE</th>
<th>PSY</th>
<th>SOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>CULTURE</td>
<td>$P = .00$</td>
<td>$F(2, 348) = 13.02$</td>
<td>$F(2, 348) = 10.06$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$p^{***}$</td>
<td>$p^{***}$</td>
</tr>
<tr>
<td>CLASS</td>
<td>$P = .00$</td>
<td>$F(1, 348) = 5.85$</td>
<td>$F(1, 348) = 9.03$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$p^{*} .016$</td>
<td>$p^{**}$</td>
</tr>
<tr>
<td>SEX</td>
<td>$P = .00$</td>
<td>$F(1, 348) = 8.03$</td>
<td>$F(1, 348) = 25.70$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$p^{**}$</td>
<td>$p^{***}$</td>
</tr>
<tr>
<td>CULTURE x CLASS</td>
<td>$P = .00$</td>
<td>$F(2, 348) = 6.37$</td>
<td>$F(2, 348) = 2.61$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$p^{**}$</td>
<td></td>
</tr>
<tr>
<td>CULTURE x SEX</td>
<td>$P = .01$</td>
<td>$F(2, 348) = 0.28$</td>
<td>$F(2, 348) = 6.92$</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$p^{***}$</td>
<td>$p^{***}$</td>
</tr>
<tr>
<td>CLASS x SEX</td>
<td>$P = .21$</td>
<td>$F(1, 348) = 0.11$</td>
<td>$F(1, 348) = 3.15$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CULTURE x CLASS x SEX</td>
<td>$P = .29$</td>
<td>$F(2, 348) = .81$</td>
<td>$F(2, 348) = 1.62$</td>
</tr>
</tbody>
</table>

Sig level *** $p < .001$ ** $p < .01$ * $p < .025$

Table 5.6  Marginal means for AKUADS sub-scale and total scores

<table>
<thead>
<tr>
<th></th>
<th>CULTURE</th>
<th>CLASS</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSY</td>
<td>P 8.28</td>
<td>BP 3.82</td>
<td>B 6.74</td>
</tr>
<tr>
<td>SOM</td>
<td>6.48</td>
<td>2.95</td>
<td>4.02</td>
</tr>
<tr>
<td>TOT</td>
<td>14.53</td>
<td>6.82</td>
<td>10.76</td>
</tr>
</tbody>
</table>

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Effect of class

The main effects of class were due to a significant difference in variance between middle class and working class respondents on the total scale: \( F(1, 348) = 16.22, p < .001 \), the psychological sub-scale, \( F(1, 348) = 5.85 p < .05 \) and the somatic sub-scale, \( F(1, 348) = 9.03 p < .01 \). Marginal means (table 5.6) indicated that in each case it was working class respondents that scored higher than middle class respondents. The strength of the relationship between class and psychological scores was \( \eta = .03 \), and class and somatic scores was \( \eta = .049 \), and class and the total scale was \( \eta = .044 \).

Effect of sex

The main effect of sex was due to a significant difference in variance between men and women on the total scale, \( F(1, 348) = 32.70 p < .001 \), on the psychological sub-scale, \( F(1,348) = 8.03, p < .01 \) and on the somatic sub-scale, \( F(1, 348) = 25.70 p < .001 \). Marginal means indicated that in each case it was women that scored higher than men. The strength of the relationship between sex and psychological scores was, \( \eta = .048 \), and sex and somatic scores was \( \eta = .10 \), and sex and the total scale was \( \eta = .09 \).

Table 5.7 Cell means for AKUADS sub-scales and total scale scores

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th></th>
<th>BP</th>
<th></th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC M</td>
<td>MC M</td>
<td>WC F</td>
<td>WC F</td>
<td>MC M</td>
</tr>
<tr>
<td>PSY</td>
<td>4.13 6.76 9.07 13.17 3.07 4.87 1.87 5.47 5.30 7.67 6.93 7.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOM</td>
<td>2.77 6.13 5.17 11.87 1.90 3.23 1.60 5.07 3.00 4.20 4.10 4.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOT</td>
<td>6.90 12.97 13.57 24.70 4.97 8.10 3.67 10.53 8.30 11.87 11.03 11.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Effect of culture and class

The interaction between culture and class was due to a significant difference in middle class and working class P, BP and B respondents scores on the psychological, \( F(2, 348) = 6.37 p < .01 \) and total scales, \( F(2, 348) = 8.98 p < .001 \). Cell means (refer to table 5.7) indicated that P working class respondents scored substantially higher than P middle class respondents. In comparison there was very little difference in BP and B middle class and
working class respondents scores. The strength of the relationship between culture, class and psychological sub-scale was eta = .06, and between culture, class and total scale was eta = .05.

Effect of culture and sex

The interaction between culture and sex was due to a significant difference in male and female P, BP and B respondents scores on the somatic, F(2, 348) = 6.92 p < .001 and total scale, F(2, 348) = 4.07 p < .05. Cell means indicated that the difference in male and female scores was greatest for the P sample followed by the BP sample. The actual difference in B male and female respondents scores was relatively negligible. The strength of the relationship between culture, sex and somatic sub-scale was eta = .04, and between culture, sex and total scale was eta = .02.

5.3.6 Caseness

On the basis of the recommended cut-off score of 19 (derived from a community validity study in Pakistan) for use in community samples 69 'probable cases' were identified. A culture by class by sex breakdown is presented in table 5.8.

Table 5.8 Breakdown of 'probable cases' identified by the AKUADS

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th></th>
<th>BP</th>
<th></th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC</td>
<td>WC</td>
<td>MC</td>
<td>WC</td>
<td>MC</td>
</tr>
<tr>
<td>M</td>
<td>2</td>
<td>8</td>
<td>8</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>F</td>
<td>21</td>
<td>8</td>
<td>1</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>

According to this criteria, once again (as in the GHQ study) the vast majority of cases were Ps - 39, especially working class females - 21. B respondents were found to be the next highest QUALIFIERS of 'probable cases' with -19, followed by BPs with -11. In all three samples relatively few middle class men were identified as 'probable cases'.

A chi square test revealed that the difference in number of 'probable cases' across the three cultural groups was statistically significant, Chi (df, 2) = 18.09, p < .001, indicating that there were significantly more P 'probable cases' followed by B 'probable cases' and finally
BP ‘probable cases’.

5.3.7 Demographics

Having looked at the effects of culture, class and sex, correlations\textsuperscript{37} and standard multiple linear regression analyses were conducted to investigate if any other demographic variables were further predictors of AKUADS scores in each sample. This enabled an investigation into the cross cultural generality and comparability of the construct the AKUADS is measuring (refer to tables 5.9, 5.10 and 5.11). The demographic variables for this analysis were chosen on the basis of previous research correlates identified with psychiatric morbidity. A number of other variables, such as age at marriage and extent of religious beliefs were also included, as they were considered particularly relevant to Pakistani cultural groups. The independent variables (IVs) for this analysis thus were: sex, class, age, marital age, number of children, separation, unemployment, social support,\textsuperscript{38} employment status in women and extent of religious beliefs.\textsuperscript{39}

From table 5.9 it can be seen that the overall regression was significant for the P sample, $F(11,108) = 7.08 \text{ p}<.001$. R square was found to be 0.42 and adjusted R square was 0.36. 42% of the variance in the P sample AKUADS scores was therefore accounted for by the combined effects of the IVs. Although correlations indicated a significant association between AKUADS scores and sex, $r= 0.33 \text{ p}<.001$; class, $r= 0.38 \text{ p}<.001$; education, $r=-0.35 \text{ p}<.0001$; marital age, $r= -0.35 \text{ p}<.001$; separation $r= 0.30 \text{ p}<.001$ and social support, $r= 0.23 \text{ p}<.01$, the regression analysis indicated that only sex, class and effects of separation remained significant predictors of AKUADS once the other variables were

\textsuperscript{37} NB. Pearson correlations were used for the continuous variables of age, marital age, no. children. Kendals tau was used for ordinal variables: education, religious degree. Point Biserial correlations were used for nominal / categorical variables: class, sex, unemployment.

\textsuperscript{38} This is taking absence of relatives and family living nearby (within the same district) as an indicator of lack of social support. This variable was very much delineated and chosen with Pakistani culture and the importance of family in mind.

\textsuperscript{39} Extent of religious beliefs was gauged in the demographic questionnaire by a direct question asking for rating of extent of religious beliefs, as well as, an indirect question about religious activity.
partialled out. Sex, T= 2.98 p<.05 was found to account for 4.8% of the variance of the AKUADS scores. Class, T= 2.40 p<.05 was found to account for 3.1% of the AKUADS scores. Effects of separation, T= 2.22 p<.05 was found to account for 2.7% of the AKUADS scores. The direction of correlation indicated that women and working class respondents and those respondents that were divorced or widowed scored higher on the AKAUDS.

Table 5.9  Demographic correlations and multiple regression analysis of AKUADS scores in P sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beeta</th>
<th>T</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.35***</td>
<td>6.50</td>
<td>2.18</td>
<td>2.98*</td>
<td></td>
</tr>
<tr>
<td>Class</td>
<td>0.38***</td>
<td>6.50</td>
<td>2.71</td>
<td>2.40*</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>-0.35***</td>
<td>-0.80</td>
<td>0.11</td>
<td>-0.93</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.01</td>
<td>0.04</td>
<td>0.03</td>
<td>0.33</td>
<td></td>
</tr>
<tr>
<td>Marital age</td>
<td>-0.35***</td>
<td>-0.28</td>
<td>-0.16</td>
<td>-1.85</td>
<td></td>
</tr>
<tr>
<td>No of children</td>
<td>0.19</td>
<td>0.32</td>
<td>0.07</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>0.30***</td>
<td>9.85</td>
<td>0.18</td>
<td>2.22*</td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>0.13</td>
<td>0.30</td>
<td>0.06</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>0.23**</td>
<td>0.83</td>
<td>0.03</td>
<td>0.40</td>
<td></td>
</tr>
<tr>
<td>Working women</td>
<td>-0.15</td>
<td>-0.28</td>
<td>-0.05</td>
<td>-0.54</td>
<td></td>
</tr>
<tr>
<td>Religious extent</td>
<td>-0.03</td>
<td>-0.13</td>
<td>-0.01</td>
<td>-0.91</td>
<td></td>
</tr>
<tr>
<td>(Constant)</td>
<td></td>
<td>0.00</td>
<td></td>
<td>1.00</td>
<td></td>
</tr>
</tbody>
</table>

F(11, 108) = 7.08***
R Square = 0.42
Adjusted R Square = 0.36

Sig level  ***p<.001  **p<.01  *p<.05

From table 5.10 it can be seen that the overall regression was not significant at the 5% level in the case of the BP sample. Although correlations indicated a significant association between AKUADS scores and sex, r= 0.5 p<.001 and employment status of women, r= -0.23** p<.01, the regression analysis indicated that only sex remained a significant predictor of AKUADS scores once the effects of all other variable were partialled out. Sex, T= 3.19** p<.01 was found to account for 1.4% of the variance in
the AKUADs scores.

Table 5.10  Demographic correlations and multiple regression analysis of AKUADS scores in BP sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beeta</th>
<th>T sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>0.35***</td>
<td>5.43</td>
<td>0.37</td>
<td>3.19**</td>
</tr>
<tr>
<td>Class</td>
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<td>-0.39</td>
<td>-0.27</td>
<td>-0.22</td>
</tr>
<tr>
<td>Education</td>
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<td>-0.47</td>
<td>-0.94</td>
<td>-0.69</td>
</tr>
<tr>
<td>Age</td>
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<td>0.06</td>
<td>0.08</td>
<td>0.73</td>
</tr>
<tr>
<td>Marital age</td>
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<td>0.10</td>
<td>0.07</td>
<td>0.58</td>
</tr>
<tr>
<td>No of children</td>
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<td>-0.25</td>
<td>-0.05</td>
<td>-0.45</td>
</tr>
<tr>
<td>Separated</td>
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<td>-3.51</td>
<td>-0.11</td>
<td>-1.17</td>
</tr>
<tr>
<td>Unemployed</td>
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<td>2.27</td>
<td>0.13</td>
<td>1.37</td>
</tr>
<tr>
<td>Social support</td>
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<td>0.16</td>
<td>0.01</td>
<td>0.10</td>
</tr>
<tr>
<td>Working women</td>
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<td>-2.25</td>
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<td>-1.48</td>
</tr>
<tr>
<td>Religious extent</td>
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<td>-0.91</td>
<td>-0.08</td>
<td>-0.76</td>
</tr>
<tr>
<td>(Constant)</td>
<td></td>
<td>-1.61</td>
<td></td>
<td>-0.16</td>
</tr>
</tbody>
</table>

F(11, 108) = 2.54
R Square = 0.21
Adjusted R Square = 0.13

Sig level  ***p<.001  **p<.01  *p<.05

From table 5.11 it can be seen that no single IV was found to correlate significantly with the AKUADS scores in the case of the B sample, or exert an effect in the regression analysis at the 5% level.

No single demographic variable was therefore found to significantly predict AKUADS scores in all three samples. Rather variables that appear to be particular to each cultural group were: sex, class and separation in the P sample and sex in the BP sample.
Table 5.11 Demographic correlations and multiple regression analysis of AKUADS scores in B sample

<table>
<thead>
<tr>
<th>IVs</th>
<th>r</th>
<th>B</th>
<th>Beta</th>
<th>T sig</th>
</tr>
</thead>
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<td>1.48</td>
</tr>
<tr>
<td>Class</td>
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<td>0.72</td>
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<td>-0.00</td>
<td>-0.00</td>
</tr>
<tr>
<td>Age</td>
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<td>-0.01</td>
<td>-0.01</td>
<td>-0.08</td>
</tr>
<tr>
<td>Marital age</td>
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<td>0.11</td>
<td>1.15</td>
</tr>
<tr>
<td>No of children</td>
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<td>1.00</td>
<td>0.15</td>
<td>1.25</td>
</tr>
<tr>
<td>Separated</td>
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<td>Social support</td>
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<td>0.94</td>
<td>0.05</td>
<td>0.54</td>
</tr>
<tr>
<td>Working women</td>
<td>-0.06</td>
<td>-1.61</td>
<td>-0.09</td>
<td>-0.90</td>
</tr>
<tr>
<td>Religious extent</td>
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<td>0.02</td>
<td>0.19</td>
</tr>
<tr>
<td>(Constant)</td>
<td></td>
<td>3.90</td>
<td></td>
<td>0.41</td>
</tr>
</tbody>
</table>

\[ F(11, 108) = 0.72 \]
R Square = 0.07
Adjusted R Square = 0.02

Sig level ***p<.001 **p<.01 *p<.05

5.4 DISCUSSION

Analysis of the internal structure of the AKUADS revealed surprisingly little difference between the three samples at the structural level. Alpha reliabilities, intercorrelations and factor analyses attested to the pan-cultural structural validity of the AKUADS and suggested that it can be reliably used in all three cultural groups. Intercorrelation patterns and item analysis did, however, indicate a higher degree of equivalence, between the P and BP samples as predicted by hypothesis I (both of whom were administered the Urdu version). This is discussed in relation to the influence of language and cultural conceptions predicted in hypothesis IIa.

The most striking finding, however, pertained to hypothesis IIb and the somatisation of mental distress in Pakistanis, which was not upheld in this study. All three samples,
including the Pakistani sample, were found to score higher on the psychological sub-scale than the somatic sub-scale. Moreover, factor analysis further indicated that the psychological factor (counter to predictions) accounted for relatively more variance than the somatic factor. It is argued that this finding was indicative of the conceptual and linguistic isomorphism of the AKUADS to Pakistani culture. In turn, it is suggested that somatisation, as conceptualised in psychiatric nosology, is a notion rooted in the context of a western mind body dichotomy.

Multivariate and univariate analysis of variance revealed, as predicted in hypotheses III and IV, that in P respondents scored significantly higher on the total scale and sub-scales than the BP and B samples. B respondents, in turn, (as in the GHQ study) were found to score higher than BP respondents (P>B>BP), although the difference was less marked. Significant sex and class effects were also found, especially in the P sample, with women and working class sub-groups scoring higher than men and middle class sub-groups. Once again, however, the effects of other demographic variables in identifying risk groups, were not found to be consistent across all three cultural samples.

5.4.1 Hypothesis I - Structural Level

Alpha coefficients indicated that both psychological and somatic sub-scales, as well as the total scale, held a high degree of internal consistency for both Urdu and English language versions. Intercorrelation matrices, however, indicated that in the case of the P and BP samples there was greater correlation between psychological and somatic items. These high intercorrelations could either have been reflective of a 'yeah saying' effect, in which both P and BP respondents were simply responding 'yes' more frequently and indiscriminately than B respondents, or indicative of a more meaningful connection. It is argued that the former explanation is the more unlikely, as if this was the case, than one would expect the 'yeah saying' effect in these two samples to be accompanied by comparably high total scores on the AKUADS. In fact contrary to this, the P and BP respondent scores marked either end of the continuum in this study, with P respondents scoring the highest and BP the lowest, thus lending credence to the latter explanation. In spite of these large differences in scores the P and BP samples showed markedly similar
item endorsement patterns, suggesting a mediatory effect of culture. It is proposed that the observed overlap in psychological and somatic symptoms is reflective of a unified mind and body, in line with the conceptualisation of the traditional Asian medical paradigms of Ayuverda and Unani medicine. These paradigms, do not characteristically draw a sharp distinction between psyche and soma and advocate a more holistic, overlapping perception of mind and body (Kakar, 1975; Zimmerman, 1987) (refer to hypothesis IIb)

Apart from the intercorrelational similarities in the P and BP samples, at the structural level the AKUADS appeared to be pan-cultural. This was to the extent that the somatic and psychological sub-scales were replicated in all three samples by confirmatory factor analysis. This pan-cultural structural validity of the AKUADS may in part have been due to the AKUADS simple sub-scale structure, in which the line of demarcation was only drawn at psychological and somatic symptoms. Such a distinction can be more simplistic and arguably universal than an attempt to delineate distinct disorder categories. Indeed, it is probably this very structure that made the AKUADS amenable to cross cultural study. The structural consistency in the AKUADS suggested a consistency in the construct the AKUADS was measuring in all three cultural samples. The exact nature of this construct; that is, whether it was a specific index of depression / anxiety or a more general form of distress are addressed later in relation to hypothesis III.

5.4.2 Hypothesis II - Linguistic Level

Item analysis enabled a closer look at the influence of translation, language and inter-related cultural conceptions on the samples responses. Indeed, as predicted by hypothesis II, differential endorsement patterns counter to the general trend of P>B>BP were observed on several items.

B respondents were found to have higher symptom levels than Ps and BPs on six out of thirteen psychological items (1, 2, 4, 6, 7, 11). Whilst this may in part be a reflection of certain psychological items being more relevant to British cultural groups, a closer semantic inspection of these items revealed that in certain cases the differential endorsement patterns were a consequence of the translation procedure from Urdu into
English. In contrast to the preceding GHQ study and predominantly Western centicultural bias, this analysis identified items that were inappropriate to and / or difficult to translate into a British cultural context. It thereby also exposed linguistic and conceptual assumptions integral to Pakistani cultural beliefs.

A particular example of such translational problems, and one also previously identified by the devisors of the AKUADS was item 4 - "Have you felt anxious" (refer to section 5.2.2). The original Urdu term used in this item 'gabrahat' posed an interesting translational dilemma. However whilst 'anxiety' evoked an interpretation with more psychological connotations, 'palpitations' evoked an interpretation with more somatic connotations. Neither term evoked the true essence of the psyche / soma overlap inherent in the linguistic term 'gabrahat'. This type of translational problem, it is suggested, is fundamentally due to the metonomic nature of the Urdu statement, which in turn reflects the metonymy correspondence and correlation stressed by the Ayuverdic (Zimmerman, 1987) and Unani treatises (refer to Part III for a fuller understanding of this argument). Such a conceptual leap is difficult to bridge and translate into a language such as English which, on the other hand, constructs a separation in psyche and soma in line with its own cultural conceptions of modern medicine. This subtle un-equivalence in meaning in item 4 may be responsible for the observed differential endorsements of the P / BP and B samples.

In contrast to the differential pattern evident in the direction of the B sample, on five psychological and somatic items (8, 9, 15, 21, 25) both P and BP samples (counter to the general trend) were found to have higher symptom levels than the B sample. This suggested that these items, in turn, may be more relevant or appropriate to Pakistani cultural groups.

Interestingly, item 9 - "Have you felt hopeless" counter to previous studies (Currer, 1986; Krause et al., 1990), as well as the GHQ study (refer to Chapter 4), was marked by relatively high endorsements in the P and BP samples. Currer (1986) and Krause et al. (1990) suggested that the low endorsements they observed with regards to this notion in
their samples was attributable to the difference between Western and South Asian world views (Obeyesekere, 1982; Shweder & Bourne, 1982). They argued, in more devotional South Asian cultures, hope and worthiness are not considered the domain of the individual but rather the domain of the divine and fate. The concept of 'hopelessness', thus, as juxtaposed to 'hopefulness' embues or assumes the individual to have some control. Gaines (1992) points out that this very notion is reflective of western cultural thinking and a belief in an internal locus of control. The reason for this some-what counter intuitive findings in the AKUADS, however, can again be traced to the translation procedure and the subtleties in alteration of meaning. The original Urdu term that was translated into 'hopelessness' was *mauosee*, which more literally translated as 'despondency'. In can be argued, that this concept of 'despondency' / *mauosee* in Urdu does not evoke or carry the same religious connotations as the notion of 'hopelessness'. The religious connotations of hopelessness are more evident in the Urdu terms *nakabi* or *naomeed* (as was used in the GHQ). This bypassing of the religious connotations, it is suggested, leads to the greater endorsement of item 9 by more P and BPs than Bs in this study, and in comparison to previous studies.

The other psychological item that was endorsed more by the Ps and BPs was item 8 - "Have you felt lonely". What was interesting about this item was that the Urdu term *thanhayi*, meaning 'lonely' is often given as a conceptual translation of the English term 'depression'. It can be speculated that the inherent social, or 'lack of social', nature of this term and the relatively greater endorsement of it may relate to a more socially as opposed to individually defined concept of sadness in Pakistanis.

This greater emphasis on the social also appears to correspond with the conceptual misinterpretation of item 7 - "Have you wanted to be by yourself". Item 7 was questioned by many of the P and BP respondents, even though this may seem some-what counter intuitive considering that the AKUADS was developed in Pakistan. Many respondents interpreted item 7 as expressing a preference for living alone in a nuclear family as opposed to a joint family. Subsequently responses were heavily prone to a social desirability effect. Pakistani cultural values of the extended family and preference for
living with others in an extended network was repeatedly re-affirmed by the respondents. This may then have accounted for the particularly low endorsement and differential factor loading of this item in Ps and BPs.

In the case of the somatic sub-scale, higher P and BP symptom ratings were found on items 15 - "Have you had heartburn", 21 - "Have your hands or feet gone numb" and 25 - "Have you had to urinate again and again". These items refer to somatic symptoms that are not frequently found in Western inventories of depression and anxiety and thus appear to represent somatic symptoms or associations that are specific to Pakistani cultures. They are also covered in Mumford et al.'s. (1991b) somatic inventory.

5.4.3 Hypothesis IIa - Somatisation

In spite of the invariably greater endorsement of somatic items by Ps (and in some cases BPs), the somatisation hypothesis; that is the prediction of greater scores on the somatic sub-scale than the psychological sub-scale, was not upheld. All three samples scored higher on the psychological sub-scale than the somatic sub-scale. In addition, the psychological factor was also found to account for greater variance in all three samples than the somatic factor. Whilst these findings, on the one hand, cast doubt on the somatisation stereotype in Asians they also, on the other, indicate the isomorphic nature of psychological items in the AKUADS to Pakistani culture. For example, the term 'gabrahat' (as already discussed) and its metonymic nature, relates to the crux of the somatisation hypothesis. Bearing in mind the argument put forward in relation to this term, a subsequent re-consideration of the somatisation hypothesis reveals the limited understanding of the concepts of Ayurveda and Unani holism that this notion was based upon. The refutation of the somatisation hypothesis may therefore be more culturally in tune than appears at first sight.

The somatisation notion has often been based by researchers on the holistic approach to mind / body in Ayurvedic and Unani medical systems. However, it is argued that Western researchers in proposing this notion have been unable to fully escape their dichotomous mind / body thinking, and have consequently perpetuated the Cartesian dualism by
recreating the split in the notion of 'somatisation', as juxtaposed to 'psychologisation'. This notion has then been further sustained by research using either western standardised screening instruments consisting primarily of psychological items, or alternatively exclusive somatic based inventories. The holism and quintessential connection of both psyche and soma in Ayuverdic and Unani medicine has consequently, been overlooked.

It can be further argued, that the very notion of somatisation implies a physical expression of distress, which in terms of western medicine denigrates the role of the somatic as metaphorical or a mask for the psychological (Weiss et al, 1995). As Krause (1994) points out, metaphor in cross cultural psychiatry is frequently used to imply that a word used in one context is borrowed from another, and that the borrowed meaning is opposed to the meaning that 'really belong' to the word. Accordingly, somatic sensations are used metaphorically to express the 'real' underlying psychological symptoms. Such a formulation bridges to some extent the gap between somatic sensations and abstract psychological language in western cultures. However, it still continues to assume the psychological to be 'real' and somatic to be 'metaphorical'. It is, therefore, quintessentially counter to the very correspondence between psyche and soma that is advocated in Ayuverdic and Unani frames of explanation.

It is thus argued that it is somewhat simplistic to assume that Asians 'somatise' distress. Rather, their presentation of physical symptoms have to be seen in terms of the conceptual connection between psyche, soma and emotions, as well as in the context in which they generally occur; that is a General Practitioner surgery setting. The lack of psychological presentation and subsequent 'somatisation' may in fact, be attributable to the context and source of help that General Practitioners are perceived to provide. Shifa (1990) has suggested that the source of help that is sought in Pakistan is dependent on the nature of the symptomatology and the perceived cause. If symptoms are predominately psychological then the cause is usually related to some kind of 'asaar' - magical effect and help is traditionally sought from 'Mulvis' and 'Pirs' (religious healers). On the other hand, sufferers tend to turn to medical doctors and hakims for help if symptoms are predominantly somatic. If the source of help is thus deemed appropriate, or in the case.
of a screening instrument if the item is culturally isomorphic, then Pakistanis do appear to express mental distress in psychological terms (as well as somatic). This was evident in the responses of the P and BP samples to the AKUADS, which having been based on the reported symptoms of indigenous Pakistani patients was culturally isomorphic and thereby not perpetuating of the somatisation notion. Even though the AKUADS demarcated psychological and somatic sub-scales, it was able to avoid sharp western based dichotomising and drawing of distinction between psyche and soma.

5.4.4 Hypothesis III - Cultural Demographic Level
A breakdown analysis of the AKUADS subs-scale and total scores revealed distinct cultural and sub-group patterns. P respondents, as predicted, were found to score significantly higher than the other two samples on both sub-scales and the total scale. B respondents, in turn, were found to score significantly higher than BP respondents on both sub-scales and the total scale. Although, as in the GHQ study, it is not conclusive whether this finding can be taken as a definitive indication of greater psychiatric morbidity in the indigenous P sample, followed by the B sample and finally the BP sample. Once again in order to determine comparability of the construct, it is necessary to address the issues of normative uncertainty, cut-off points and the context and participant appraisal of the study. The first and second issues require the same considerations as in the preceding GHQ Chapter (refer to Chapter 4). However, as previously discussed, the issue of construct is slightly at variance in this study. Structural validity in this case suggested that the construct the AKUADS was measuring was comparable across all three cultural samples. The construct the AKUADS was designed to measure was anxiety and depression. Whether or not this is the case, however, is open to debate.

Whilst the items in the AKUADS and the construct it is measuring can be said to be culturally isomorphic, they are also notably amorphous. For the most part, in comparison to the GHQ, endorsement percentages on the AKUADS were notably high for all three samples. This may partly be a consequence of the differential scoring methods in the two instruments and the indistinctiveness of certain AKUADS items. For example, item 11 - "Have you been worried" - was found to have exceptionally high endorsement percentages,
ranging from 55% to 79.2%. It is then doubtful if item 11 can be taken as indicative of pathological distress or distinct disorder categories; that is, at least without the specification of a context or preface. In fact, bearing in mind the mode of construction of the AKUADS (i.e. patients reported symptoms) it can be argued that the AKUADS is measuring a general non-distinctive construct of distress, as opposed to depression / anxiety per se. Indeed the findings of Ali et al. (1993b) also reported a relatively high prevalence of mixed anxiety and depression in Pakistan. Weiss et al. (1995) have also questioned the distinctiveness of disorder categories, such as depression, anxiety and somatoform disorder in Indian populations. This ambiguity, however, is not really surprising. It corresponds with the context in which the AKUADS was developed; that is, a culture in which mental distress is only recently beginning to have pathological medical status as 'depression / anxiety' under the auspices of the profession of psychiatry. Previously distress has, to a large extent, been treated with indigenous folk approaches and has not been isolated as pathological by popular and professional cultures to the same extent as it is in the West. This vague nature of items in the AKUADS are then probably the very property that render it an isomorphic instrument for Pakistani cultural contexts. There is no doubt that further discriminatory analysis studies and sub-scale development on the AKUADS will contribute to this debate.

5.4.5 Hypothesis IV - Socio-demographic Level

In terms of demographic profiles, as in the GHQ study, there was no one variable that exerted a significant effect on the AKUADS score consistently throughout all three samples. Therefore a common risk group could not be delineated across all three cultures. The significant predictors that were found hinted at salient social factors in each particular culture. Sex, class and effects of marital separation were found to be significant predictors of AKUADS scores in the P sample. Sex was found to be a significant predictor of AKUADS scores in the BP sample. No single variable was found to significantly predict the AKUADS scores in the B sample. The generality, in terms of demographic variables, of the construct being measured by the AKUADS scores is thus once again questionable. As discussed in the GHQ chapter, variables indicating vulnerability reflect practices and values of particular cultures, and are thereby cultural specific (refer to Chapter 4).
Sex, however, as predicted was found to exert a significant effect on AKUADS scores. Women were found to score significantly higher than male sub-groups. Interactive effects indicated that this was primarily due to female Ps and female BPs (although to a smaller extent) scoring higher than male Ps and BPs on the somatic and total scales. The difference in male and female B respondent scores was relatively small.

Class, as predicted, was also found to exert a significant effect and working class sub-groups were found to score significantly higher on the AKUADS than middle class sub-groups. Interactive effects again indicated that this effect was primarily due to a more marked difference in working class and middle class P respondents scores on the psychological and total scales. The difference in middle class and working class BP and B respondents scores on these scales was much smaller.

It therefore appears that working class and female Ps score higher than middle class and male Ps on all sub-scales, an effect which is not evident to the same extent in B and BP samples. It is this effect which accounts for most of the observed statistical interactions. The lack of corresponding sizeable differences within B and BP sample sub-groups scores indicates that although the BP response profile closely matched the P samples, their socio-demographic profile corresponded more to that of the B samples. The similarity between B and BP sample socio-demographic profiles (which was also observed in the GHQ study) is probably a consequence of these samples residing in the same country and sharing a more comparable standard of living. This contrasts with Pakistan (a non welfare state) where there is a marked difference in lifestyle between men and women, and the middle classes and working classes. Indeed P working class women were found to represent the largest number of 'probable cases' in this study. Possible reasons for higher rates of mental distress in women and working class respondents are discussed in more detail in Chapter 7.
5.5 CONCLUSION

To conclude, the development of an indigenous screening instrument for depression and anxiety in Pakistan - the AKUADS, has provided an invaluable opportunity for research that reverses the prevalent approach of applying Western standardised instruments to non-Western cultures. It offers semantic insight, through linguistic and conceptual translational problems, into wider Pakistani cultural themes tied to mental distress, and thereby re-addresses the centicultural bias of Western instruments. The metonymy and correlation of somatic and psychological symptoms, as raised in item 4 and the socially rooted connotations of items 7, 8 and 9 all offer a wider perspective on the meaning and communication of distress for Pakistanis. This, however, is not to say that the presentation of somatic symptoms with psychological symptoms and the connection of loneliness with depression is only true of Pakistanis. Rather there being raised in an instrument indigenous to Pakistan indicates their cultural salience and helps build a more complete picture of the communication of distress in this cultural setting. Much of this could easily be overlooked if one was to rely on Western screening instruments alone.

The indigenousness of this study has also enabled a questioning of the stereotype of 'somatisation' of mental distress in Asians. It has been suggested that an emphasis on somatisation, through extended use of culturally biased screening instruments and research has obviated the holistic conceptual link between psyche and soma in the presentation of psychological distress in Asians.

The pan cultural structural validity of the AKUADS suggests that it may be a valuable tool for cross cultural comparison in the context of Pakistani and British culture. It has been argued, however, that the comparative construct can only be taken as a generalised form of distress, rather than anxiety or depression per se at this stage. Indeed, it is worth remembering that the AKUADS is still in the early stages of its development and requires further validation and discriminatory studies before definitive cross cultural conclusions can be drawn. The AKUADS also needs refinement for use in Pakistani samples, as indicated by misinterpretations such as in item 7. Studies addressing these issues are currently being conducted by the team of researchers that developed it. In conducting
these further discriminatory studies, however, it is important to be cautious that the cultural isomorphism and cross cultural appropriateness of the AKUADS are not detracted by the demarcation and identification of further distinct pathological sub-scales. The isomorphism of the AKUADS appears to be inherent in its very amorphous non-distinctive and generalised nature.
-CHAPTER 6-

THE MENTAL DISTRESS EXPLANATORY MODELS QUESTIONNAIRE

6.1 INTRODUCTION
The previous two chapters addressed the symptomatology of distress / depression across cultures. They questioned whether the construct the GHQ and AKUADS were measuring could be concluded to be a general form of distress or more specifically depression. The comparability of the construct was also open to question. This matter and the presentation of symptoms may be better understood by considering health beliefs and etiology. Weiss (1996) has argued that illness meaning should be an integral consideration for diagnostic validity. On a more practical level other researchers have also attested to its necessity for good patient / healer communication (Kleinman, 1975; Lazare et al., 1975; Tuckett & Williams, 1984; Greenfield et al., 1987).

The way in which people explain their illness has been shown to be strongly related to wider cultural health beliefs (Herzlich & Peirret, 1986). The way symptoms are presented (White, 1982; Good, 1977; Krause, 1989; Bal, 1987), the attributions placed on the illness (Abrahamson et al., 1961; Rippere, 1977a) and subsequent help seeking behaviour (Karstair & Kapur, 1976; Rippere, 1977b; Weiss et al., 1986) have all been argued to be culturally influenced.40 Kleinman's (1978) disease / illness distinction helps avoid this assumption, and his explanatory models (EMs) framework provides a template for researching cross cultural and intra cultural health beliefs (Kleinman et al., 1978). This chapter reviews the literature on EMs across and within cultures and their relevance for healing, with particular reference to Pakistani cultural health beliefs. It investigates the differences and similarities in P, BP and B samples EMs as identified through Eisenbruch's (1990) Mental Distress Explanatory Models Questionnaire (MDEMQ).

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40 This although does not necessarily imply an exact correspondence between the professional and popular health domains within a given culture.
Kleinman at al. (1978) refers to Explanatory Models (EMs) as the culturally rooted complex structures that specify notions about the illness episode and its treatment, including the name of the illness, attribution of cause and prognosis. Kleinman (1986) regards EMs to be cultural constructions and by this virtue also historical and socio-political products. Considering this shared base of EMs one would expect considerable overlap and symbiosis in patient and healers EMs, within a given culture. Indeed, for healing to take place there needs to be a connection between the expectations and beliefs of both patient and healer (Helman, 1985). Whilst this is often assumed to be the case, especially by medical practitioners (Littlewood, 1991), Eisenberg (1977), Kleinman (1980) and Hahn (1984) have suggested that there is an inherent conflict between the perspectives of modern medical practitioners and patients. In other words this pertains to the disease / illness dichotomy.

To elaborate on this conflict, the disease perception of modern medicine is characterised by a mind / body dualism and biophysical reductionism, whereas the illness perspective refers to the subjective experience and societal reaction to disease (Fabrega, 1992). Kleinman (1977) argues that according to the biomedical or disease view, biological data is treated as being more real and clinically significant than social information for establishing a diagnosis. Disease in this sense is seen as a malfunctioning in biology or psychological processes and an abstract recurring identity irrespective of the socio-cultural setting that it appears in (Fabrega, 1992). Illness in contrast involves how the patient and those close to him / her perceive the origin and significance of the event and how it effects their emotional state, behaviour and relationships with others (Helman, 1991). Illness in this sense is a more diffuse concept than disease and is patterned by social, psychological and cultural factors.

Contemporary modern medical systems in this formulation, therefore, are predominantly disease centred. Young (1976) and Foster (1976) consequently argue that in these systems the patients perspective is often depreciated and their role is reduced to 'object'

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41 Kleinman draws a distinction between healing and cure, with healing referring to the 'illness' aspect and cure to the 'disease' aspect.
rather than 'active' participant capable of initiating action or a choice of alternatives in the illness episode. The consequence of this assumption, however, can be far reaching. For example, Kleinman (1975) and Lazare et al (1975) have found that health care was impeded when EMs conflicted. Furthermore, research specifically addressing communication and information exchange in the clinical setting has shown how communication, which is arguably a function of compatible EMs or an awareness of patients EMs, is a major determinant of patient compliance, comprehension (Greenfield et al., 1987; Heurtin & Reisin, 1992) and satisfaction (Tuckett & Williams, 1984) and thus appropriate use of health services. Helman (1985) in a study on patient and providers perception of illness found the particular areas of divergence in patient and practitioners EMs to be with regards to: etiology of the condition, origins of the condition, and effects on the patients social relationships; that is, the very social aspects which have been repeatedly identified as having been undermined and underestimated by practitioners.

Beyond the cognitive elements of EMs there are, however, also socio-political dimensions to the consultation setting which cannot be ignored. Littlewood (1991) points out that the medical beliefs of a society are also connected to its wider values, including the symbolic representation of power and general social structure. The actual relationship between patient and practitioner can also then be pervaded by factors such as, social distance in terms of status and role between patient and doctor, incompatible frames of reference regarding what information should be shared, sociolinguistic differences and extent of shared knowledge (Mathews, 1983). These factors Mathews suggests lead to an evaluation by the practitioner of the ability of patients to process information, their desire to learn about their illness and, in turn, the amount of information that is shared with them (Pendelton & Bochner, 1980). Practitioner 'patient typing' and lack of knowledge of EMs has, not surprisingly, been found to be particularly marked where less educated and working class patients are concerned (Helman, 1985). The negative effect of this on recognition of psychological morbidity in the consultation setting has been discussed in Chapter 4. In addition Stein (1986) has suggested that historical and subjective influences also operate in the consultation setting. The other power dimension that, thus, cannot be dismissed from the consultation setting is the possibility of racism.
Fernando (1995) has underlined that successive Biennial Reports of the Mental Health Act Commission (1987, 1989) have identified the needs of black and ethnic minorities as a priority, and have quoted the disadvantages that are being suffered by black people in Britain because of racism. Within health authorities there is now growing concern that Asian minorities are under-utilising health services and more research investigating their mental health needs has recently been undertaken. Whether under-utilisation is simply a consequence of a mis-match in patient and practitioners EMs and subsequent poor detection of psychological distress in Asian minorities or a consequence of racism is difficult to tease apart. There is some evidence, however, of ‘patient typing’ and poor patient / practitioner communication in cultural minorities. Donovan (1986) found that Asian and African women in her sample appeared to be uncertain of expectations in the doctor / patient relationship. Cartwright and Anderson (1981) (as discussed in Chapter 3) have suggested that even if doctors do recognise the symptoms of mental illness in minority patients, they may think it is not appropriate to refer them to other agencies. Indeed overall it seems likely that given cultural differences and a linguistic barrier, practitioners would be less inclined to elicit EMs in minority patients.

In terms of EMs and symptom presentation, Bal (1987) has suggested that greater somatisation in Asian patients can be understood by referring to their traditional health beliefs. The medical health beliefs of South Asian cultures have been described by Leslie (1976) and Weiss et al. (1986) as being medically pluralistic. These pluralistic settings offer, not only a range of socially acceptable treatment options, but also a range of cognitive options or ways of understanding the illness (Weiss et al., 1986). Leslie (1976) has identified three medical theories and types of etiologies that operate in India. These can also be said to operate in Pakistan. They include allopathic or modern medical etiologies, humoral aetiologies and sacred / supernatural aetiologies. The basic tenets of these medical theories and their therapeutic forms are outlined briefly, below:

(i) Allopathic - afflictions are thought to result from mechanistic dysfunction of normal physiological processes as elaborated in Western biomedical contexts. The response is to employ specific medicines / surgical interventions to correct the dysfunctional biological
mechanisms.

(ii) Humoral ie Ayuverdic / Unani - afflictions are thought to result from a disturbance of the normal healthy humoral balance. The response is to restore the humoral balance with medicines, a change of regimen, massage and other manipulations.

(iii) Sacred - afflictions are thought to result from a supernatural cause, for example punishment by a sorcerer or God. The usual response is to mediate between the social conflicts and transgressions that initiated the punitive act. This is achieved through ritual acts which are intended to propriate the supernatural forces.

Within a Pakistani or Indian cultural framework then mental distress can be attributed to a number of causative categories, ranging from psychological to physiological to supernatural. From the above it can be seen that as the etiology varies, so the treatment varies. Likewise, symptom presentation would also be expected to vary. Indeed Weiss at al., (1986) have found some evidence that the conceptual model by which patients understand their illness is predictive of symptom presentation and help seeking.

To what extent, however, is this pluralistic description of EMs applicable to BPs, and to what extent have they reframed their medical beliefs in line with the dominant medical system? In order to investigate this, as well as, general beliefs about causes of mental distress in the P, BP and B samples, the MDEMQ designed by Eisenbruch (1990) was used.

6.1.1 CONSTRUCTION OF THE MDEMQ

Eisenbruch's (1990) MDEMQ is a multicultural instrument, which has been designed with the intention of being a quick screening instrument for use in Western non-patient samples, where limitations on time frequently prevent clinicians from conducting detailed enquiries into patients EMs. Based on Kleinman's explanatory model framework, it combined epidemiology with an anthropological approach to research cross cultural illness beliefs. In order to do this Eisenbruch drew on the medical classificatory systems of Foster (1976), Young (1976) and Murdock et al. (1978). These classificatory systems had all attempted to comprehensively classify how different societies explain their
reactions to misfortune. The lines of demarcation adopted by these classificatory systems were slightly variant. Whilst Foster (1976) and Murdock et al. (1978) respectively drew distinctions between naturalistic / personalistic and natural / supernatural, Young distinguished internal from external. A brief summary of the different classificatory systems and their criteria are given in table 6.1

Table 6.1 Summary of Foster (1976), Murdock et al. (1978) and Young's (1976) classificatory systems of illness beliefs

<table>
<thead>
<tr>
<th>FOSTER (1976)</th>
<th>PERSONALISTIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATURALISTIC</td>
<td>eg. magic and religion</td>
</tr>
<tr>
<td>. eg. chemical imbalance</td>
<td></td>
</tr>
<tr>
<td>. Theory restricted to the disease</td>
<td></td>
</tr>
<tr>
<td>. Marked by loss of equilibrium</td>
<td></td>
</tr>
<tr>
<td>. Unrelated to other misfortune</td>
<td></td>
</tr>
<tr>
<td>PERSONALISTIC</td>
<td>Caused by active agent (human /non human)</td>
</tr>
<tr>
<td>. 'Who' and 'Why' must be specified by the healer</td>
<td></td>
</tr>
<tr>
<td>. Special case of misfortune</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MURDOCK ET AL. (1978)</th>
<th>SUPERNATURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATURALISTIC</td>
<td>eg. magic and religion</td>
</tr>
<tr>
<td>refer to above</td>
<td>Split into three sub-categories:</td>
</tr>
<tr>
<td></td>
<td>. Mystical</td>
</tr>
<tr>
<td></td>
<td>. Animistic</td>
</tr>
<tr>
<td></td>
<td>. Magical</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUNG (1976)</th>
<th>EXTERNALISING</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTERNALISING</td>
<td>Etiological explanations emphasised</td>
</tr>
<tr>
<td>. Physiological explanations emphasised</td>
<td></td>
</tr>
<tr>
<td>. Etiology linked to sequence of biophysical causes</td>
<td></td>
</tr>
<tr>
<td>. Events ordered within the body from onset of symptom to conclusion of illness</td>
<td></td>
</tr>
<tr>
<td>EXTERNALISING</td>
<td>Narratives are given in which some medically important events take place outside the patients body</td>
</tr>
<tr>
<td>. Links in time identified between agencies / events with causes / effects</td>
<td></td>
</tr>
</tbody>
</table>

adapted from Eisenbruch (1990)

Neither of these classificatory systems, however, are all encompassing and they have all been criticised on various grounds (Landy, 1983). In short, they are all more heuristic than absolute. Littlewood (1990) has suggested that the demarcations used in these classificatory systems are themselves heavily influenced by a Western medical frame of reference. In actual fact many medical systems world wide share some common origins. For example, both the humoral paradigms of Ayuverda and Unani Tibb are rooted in
Greek humoral theory, which is also the basis of modern medicine (Fabrega, 1992). None-the-less in the context of multi-cultural settings there is still a need for a comparative instrument like the MDEMQ.

Eisenbruch thus in developing the forty two item MDEMQ drew upon the above classificatory systems, in addition to his own experience of participant observation in Cambodia. The important point to note from this methodology was that it focused on popular EMs as opposed to strictly professional ones. The resultant questionnaire was structured in terms of a natural category, which was sub-divided into Western physiological causes and non-Western physiological causes; and a personalistic category, which was sub-divided into stress causes and supernatural causes. The supernatural causes were further split into magical, Animistic and mystical categories, (Murdock et al., 1978).

The four sub-categories stipulated by Eisenbruch in the structure of the MDEMQ were further confirmed in a pilot study on 261 Australian college students. Multidimensional scaling analysis found four clusters of mental distress causation, which corresponded with stress, Western physiological, non-Western physiological and supernatural categories. The clusters were found to form two dimensions. The first related to differences in Western and non-Western explanations ie. Western physiological and stress vs non-Western physiological and supernatural. The second dimension related to naturalistic and personalistic dichotomies discussed by Foster and Murdock et al. It is on the basis of these four categories that the results in this study are analysed.

6.1.2 Aim and Hypotheses
The aim of this MDEMQ study was to ascertain the EMs of P, BP and B samples and thereby the influence of culture on beliefs about causes of mental distress.
Hypotheses predicted that:

I. The structure and response style of the MDEMQ (as measured by intercorrelation and multidimensional scaling analysis) should be more similar across the P and BP samples than the B sample, bearing in mind the strong retention of culture of origin in first generation BPs (Ballard, 1994).

II. P and BP respondents would score higher than their B counterparts on non-Western causative categories - (ie non-Western physiological and supernatural items), but also relatively high on Western causative categories - (ie Western physiological and stress items), considering the integration of Western allopathic medical systems with the more traditional indigenous medical systems in Pakistani culture (Leslie, 1980). In comparison, B respondents would score lower on non-Western categories - (ie non-Western physiological and supernatural items).

III. Women and working class respondents would have slightly differential EMs to male and middle class respondents, in line with their differential symptomatology in the GHQ and AKUADS studies.

6.2 METHOD

6.2.1 Sample and Procedure
The sample and procedure of the overall study have been described in detail in Chapter 3.

6.2.1 Translation of MDEMQ
The MDEMQ [appendix 3.5] was translated into Urdu by a proficient English and Urdu speaker. Emphasis was placed on conceptual equivalence rather than literal translation. The translated Urdu version was then subjected to an independent back translation into English. Any differences between the two versions were assessed and negotiated before
a final Urdu version was drafted [appendix 3.6].

The MDEMQ, notably, in comparison to the GHQ and AKUADS posed no real problems in translation into Urdu.

6.3 RESULTS

The results were analysed in terms of the following categories: stress, Western physiological, non-Western physiological and supernatural, on the basis of which the MDEMQ was constructed. These categories were further confirmed in Eisenbruch's pilot study on a student sample. A list of the items in each category is given in table 6.2.

Table 6.2 Items in stress, Western physiological, non-Western physiological and supernatural categories of the MDEMQ

<table>
<thead>
<tr>
<th>Category</th>
<th>No.</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>1</td>
<td>Bad experiences during childhood</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Intentionally physically harmed by another person</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Exposure to fright or shock</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Pace of modern life</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>Having had an accident</td>
</tr>
<tr>
<td></td>
<td>22</td>
<td>Death of a relation / close friend</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Migration to a new country</td>
</tr>
<tr>
<td></td>
<td>33</td>
<td>Not having enough money</td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>Too much work or study</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>Conflict or break up of family relationships</td>
</tr>
<tr>
<td></td>
<td>41</td>
<td>Unemployment</td>
</tr>
<tr>
<td>Western Physiological</td>
<td>8</td>
<td>Bad nerves in the body</td>
</tr>
<tr>
<td>Physiological</td>
<td>9</td>
<td>The effects of old age</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Infection</td>
</tr>
</tbody>
</table>
Non western
5 Being hot

Physiological
6 Wind or gas or currents flowing through the person's body
13 Eating food which is wrong for that person (but not socially forbidden)
14 The person's body being out of balance
17 One or more of the person's vital organs being disrupted

Supernatural
7 Contact with something or someone taboo
19 The person had a bad or ominous dream or sensation
20 Bad luck or chance
27 Astrological destiny
28 The person's karma
29 A dangerous unprovoked spirit
30 A spirit who was angry because someone did something wrong
31 The person's soul temporarily leaving the body and becoming scattered
34 Contact with something or someone dangerous or unclean or contaminated or contagious or unclean
35 Doing something forbidden by social or cultural rules
37 Someone unwittingly casting a spell
38 Someone wanting to hurt the person and casting a spell
40 Someone wanting to hurt the person and engaging a witch or shaman to cast a spell
42 The person seeing or hearing or feeling something ominous
In this study items: 21- "Doing the wrong thing during pregnancy", 23 - "Failure to properly observe rituals after giving birth", 25 - "Birth control against religion and culture", 26 - "Doing the wrong thing when menstruating" were not included in the statistical analysis. This was due to the omission of these items in the P and BP male samples. These were omitted in these sub-samples, as in the context of a female researcher addressing a male respondent they were deemed culturally insensitive.

6.3.1 Internal Consistency

Alpha coefficients of internal reliability were calculated for each of the three cultural groups, thereby testing the internal consistency of the four MDEMQ causative categories: Stress, Western physiological, Non-Western Physiological and Supernatural (refer to table 6.3)

Table 6.3 Alpha reliabilities of MDEMQ causative categories for P, BP and B samples.

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>STR</td>
<td>.76</td>
<td>.74</td>
<td>.87</td>
</tr>
<tr>
<td>WP</td>
<td>.75</td>
<td>.72</td>
<td>.71</td>
</tr>
<tr>
<td>NWP</td>
<td>.72</td>
<td>.70</td>
<td>.76</td>
</tr>
<tr>
<td>SUP</td>
<td>.87</td>
<td>.74</td>
<td>.90</td>
</tr>
</tbody>
</table>

All four categories were found to have high levels of internal consistency in each sample. The stress and supernatural categories i.e. personalistic items having the highest internal reliabilities in the case of all three samples.

6.3.2 Intercorrelation of Causative Category Scores

Intercorrelations between the four sub-scales were calculated for each of the three cultural groups (refer to table 6.4). Both of Eisenbruch's dimensions: (1) Western vs non-Western and (2) naturalistic vs personalistic appeared to be supported by intercorrelation patterns
in the three samples.

With reference to dimension one, stress and Western physiological items were found to correlate highly (especially in the B sample), and non-Western physiological and supernatural items were found to correlate highly, in all three cultural groups. In the case of the B sample, it was interesting to further note that the intercorrelation between the non-Western physiological and supernatural items was especially high. This suggested that in the B sample the non-Western physiological and supernatural items comprised a class of explanations quite distinct from the stress and Western physiological explanations, whereas in the P and BP samples there appears to be more overlap in all four categories of explanations.

Table 6. Intercorrelations matrices of MDEMQ causative categories for P, BP and B samples

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>B</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>STR</td>
<td>WP</td>
<td>NWP</td>
</tr>
<tr>
<td>WP</td>
<td>.57***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWP</td>
<td>.53***</td>
<td>.66***</td>
<td></td>
</tr>
<tr>
<td>SUP</td>
<td>.66***</td>
<td>.49***</td>
<td>.59***</td>
</tr>
<tr>
<td></td>
<td>STR</td>
<td>WP</td>
<td>NWP</td>
</tr>
<tr>
<td>WP</td>
<td>.54***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWP</td>
<td>.52***</td>
<td>.58**</td>
<td></td>
</tr>
<tr>
<td>SUP</td>
<td>.48***</td>
<td>.35**</td>
<td>.35**</td>
</tr>
<tr>
<td></td>
<td>STR</td>
<td>WP</td>
<td>NWP</td>
</tr>
<tr>
<td>WP</td>
<td>.66***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWP</td>
<td>.21*</td>
<td>.54***</td>
<td></td>
</tr>
<tr>
<td>SUP</td>
<td>.20*</td>
<td>.44***</td>
<td>.61***</td>
</tr>
</tbody>
</table>

Sig level *** p< .001 ** p< .01 * p< .05

Eisenbruch's dimension two; referring to personalistic and naturalistic explanations also appeared to be confirmed by the high intercorrelations between naturalistic - Western physiological and non-Western physiological items for all three samples. The intercorrelation between personalistic items - stress and supernatural was relatively high.
for the P and BP samples but not for the B sample.

6.3.3 Multidimensional Scaling Analysis

A multidimensional scaling analysis was performed on each sample in order to illustrate and verify the relationship between the forty two possible causes. A multidimensional scaling procedure was adopted for two reasons. Firstly, to investigate if Eisenbruch's two dimensional solution was replicated in the three samples in this study. Secondly, because multidimensional scaling, unlike factor analysis did not require the data to fulfill criteria of homogeneity of variance, normality of distribution and independence of sampling. A two dimensional solution was obtained for all three samples on the basis of Kruskal's / Young's stress configuration.

Plots of the multidimensional scaling analysis (refer to figures 6.5, 6.6, 6.7), whilst indicating a somewhat unclear distinction marked by dimension I, indicated a more definitive distinction marked by dimension II. Dimension II marked a general separation from left to right between Western and non-Western categories (relating to Eisenbruch's dimension I). Furthermore cluster patterns of items was found to be more similar between both P and BP samples.

Pakistanis and British Pakistanis

In the case of the P and BP samples the naturalistic causes of mental distress - that is Western physiological and non-Western physiological items aggregated closely in the centre of the diagram. Although the items were split along dimension II into Western and non-Western explanations, there was very little actual distance between them. The supernatural items however were found to form clusters to the further left of dimension II and stress items to the further right of dimension II.
Figure 6.5
Multidimensional scaling diagram of P sample

D II - West/non-West

D I
DII - West / non-West

Multidimensional Scaling diagram of BP sample
In the case of the Supernatural items: Animistic and magical items referring to spirits and spells (items: 29, 30, 37, 38 & 40) were found to form a tight distinct cluster. The mystical items, on the other hand, were found to split into two groups. Those referring to ominous sensations and contagion (items 34 & 42) were inter-dispersed with the naturalistic items, and those referring to fate, astrology and karma (items 37 & 28), as well as, the Animistic item 31 (persons soul temporarily leaving the body) were found to lie on the outskirts of the diagram, forming no distinct clusters with any other items. These items are, in fact, argued to be particularly irrelevant to the P and BP samples and counter to Islamic religious beliefs.

Stress items on the other hand formed separate clusters to the right of dimension II, in the Western section. In both samples pace of life and migration were closely associated (items 4 & 32), and not enough money and unemployment were closely associated (items 33 & 41). Death was associated with family conflict in the P sample (items 22 & 39) but not in the BP sample. In the BP sample item 39 (family conflict) was not closely associated with any other stress items. In sum, within the stress cluster there were no particularly characteristic sub-clusters.

British

In the case of the B sample the multidimensional scaling was almost one dimensional. The Western physiological and non-Western physiological items were not found to form a tight cluster in the middle. The Western physiological items were inter-dispersed with the stress items and the non-Western physiological with the supernatural items. The distance between the Western and non-Western categories was greater than in the P and BP samples. Two distinctive clusters were apparent in the non-Western section. The mystical, fate and Animistic items were found to form one cluster and the remaining magical items were inter-dispersed with the non-Western physiological items. In the Western section there were no distinctive cluster patterns; the stress and physiological items were inter-dispersed with each other.
Fig. 6.7
Multidimensional scaling diagram of B sample
6.3.4 Item Analysis

An item analysis was conducted in order to enable a closer investigation of the differences in endorsement patterns across the three cultural groups. This thereby indicated which items were more or less salient to which cultural group. All score of 3, 4 or 5 were recoded as 1 and taken as positive endorsements of an item. The endorsement percentages were thus calculated, and are presented in table 6.8.

The Endorsement percentages indicated that:
In the stress category all items were relatively highly endorsed by all three cultural groups. In the Western physiological category four out of nine items: 8, 10, 12 and 17 were endorsed more by P and BP respondents. Only one item (11 - genetic defects) was endorsed by considerably more B respondents. In the non-Western physiological and supernatural categories P and BP respondents were again found to endorse items more than B respondents. This was on all items apart from items 31 -"Soul temporarily leaving the body and becoming scattered", which it should be noted was particularly counter to Islamic beliefs.

Therefore almost all naturalistic (Western and non-Western) and supernatural items appeared to be more salient to Pakistani cultural groups.

Table 6.8 Endorsement percentages of MDEMQ items by P, BP and B sample

<table>
<thead>
<tr>
<th>MDEMQ ITEMS</th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bad experiences during childhood</td>
<td>88.3</td>
<td>88.3</td>
<td>93.3</td>
</tr>
<tr>
<td>2. Intentionally physically harmed by another person</td>
<td>80.0</td>
<td>85.0</td>
<td>95.0</td>
</tr>
<tr>
<td>3. Exposure to a fright or shock</td>
<td>80.0</td>
<td>88.3</td>
<td>85.8</td>
</tr>
<tr>
<td>4. Pace of modern life</td>
<td>80.8</td>
<td>80.8</td>
<td>76.7</td>
</tr>
<tr>
<td>18. Having had an accident</td>
<td>92.5</td>
<td>97.5</td>
<td>87.5</td>
</tr>
<tr>
<td>22. Death of a relation or close friend</td>
<td>95.0</td>
<td>96.7</td>
<td>97.5</td>
</tr>
<tr>
<td>32. Migration to a new country</td>
<td>77.5</td>
<td>84.2</td>
<td>68.3</td>
</tr>
<tr>
<td>33. Not having enough money</td>
<td>95.0</td>
<td>93.3</td>
<td>85.8</td>
</tr>
<tr>
<td>Number</td>
<td>Description</td>
<td>Values</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Too much work or study</td>
<td>90.8</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Conflict or break up of family relationships</td>
<td>95.8</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Unemployment</td>
<td>98.3</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Bad nerves in the body</td>
<td>90.0</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>The effect of old age</td>
<td>75.8</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Infection</td>
<td>82.5</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Genetic or inherited defect</td>
<td>60.0</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Being born this way</td>
<td>90.0</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Physical illness</td>
<td>90.0</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Chemical imbalance in the brain</td>
<td>93.3</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Brain Damage or head injury</td>
<td>91.7</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Being hot (but not from climate or temperature)</td>
<td>60.8</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Wind or gas or currents flowing through the person's body</td>
<td>64.2</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Eating food which is wrong for that person</td>
<td>60.8</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>The person's body being out of balance</td>
<td>68.3</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>One or more of the person's vital organs being disrupted</td>
<td>87.5</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Contact with something or someone taboo</td>
<td>71.7</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>The person had a bad or ominous dream or sensation</td>
<td>81.7</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Bad luck or chance</td>
<td>79.2</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Astrological destiny</td>
<td>39.5</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>The person's karma</td>
<td>58.3</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>A dangerous unprompted spirit</td>
<td>50.8</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>A spirit who was angry because someone did something wrong</td>
<td>42.5</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Person's soul leaving the body and becoming scattered</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Contact with something or someone dangerous / unclean</td>
<td>72.5</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Doing something forbidden by social or cultural rules</td>
<td>89.1</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Someone unwittingly casting a spell</td>
<td>48.3</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Someone wanting to hurt the person and casting a spell</td>
<td>55.0</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Someone engaging a witch / shaman to cast spell</td>
<td>57.5</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>The person seeing / hearing / feeling something ominous</td>
<td>79.2</td>
<td></td>
</tr>
</tbody>
</table>
6.3.5 Effect of Culture, Sex and SES on Causative Categories

A multivariate Analysis of Variance was performed on the four causative categories in the MDEMQ in order to test for differences in scores (ie endorsement of causes) across: a) cultural samples b) male and female sub-groups and c) middle class and working class sub-groups

Prior to conducting any statistical tests normality of variance and homogeneity of variance test assumptions were verified. Consequently the supernatural scale was transformed using logarithmic function. The results of the multivariate analysis of variance and univariate F tests are presented in table 6.9.

From table 6.9, using Pilais criteria it can be seen that the combined DVs show a number of significant main effects of: culture, with $F(2, 348) = 26.75 \ p < .001$, class, with $F(1, 348) = 5.85 \ p < .001$ and sex, with $F(1, 348) = 8.29 \ p < .001$. There was also a significant interaction between culture, class and sex, with $F(2, 348) = 2.16 \ p < .05$. To further investigate the impact of each main effect and interactive effect a series of univariate F tests were performed on the separate category scores. The significance level of the F tests was adjusted to 0.025 using Bonferroni contrasts to account for type I (multiple testing) error.

Effect of Culture

The main effect of culture was due to a significant difference in variance in P, BP and B respondents scores in the: Western physiological category, with $F(2, 348) = 8.56 \ p < .001$, non-Western physiological category, with $F(2, 348) = 51.97 \ p < .001$ and supernatural category, with $F(2, 348) = 72.50 \ p < .001$. Marginal means in table 6.9 indicated that it was P and BP respondents that scored higher than B respondents, especially in the case of the non-Western physiological and supernatural categories. The association between culture and the Western physiological category was $\eta = .05$, and culture and the non-Western physiological category was $\eta = .23$, and culture and the supernatural category was $\eta = .29$.
Table 6.9  Multivariate and univariate analysis of variance of MDEMQ categories by culture, class and sex

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>PILLAI</th>
<th>STRESS</th>
<th>WP</th>
<th>NWP</th>
<th>SUP</th>
</tr>
</thead>
<tbody>
<tr>
<td>CULTURE</td>
<td>P = .00</td>
<td>F(2,348)=2.72</td>
<td>F(2,348)=8.56</td>
<td>F(2,348)=51.97</td>
<td>F(2,348)=72.50</td>
</tr>
<tr>
<td>CLASS</td>
<td>P = .00</td>
<td>F(1,348)=0.54</td>
<td>F(1,348)=1.65</td>
<td>F(1,348)=5.98</td>
<td>F(1,348)=16.45</td>
</tr>
<tr>
<td>SEX</td>
<td>P = .00</td>
<td>F(1,348)=14.69</td>
<td>F(1,348)=14.02</td>
<td>F(1,348)=21.49</td>
<td>F(1,348)=24.86</td>
</tr>
<tr>
<td>CULTURE x CLASS</td>
<td>P = .00</td>
<td>F(2,348)=3.61</td>
<td>F(2,348)=0.86</td>
<td>F(2,348)=0.88</td>
<td>F(2,348)=5.62</td>
</tr>
<tr>
<td>CULTURE x SEX</td>
<td>P = .04</td>
<td>F(2,348)=0.47</td>
<td>F(2,348)=0.98</td>
<td>F(2,348)=0.52</td>
<td>F(2,348)=6.19</td>
</tr>
<tr>
<td>CLASS x SEX</td>
<td>P = .12</td>
<td>F(1,348)=4.40</td>
<td>F(1,348)=1.05</td>
<td>F(1,348)=3.60</td>
<td>F(1,348)=0.77</td>
</tr>
<tr>
<td>CULTURE x CLASS x SEX</td>
<td>P = .03</td>
<td>F(2,348)=1.05</td>
<td>F(2,348)=0.75</td>
<td>F(2,348)=5.80</td>
<td>F(2,348)=2.87</td>
</tr>
</tbody>
</table>

Sig level ***p<.001 **p<.01 *P.025

Table 6.10  Marginal means for MDEMQ causal categories

<table>
<thead>
<tr>
<th>EFFECT</th>
<th>CULTURE</th>
<th>CLASS</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>P</td>
<td>BP</td>
<td>B</td>
</tr>
<tr>
<td>STRESS</td>
<td>40.44</td>
<td>38.78</td>
<td>39.80</td>
</tr>
<tr>
<td>WP</td>
<td>30.31</td>
<td>28.34</td>
<td>27.92</td>
</tr>
<tr>
<td>NWP</td>
<td>21.55</td>
<td>20.64</td>
<td>16.84</td>
</tr>
<tr>
<td>SUP</td>
<td>38.00</td>
<td>32.29</td>
<td>25.76</td>
</tr>
</tbody>
</table>

Effect of Class

The main effect of class was due to a significant difference in variance between middle class and working class respondents scores: in the non-Western physiological category,
with $F(1, 348) = 5.98 p<.01$ and supernatural category, with $F(1, 348) = 16.45 p<.001$. Marginal means indicated that it was working class respondents that scored higher than middle class respondents, especially in the case of the supernatural category. The strength of the relationship between class and non-Western physiological category was $\eta = .01$, and class and the supernatural category was $\eta = .04$.

Effect of sex

The main effect of sex was due to a significant difference in variance between male and female respondents scores in all four categories: stress, with $F(1, 348) = 14.69 p<.001$, Western physiological, with $F(1, 348) = 14.01 p<.001$, non-Western physiological, with $F(1, 348) = 21.49 p<.001$ and supernatural, with $F(1, 348) = 24.87 p<.001$. Marginal means indicated that it was women that scored higher than men, especially in the case of the supernatural category. The strength of the relationship between sex and the stress category was $\eta = .04$, sex and the Western physiological category was $\eta = .03$ sex and the non-Western physiological category was $\eta = .06$ and sex and the supernatural category was $\eta = .07$.

Table 6.11  Cell means for MDEMQ causal categories

<table>
<thead>
<tr>
<th></th>
<th>P</th>
<th>BP</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MC</td>
<td>MC</td>
<td>WC</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>STR</td>
<td>39.23</td>
<td>39.93</td>
<td>38.73</td>
</tr>
<tr>
<td>WP</td>
<td>28.90</td>
<td>30.27</td>
<td>29.03</td>
</tr>
<tr>
<td>SUP</td>
<td>32.53</td>
<td>36.30</td>
<td>36.30</td>
</tr>
</tbody>
</table>

Effect of culture by class

The culture by class interactive effect was due to a significant difference in variance on the supernatural sub-scale, with $F(2,348) = 5.62 p<.01$. Cell means (refer to table 6.11) indicated that P and B (although to a lesser extent) working class respondents scored higher than their middle class counterparts on the supernatural sub-scale. The strength
of the relationship was $\eta = .01$.

**Effect of culture by sex**

The culture by sex interactive effect was due to a significant, although weak difference in variance across culture and sex on the supernatural sub-scale (which is not borne out in the multivariate statistic), with $F(2, 348) = 6.19, p<.001$. Cell means (refer to table 6.11) indicated that P and B women scored higher than their male counterparts. The strength of the relationship between culture, sex and the supernatural category was $\eta = .01$

### 6.4. DISCUSSION

The intercorrelation, multidimensional scaling, endorsement percentages and ANOVA results indicated that P and BP respondent showed greater overlap on all four causative categories thus confirming hypothesis I. Intercorrelation analysis and multidimensional scaling suggested that these samples drew less sharp distinctions between the so called Western and non-Western categories. In the multidimensional scaling analysis although the Western physiological and non-Western physiological categories were separated by dimension II they were markedly close in proximity.

The ANOVA results confirmed hypothesis II and further indicated that P and BP samples scored significantly higher than the B respondents on three out of the four causal categories. The one category in which there was no significant difference observed in scores across cultures was the stress category. This category was also notably the one endorsed the most by all three samples.

Class and sex differences were also observed in causal categories, as predicted in hypothesis III. Female respondents endorsed all four causative categories more than male respondents, and working class respondents endorsed the, so called, non-Western categories more than their middle class counterparts. Interactive effects, once again, indicated that P working class women scored the highest on the non-Western physiological and supernatural categories.
6.4.1 Hypothesis I and II - Structural and Cultural Demographic Levels

Pakistani and British Pakistani samples

P and BP samples (but especially P samples) were found to score higher on and endorse the Western physiological, non-Western physiological and Supernatural categories more than the B sample. They were also found to show less differentiation between Western and non-Western causes, as indicated by intercorrelations and multidimensional scaling.

The observed overlap in Western and non-Western causal categories in the P and BP samples appears to be reflective of the medically pluralistic setting of Pakistan, in which all four causative categories exist within the etiologies of allopathic, humoral and sacred medicines (Leslie, 1976). This fluidity that is observed in P and BPs EMs, has been ascribed by Bhattacharya (1986) to the assimilative character of medically pluralistic settings. Assimilation refers to the blurring of boundaries and loss of autonomy in the relationship between one system and another. Bhattacharya argues that whilst the practitioners may view their system in a particular way and in competition with other medical systems, Indian patients tend to view the system as more or less appropriate and interchangeable alternatives. Assimilation in these settings is further facilitated by an 'uncritical attitude' (Horton, 1967; Polanyi & Prosch, 1975) and 'everyday thinking' characteristic of most societies and lay people (Young, 1976). This is as opposed to the 'systematised thinking' characteristic of scientific approaches. Young (1976) argues that in 'everyday thinking' the individual focuses on things that effect his / her life. Failure in a particular treatment is not interpreted as a test of a medical system but rather as important diagnostic information which directs change to more appropriate therapies. Confrontation in seemingly diverse medical ideas is this avoided. This is in contrast to 'systematised thinking', which typically strives for coherence and the construction of a system of ideas.

Whilst this argument of 'everyday thinking' and pluralism can also be applied to popular beliefs in the B sample, there is still a greater degree of compartmentalisation (into
Western and non-Western) evident in the multidimensional scaling analysis in the B sample. The somewhat heuristic nature of the Western / non-Western distinction in the case of the P and BP samples is further evident when one considers the actual principals of the indigenous medical traditions of Ayuverda and Unani Tibb.

Briefly, in these medical paradigms illness is attributed to the disturbance of normal healthy balance. This balance is thought to be influenced by both internal and external factors, including environmental factors of diet and climate, the effects of physiological and biological factors, as well as, the effects of stress and the supernatural. The body in Ayuverda and Unani Tibb is thus perceived as being permeable to naturalistic and personalistic effect, whether Western or non-Western (Zimmermann, 1987)\(^{42}\). This broad outlook or medical view of Indian's and Pakistanis has been described as 'holistic' by Kakar (1982). Consequently sharp distinctions in causality are therefore counter to traditional medical beliefs of the Indian sub-continent. It is suggested that this holistic view is then borne out in the close proximity of the Western physiological and non-Western physiological items in the P and BP samples multidimensional scaling analysis. These results can be contrasted with the results of the B sample.

**British sample**

The B respondents in this study endorsed the non-Western physiological and supernatural categories significantly less than the P and BP samples. Although the intercorrelation between the non-Western physiological and supernatural items was high, their intercorrelation with the stress items was markedly low. This clear demarcation between Western and non-Western causal explanations was also depicted in the multidimensional scaling analysis, where a greater distance was observed between Western and non-Western items along dimension II.

\(^{42}\)Although most supernatural items were familiar to P and BP samples, as they were based on concepts of djinns, evil eye and other sinful activities depicted in the cosmology of the Quran, certain items such as item were particularly counter to Islamic beliefs. Most notable amongst these was item 31, which respondents argued was nonsensical as it implied death.
This greater compartmentalisation of the EMs of the British sample appears to correspond with the mechanistic view of modern Western medicine described by Rabinbach (1990). According to this mechanistic view the body is perceived as being subject to the principals of mechanical operation and being bound from the external. Fabrega (1992) along similar lines argues that modern Western medicine is unique in its perception of illness. Unlike other medical traditions it perceives illness to have a 'unique' identity, natural history, a particular manifestation and causal mechanism which invade or lodge in the person. Consequential to this compartmentalisation in modern medicine, the external impacts of the environment or the supernatural have progressively become divorced from illness. It is speculated that this underlying conceptual demarcation may explain the predominant endorsement of Western as opposed to non-Western EMs in the B sample.

**Similarities**

In spite of these observed differences in scores and endorsement of EMs in the three samples there were also some similarities which warrant attention. The most notable similarity between all three samples was the relatively high and comparable attribution of stress causes to mental distress. Stress items featured as major components of the EMs of all three cultural groups. Stressful life events, such as death and family conflict, have been argued by Carr & Vitaliano (1985) to be quintessential universal human experiences. Indeed Mahmud (1987) reported no significant difference in reporting of serious life events in British and Pakistani females. Cross-cultural consensus of mental distress resulting from stress could therefore serve as the focus for universal phenomena, whereby individuals locate distress in personal relationships, set backs, losses, financial pressures, unemployment etc...

**6.4.2 Hypothesis III - Socio-demographic Level**

The results pertaining to class and gender differences in the attribution of cause to mental distress indicated that working class sub samples scored significantly greater than middle class sub-samples on non western physiological and supernatural sub- categories, and that female sub samples scored significantly greater than male sub-samples on all four causative categories. The interactive effect, however, indicated that in the case of the non-
Western physiological category and supernatural category it was P working class women that scored significantly higher than all other sub-groups.

In line with Kleinman's (1986) assertion that EMs are also socio-historical products, Stacey (1988) argues that health beliefs are also conditioned by social position and power. Indeed Helman (1985) has suggested that there is greater divergence in working class and less educated patients and practitioners EMs. Indeed the relatively greater emphasis on non-Western physiological and supernatural categories in working class and female respondents also attests to the heuristic nature of the Western / non-Western distinction. Even within British EMs the remnants of humoral and fatalistic ideas have been found. Helman (1986) in his paper 'Feed a Cold Starve a Fever' demonstrated the existence of humoral concepts in popular British EMs. Gifford's (1994) study on menopause in Italio-Australian working class women also uncovered discourses which used humoral paradigms to express health, illness and distress. Gifford suggested that the discourse of these women on health and illness, which centred around the physical conditions of bad blood and nerves, served to metaphorically express feelings of personal loss.

Similarly Pill and Stott (1996) also found, supposedly 'non-Western' environmental or external views of illness causation in their sample of Welsh working class mothers. The external EMs most frequently given by these working class women to account for illness was the 'germ theory'. Helman (1986) succinctly points out that the paradoxical internal / external dichotomy of germs; that is, their lying outside the individual but within human society, insinuates the social dimension of illness. This is somewhat counter to the individualistic internal focused EMs of modern medicine. Pill and Stott (1986) have suggested that the externalising of illness through the idea of germs may serve to distance the disempowered individual from the responsibility of the illness.

EMs thus do not appear to simply be functions of cultures, or in more gross terms Western and non-Western divisions. Rather they appear to be more complex structures and the product of cultural, social and historical factors. Considering the shared Greek origins of Western and non-Western etiologies ie allopathy and homeopathy there are then
some cross cultural similarities as well as differences in the P, BP and B samples. These similarities appear to be a function of the cultural construction of social positions and more basically education.

6.5 CONCLUSION

To conclude, this study has demonstrated cultural differences in emphasis in EMs of mental distress. The P and BP samples in this study were found to have more pluralistic EMs in comparison to the B sample. They endorsed all four causal categories of mental distress whereas the B sample endorsed primarily the Western causal categories. It has been suggested that this relates to the assimilative and holistic view of Pakistanis as prescribed by the principals of Ayurvedic and Unani paradigms. This is juxtaposed to the compartmentalised and mechanistic view of modern medicine, which appeared to be evident to some extent in the B sample.

The definitiveness of the differentiation between Western and non-Western EMs as marked by dimension II was, however, questioned. This divide, in fact, also appeared to be less distinct in the working class and female sub-samples. It was argued that this distinction conceals the shared historical origin of Western and non-Western medicines. The shared basis of EMs was also evident in the endorsement of the stress category by all samples. It is thus suggested that illness beliefs are mediated by a complex interaction between cultural, social and socio-historical factors.
7.1 INTRODUCTION

In Chapters 4, 5 and 6 two juxtaposed paradigms have been adopted in investigating the influence of culture on mental distress, and more specifically depression. Chapters 4 and 5 focused on the symptomatic frame of reference, and Chapter 6 focused on the explanatory model frame of reference. Chapter 4 addressed the implications of using a Western standardised screening instrument, the GHQ, to detect depression in Non-western cultural groups, both here in Britain and in Pakistan. Chapter 5, reversed the procedure by raising the issues involved in using an indigenous Pakistani screening instrument, the AKUADS to detect depression in a Western - British cultural group. Both procedures highlighted the problems involved in cross cultural translation, and the link between conceptual structures, language and presentation within a given culture. As Helman (1985) argues, the cultural symbols used to express mental distress have polarised meanings. On the one hand they stand for personal, psychological and emotional concerns, and on the other, they indicate the social and cultural values of the general society. This link between personal and cultural meanings was further investigated in Chapter 6 - The MDEMQ study. The MDEMQ study, on a broader level, looked at the influence of culture on explanatory models and interpretation of mental distress. It thereby demonstrated the different culturally rooted belief systems used to make sense of and attribute cause to distress.

The central hypothesis in all three studies was that there would be greater similarities in symptomatic and explanatory model responses and response styles between the P and BP samples, than the B sample. It was predicted that these would be borne out at the response and item level. In terms of levels of distress Ps were predicted to have the highest scores. Within cultures it was hypothesised that there would be differences across gender and class, reflecting social position. This Chapter draws the hypotheses and
findings of these three studies together to provide comment and insight on the construct under investigation and to uncover the link between cause and symptomatology. It thereby attempts to demonstrate how causes and symptoms integrate and fit within wider cultural medical beliefs.

7.2 STRUCTURAL LEVEL
Structural analysis of the GHQ, AKUADS and MDEMQ, as predicted, revealed greater similarities in response style between the P and BP cultural samples than the B sample. Interestingly, however, the extent of divergence between the P / BP and the B samples response styles varied across the three questionnaires. The divergence in cross cultural response style was greatest in the GHQ study.

Whilst confirmatory factor analysis revealed a significantly different factor structure in the P and BP samples from Goldberg's four sub-scales, the factor structure of the B sample corresponded closely with the sub-scales advanced by Goldberg. In the P and BP samples a large general factor consisting mainly of somatic and anxiety items was found to account for the largest percentage of variance. The remaining three factors, consisting of suicide items and social dysfunction items, accounted for a relatively smaller percentage of the variance.

In contrast to the GHQ confirmatory factor analysis of the AKUADS and multidimensional scaling analysis of the MDEMQ revealed surprisingly little difference at the structural level between the three cultural groups. Both somatic and psychological sub-scale structures were replicated on the AKUADS and the Western / non-Western dimension were replicated in the MDEMQ in all three samples; thus suggesting that these instruments were more cross culturally isomorphic than the GHQ. Where cultural differences in the P/BP and B samples were, however, observed was at the intercorrelational level. The P and BP samples were found to have greater overlap and association between sub-scales on all three questionnaires. The extent of this was graphically depicted in the close proximity of Western physiological and non-Western
physiological categories in the multi dimensional scaling analysis of the MDEMQ.

The high intercorrelational findings in P and BP samples in Chapters 4, 5 and 6 were tentatively connected to the psyche / soma unity and inter-connection between the internal and external as prescribed by Ayuverdic and Unani principals (refer to section 5.4.1). In other words the presentation of psychological and somatic symptoms and the espousal of a wide range of causes of mental distress, ranging from the social to the sacred and the biomedical to the humoral were ascribed to the holistic view and undifferentiated thinking promoted by traditional Pakistani medical paradigms.

In contrast the responses of the B sample, which indicated relatively more psychological symptomatology and Western causes, were more differentiated and compartmentalised. This was borne out by smaller intercorrelations, more delineated factor structures and multidimensional scaling analysis. Such differentiated symptomatology and causation also appeared to be reflective of the mechanistic view of modern medicine (Rabinbach, 1990).

The manner of responding or response styles in the P/BP and B samples therefore appear to correspond with the wider cultural medical outlook; Ps and BPs ascribing to indigenous humoral paradigms and Bs to allopathic paradigms. The implications of these differences in response style for construct comparability will be discussed later. In the mean time the cultural differences in response style can be better understood by considering specific linguistic and conceptual findings uncovered by item analysis.

7.3 LINGUISTIC AND CONCEPTUAL LEVEL

Parekh (1974) has pointed out that translation problems are frequently a reflection of the cultural base of language and an embodiment of peoples cultural assumptions about life. According to this premise the process of translation itself can thus highlight the cultural

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43These descriptions of an undifferentiated response style in P and BPs and a differentiated response style in Bs also corresponds with field dependant and field independent cognitive styles described by Pares (1985).
assumptions on which some items are based. A similar premise has also been used in Good and Good's (1981) semantic network approach. This approach looks at patterns of association between words, situations, social interactions and forms of experience to give meaning to the vocabulary of illness and healing. They have argued that this kind of analysis can phenomenologically give an insight into the personality structure of individuals and typical stress situations within a particular society. Using a similar directive, translation problems posed by particular items in the GHQ, AKUADS and MDEMQ studies elucidated, on the one hand, culturally rooted assumptions inherent in the questionnaires, and on the other, the association between semantics and themes salient to understanding mental distress in Pakistani and British cultures.

Translation problems, in these three studies were evident from statistical analysis and feedback from respondents. Administering the questionnaire as opposed to self reporting, therefore, provided a valuable cross cultural methodological approach, as it gave respondents an opportunity to question items and challenge the cultural assumptions of particular concepts.

The GHQ, as was indicated by the structural analysis, posed the greatest translation problems. The primary conceptual translation problem was raised by the social dysfunction sub-scale, which clearly illustrated underlying cultural semantics. As previously discussed a recurring problem was the translation of the general English term 'things' into Urdu. The subsequent translation of 'things' into the Urdu term 'kam' / 'work', raised both confusion in the P and BP respondents and resulted in a confounding effect of social desirability. The social desirability effect inherent in and raised by the notion of 'work' in the P and BP samples appeared to be reflective of culturally salient values., which cannot be explained on the basis of these results alone. Currer (1986), however, has connected the similar emphasis on 'work' in her Pathan sample to duty and an emphasis on the social aspect of self, as opposed to the individual. This line of argument it is suggested could also be applied to the P and BP samples in this case, who are very close in cultural proximity to Pathans. Indeed an emphasis on socially structured self would also appear to be consistent with the undifferentiated thinking of P and BPs that
manifested at the structural level. Shweder and Bourne (1991) have in fact proposed that context specific orientated cultures also extend their undifferentiated thinking to concept of person, and in doing so they place a greater emphasis on duties. This may thus explain the P and BP samples socially biased response to items containing the culturally sanctioned notion of work or duty - 'kam'.

Translation problems, however, were not solely confined to the GHQ. The problems that arose in the translation of the somatic idiom from Urdu to English in the AKUADS study provided contrast to the problems of translating abstract English terms into Urdu. Item 4 on the AKUADS, illustrated the underlying, this time Pakistani, cultural semantics. The Urdu term 'gabrahat' contained in item 4 encompassed both psychological and somatic concepts which could not be equivalently translated into English. The English translation either resulted in a more psychological focus, 'anxiety', or a somatic focus, 'palpitations'. The choice of one term or the other in the English version meant that the metonymy of psyche and soma inherent in 'gabrahat' was lost. This type of translational problem has also been discussed by Ots (1991) in relation to Chinese traditional medicine and Western medicine. He points out the inherent difficulty in translating, what is essentially the interpretation of perceptions, across cultures that vary in their mind / body emphasis.

It can thus be seen that any kind of cross cultural translation, irrespective of direction of the translation, raises issues at the superficial language level, which in turn often signify the deeper cultural conceptual level. Tracing such semantic pathways can then help discover wider culturally salient themes, which can be uncovered through a more detailed inquiry into meaning.

The subtle but far reaching effects of translation are further illustrated by the disparate responses of Ps and BPs to seemingly equivalent items in the GHQ (23- "Felt that life is entirely hopeless") and AKUADS (9 - "Have you felt hopeless"). Here it was seen that the use of the different terms 'nakabil' and 'mauosee', although both acceptable

44 'Nakabil' re-translates as 'unworthy', as opposed to 'mauosee' which re-translates as 'despondent.'
translations for 'hopelessness'; raised different connotations; one religious and one not. This subtle difference determined the appropriateness of the item and validity of the response. The religious connotations in 'nakabil' evoked more defensive responses in the P and BP samples. The importance of religion to the P and BP samples was also attested by the defensive responses to suicide items in the GHQ.

Interestingly the MDEMQ did not pose many translational or conceptual problems in the P and BP samples. In the B sample, however, certain items such as those on the supernatural sub-scale, raised some bewilderment. Although the ideas in these items were not completely alien to the B sample, they generally thought that notions regarding magic and evil eye were not relevant to contemporary society.

In sum, without a detailed analysis of linguistics and an understanding of wider cultural concepts, the results of this quantitative analysis could quite easily have been misinterpreted. Furthermore, without the use of an indigenous screening instrument, the interpretation would have only exposed uni-directional translation problems and, thus, a bias in exposing the underlying concepts of only one culture.

7.4 SOMATISATION
The bi-directional approach taken in this study in conjunction with EMs also enabled a reconsideration of the somatisation hypothesis in Asians, and the link between health beliefs and symptoms. Whilst the somatisation hypothesis was confirmed in the GHQ study, (both P and BP samples scored significantly higher than their B counterparts on the somatic sub-scale), the notion of somatisation and the assumption of the somatic as metaphor for the psychological was more fundamentally challenged by the findings of the AKUADS study. This was the most striking point of contrast between the GHQ and AKUADS studies.

Counter to the findings of previous studies and the widely accepted somatisation hypothesis, all three cultural samples (notably the Pakistanis) were found to score higher
on the psychological sub-scale than the somatic sub-scale on the AKUADS. This finding in conjunction with the greater inter-correlations between the psychological and somatic sub-scale in both P and BP samples supports the argument of a holistic, as opposed to exclusively somatic nature of distress in Pakistanis. It has thus been suggested that the interconnection of mind and body in Ayurvedic and Unani paradigms is overlooked by the somatisation hypothesis, which implicitly precludes one set of symptoms over another. The somatisation hypothesis, in this sense, is as dualistic as the Western association of exclusively psychological symptoms with distress. Weiss et al. (1986) have argued that the mind / body dualism inherent in the hypothesis and the accompanying notion of the somatic being metaphor for the psychological is often clinically re-enacted in the denigration of somatoform disorders to depression and the idea of a ‘masked’ depression. This is in contrast to Ayurvedic / Unani medical paradigms which are based on the perception of a unified body and are accompanied by a language based on correspondences and metonymy (Zimmermann, 1987).^45

Ayuverdic and Unani notions were also found in the P and BP samples MDEMQ results. P and BP samples scored significantly higher than their B counterparts on the MDEMQ non-Western physiological causal category. This contained items which were largely based on humoral concepts, such as eating the wrong foods or wind / gas / currents flowing through the persons body. The inter-connection between humoral explanatory models and somatic presentation of distress has been discussed in more detail by (Good, 1977; Krause, 1989 and Gifford, 1994). EMs and symptoms of distress, therefore, in the P and BP samples appear to correspond with the wider cultural humoral paradigms of Ayuverda and Unani Tibb which stress holism; that is, both psyche and soma as opposed to one or the other.

7.5 CULTURAL DEMOGRAPHIC LEVEL
The cultural contrasts observed in the response patterns of the three samples, also highlight the more fundamental issue of the construct the screening instruments are

^45 As was argued in the AKUADS study with regards to item 4.
actually measuring. This has implications for both cross cultural comparisons and interpretations of the differential scores; that is whether the score ranking of Ps followed by B’s and finally BPs on the GHQ and AKUADS can be taken as a definitive index of levels of distress or depression. The point of contention then is whether the GHQ-28 and AKUADS can identify the distinctive aspect of depression (as they claim), or whether they simply detect a unitary general form of psychological distress.

In the GHQ study, factor analysis of the responses, the emergence of a large general factor, and the high intercorrelations between sub-scales suggested the GHQ detected a general form of psychological distress in the P samples. Furthermore, the GHQ severe depression sub-scale with its focus on suicidal thoughts failed to serve a differential purpose in the P and BP sample. The translation problems with the GHQ and the questionability of the social dysfunction and depression sub-scales thus suggested that no definitive conclusions about the construct of depression, at least, in Pakistanis should be drawn.

The AKUADS, in contrast, appeared to be structurally more comparable in the P, BP and B samples. It was concluded, however, that on the basis of its current format, which simply delineates psychological and somatic symptoms, the AKUADS could also only be taken as a measure of general distress. The rather vague and ambiguous phrasing of many items in the AKUADS seemed to intuitively support this contention. It was although suggested that it was probably precisely these vague properties and undifferentiated structure which rendered the AKUADS isomorphic to the P and BP samples.

In sum, the construct measured by the GHQ and the AKUADS in the P and BP samples appeared to be a more general form of distress as opposed to depression. The general structure of distress in these samples further corresponded with the holistic medical view (both symptomatically and in terms of EMs) being developed in these sample. In contrast the construct being measured in the B sample, at least on the GHQ, appeared to be differentiated enough to suggest depression.
It is thus suggested, in accordance to the guidelines proposed by Mumford (1992), that a high score on a screening instrument should only be taken as an indicator of a higher risk to psychiatric disorder, rather than evidence of a psychiatric diagnosis or ‘case’ presence. This principal should be practised in comparative research at the very least, unless construct validity can be demonstrated.
Thus, although the GHQ and AKUADS studies both ranked the three samples the same in terms of level of distress (P>B>BP) the construct comparability and therefore levels of distress or 'caseness' could not be unequivocally established. Indeed, in spite of a significant correlation between GHQ and AKUADS identified cases, with $r = 0.35$ $p<.001$ the comparability of caseness; that is, whether the same cases were identified by both screening instruments was questionable. Using the GHQ case criteria 23.3% of the whole sample were identified as cases. This was in comparison to 19.17% of the whole sample being identified as cases using AKUADS criteria. The actual overlap between identified cases was, however, only 50.8%. Much lower than expected.

7.6 SOCIO-DEMOGRAPHIC LEVEL

Analysis at the demographic level of sex and class also suggested intra-cultural differences in all three samples, between women and men, and working class and middle class respondents. Although interaction effects indicated that these were most significant in the P sample. To elaborate, both women and working class respondents were found to have greater scores on almost all the sub-scales and the total scale, especially the somatic sub-scale in the GHQ and AKUADS, as well as a greater attribution of so called 'non-Western' causes of mental distress on the MDEMQ. These response profiles therefore appeared to reflect many of the issues hitherto discussed in cross cultural terms.

Whilst these differences could be reflective of actual high rates of distress in the working classes and women and their greater exposure to stressful life events (Nathanson, 1975; Brown & Harris, 1978; Brown et al., 1987; Myers, 1988), they could alternatively be reflective of broader socio-political. A constructivist position would therefore argue that high rates of mental illness in women and working classes are, in fact, reflective of socio-cultural construction of illness and the relatively powerless social position of these sub-groups within society. Gaines (1992) argues that the 'voice of classification' inherent in DSM-III indicates an ideal self that is adult, male and German Protestant, and arguably middle class. By implication the 'other' is then female and working class. This has led some researchers to argue that it is culturally more acceptable for women and working class people to be ill. Moreover, it suggests that certain illnesses are themselves gendered. Hysteria in the late eighteenth century in Britain appears to be a prime instance of this.
association of female definition of self with illness (Showalter, 1985). More contemporarily, Block Lewis (1985) argues from a psychoanalytic point of view that women's field dependent socialisation and corresponding predisposition to shame in Western cultures makes them more prone to depression than men. She on the other hand, connects the characterisations and socialisation of men to disorders like paranoia. The current Western aetiology of anorexia, which is predominantly connected with female definition of self is another prime example. Cross culturally, the gendering of distress is also evident. For example Swagman (1989) discusses how the Yemeni folk illness of 'sudden fright' / 'Fija Super' is most commonly etiologically associated with women and children in Yemen, but seldom with men. Swagman proposed that this was due to 'fright' being contradictory to the cultural male ideal of a courageous tribesman. Taken to an extreme this line of argument would thus suggest that mental illness is a cultural construction with an inherent power dimension. As Landrine (1987) argues, diagnostic categories of mental illness and their prototypes are equivalent to the roles and stereotypes of the social groups that tend to receive them. Indeed as was argued in Chapters 4 and 6 there is some evidence to suggest that women and working class people are more likely to suffer 'patient typing' by practitioners (Marks et al., 1979; Boardman, 1987).

7.7 CONCLUSION

This Chapter through describing the findings of the three studies in Part II has therefore attempted to demonstrate the conceptual link between symptoms, explanatory models and wider cultural health beliefs. The linguistic and conceptual connections underlying this link have been discussed with reference to wider cultural themes. The constraints of the statistical analysis, however, in terms of explanatory power were evident. Without a more coherent understanding of the context of this study, in other words Pakistani culture, these results and the inter-play between the arising themes cannot be fully understood and remains speculative. Part III, which describes the qualitative findings of the interview study sets such a context, which may help substantiate the interpretation placed on these results.
PART III
THE PAKISTANI EXPLANATORY MODELS OF DISTRESS SCHEDULE

Part II used an etic approach in the investigation of the influence of culture on symptom presentation and explanatory models. From this analysis it was evident that BPs had to a large extent, as predicted, maintained indigenous Pakistani health beliefs. This was reflected by the highly similar response patterns of the P and BP samples in comparison to the B sample. Furthermore from the item analysis Pakistani cultural themes underlying responses were beginning to emerge. Part III now turns to an emic perspective, with the aim of linking these various cultural themes in order to develop a Pakistani explanatory model of distress / depression. This was done through the Pakistani Explanatory Models Schedule, which was developed on the basis of pilot research (refer to Chapter 3 [appendix 3.8]). It enabled the elicitation of phenomenological descriptions and more detailed explanatory models from the Pakistani (P) and British Pakistani (BP) respondents. The Pakistani Explanatory Models Schedule differed from Eisenbruch's MDEMQ in its interpretive methodology, as well as, its open ended format, which imposed less of a structure on the respondent's replies. Moreover it arose out of an exclusively Pakistani cultural context and was thus more isomorphic. Marsella and White (1982) suggest that the use of an interpretive approach for deciphering mental illness explanatory models particularly apt, as they quintessentially mirror the very process that goes on in the consultation setting or in peoples everyday lives. They argue that the deciphering of expressions and behaviour in these situations is arguably a contextual and interpretive process in itself.

8.1 INTERVIEW METHOD AND ANALYSIS

In order to further develop this coherent picture, explanatory models of mental distress were elicited from half of the P and BP samples. In total sixty Ps and sixty BPs, (half of whom were male and half female, and half of whom were of middle class SES and half
working class SES), were asked to participate in a more detailed semi-structured interview. A concerted effort was made to ensure that this sub-section of the sample was representative of the age range being researched. This was done by asking respondents that fell into each age bracket to participate in the interview study. These interviews were conducted in the respondents homes and on average lasted one hour. Each respondent was read a vignette of a man / woman suffering a number of symptoms of an un-named condition. Respondents were then asked to name the condition and thereafter the name they gave, be it depression or something else was referred to throughout the interview. Through this, it was hoped that the Pakistani respondents' own cultural concepts in terms of their description of symptoms, causes, related illnesses and appropriate ideas of prevention and cue, as well as, their language for distress would be elicited. In many ways it was felt that by using such an approach the negative impacts of interviewer effect observed in the etic study (where respondents were asked to respond to symptom checklists) was decreased. This was primarily due to the interviewer / respondent relationship developing during the course of the hour, or so, long interview.

One hundred and eight of the interviews were taped after seeking the respondents permission, and detailed notes were made on the remaining twelve. For the purposes of analysis all one hundred and twenty interviews were translated and transcribed into English. Urdu terms were retained in the transcripts where conceptually and linguistically relevant. The transcripts were then subjected to an ethnographic content analysis (Bernard, 1988), whereby relevant cultural themes were highlighted. This was done by identifying categories and sub-categories for each question in the Explanatory Models Schedule. The data were coded according to these categories, using a coding strategy of awarding two points for voluntary descriptors and one point for prompted descriptors. The inter-coder reliability was, thus, found to be r = 0.91. For each sub-category descriptive grids, containing pertinent information for each respondent were constructed. The data was carefully reviewed across categories, sub-categories and respondents to identify major cultural themes. The findings of this analysis, along with illustrative quotes from the respondents are discussed in this Chapter.
8.2 CASE EXAMPLE - "DEPRESSION KILLS MORE THAN A SELF"

Feroza, a young Pakistani woman in her thirties, came to England eight years ago after marriage to a second generation British Pakistani. She clearly recognised the vignette as depression. Below is an edited version of her description of her personal experience of depression.46

"She has depression. She is saying her body aches, but maybe the doctor would say she is okay health wise......This happens to me also. I went to the doctor two weeks ago and told him that (I) stay very tired. What happens is that, I keep falling asleep even during prayers...... it is very difficult. He on seeing me told me I looked anaemic, "your colour is very yellow". He prescribed me with some tablets and told me to make an appointment for a blood test. They did the blood test but now say that I am completely okay, I am not anaemic. (My) body aches all the time, (my) back aches since my last pregnancy and (my) body feels weak all the time. My colour is yellow, even the doctor said I looked anaemic, but they did test and the tests are okay.

[So what do you think is wrong with you?] This depression. Look, my parents, brothers and sisters are in Pakistan, I have nobody here. It is me alone. When a girl gets married she leaves everyone for her husband and his family, then when her husband isn't good with her and isn't aware of his responsibilities then obviously depression happens. You have no importance and when (you) can't see any importance or value to your own life then distress does happen.] Then (you) are away from (your) parents you can only write a letter or phone once in a while. Even if you phone there is a financial issue. When you live alone with your husband it is a different matter, but when you live with in-laws, with family you have to live very depressed in case they take anything badly, " why you have taken longer in doing this then you said". These marriages within families bring many issues.

46The quotes given in this chapter are translations of the Urdu versions. In these translations emphasis was placed on retaining the conceptual essence of what the respondents were saying. The English versions consequently reflect this.
Then when you get married it is never that both parents agree, one agrees and the other doesn't. This happened to me as well. Then when anything goes wrong it leads to disagreements. The domestic atmosphere can never be right. The one that wasn't happy about the match keeps an eye on every little thing, the smallest thing they use as a target and exaggerate it. The domestic atmosphere will obviously be bad. The husband - it is his mother. It is bad if he does anything wrong or says anything wrong to his mother. The mother has her status, she has more rights on her son than even a father. So then if I say anything, "that this happened, that happened" then slowly slowly disputes will obviously happen. He should be aware and think himself how he will balance these things. The mother is in her place, the wife is in hers and with her there are children. If we have tension between us then what effect will it have on the children? They are small but they understand everything.

And then there is work to do as well. If you are happy it doesn't matter how much work you have to do. To me it always seems too much. When the children's holidays are approaching I already have tension - that what will I do, they will irritate me. It all depends on your mood. They come from school and they fight so much. I have essential things to do, work in the kitchen, in the house. If I go to the bathroom he will hit her and she will hit him. Because of them I also have depression, they irritate me a lot. There is house work to do and children's work to do also - clothing them, feeding them, everything. The torture of work also causes depression. But I think if a person is happy everything is happy. Then even the most work is nothing. If my husband's mood is good I feel my day has passed well, if it is bad then it all goes wrong. It comes out for no reason on the children. Then I think I am doing wrong and I regret it. One minute I hit them and the next minute I cuddle them. They are only children, but you can't take your anger out elsewhere and then by itself no matter how much control you do it comes out on them. If children grow up in such an environment, seeing their parents tension.....my oldest son, he isn't very big but he understands everything. All these things effect their personality from the day they are born. If (we) stay sad and distressed all the time then what will that child become?
My husband doesn't understand, he has his own problems. When we got married... he is my Chacas (father younger brothers) son. His father was happy with the marriage, but the mother wanted someone from her side of the family. He (husband) liked me, but his mother didn't want me. He understood it all, he wanted to be married but he also didn't want to be married. In this confusion he also stayed very depressed..... he is trapped in his own situation. Then on top of that there are marital responsibilities. Up until now that atmosphere, which there should be in a home after marriage, isn't there. All these things have caused depression.

[So what are the signs of depression?] Crying, the body is tired and exhausted. I feel tired myself. Whenever (I) go to the doctor he says it is nothing, I am okay, I am healthy. A persons face shows it all. People can recognise from their face that they are in depression. Some people you will have seen are not much health wise, they have illness. Now me (I) have no gas, no blood pressure, asthma isn't in me, no illness, but the colour in my face isn't right. I am absolutely okay, I have no illness. And then there are some people who are ill, but from their face they look fine and happy. Depression kills more than a self.

[Is it an illness in itself?] No it is not, we have created it ourselves. Our circumstances create it. It is nothing by itself. Because of it something or the else gets created. The other woman that I told you about in Pakistan - she has been ill all her life and now they say she has no illness - just psychological.

[What is the cure for it in your opinion] Whoever keeps faith in God depression cannot happen to. When I pray or read Quran I feel my God is with me, even though I am alone. When I have my periods and I can't pray then I have it more. After all, a person is alone, you want someone who cares about you that you can tell things to, what is in your heart. Most sincere are parents, brothers and sisters, but then they have their own also. Sisters care, but then brothers...there are sister in laws and you feel differently.

______________________________________________________________

47Women in Islam are prohibited from praying or handling the Quran during menstruation.
But most parents do. Over here (in Britain - away from home) who can you think is your own, (you) can't talk to anyone as (you are) scared that they may tell your in laws. Then that will become a problem. In laws just need one thing to become an issue. So many things cause depression.... I have true faith in God - then happiness is from him and distress is from him, from this depression decreases a lot.

......Dr's can't do anything, it is just your domestic atmosphere....Look, my doctor he is just seeing it physically, I am telling him (I) am tired, (I) can't do anything, (I) sleep a lot. Everyone knows a sign of depression is exhaustion, but he isn't understanding..... If someone is your confidante then it is your parents. But then husband can give love also. If my husband was okay my depression would not stay. When I go out to classes or somewhere I am fine, but when I am at home it starts again.

Feroza's description of depression highlighted some of the cultural themes that shaped and made meaningful her experience of distress. She raised many of the cultural themes that were also discussed by many of the other respondents, as will be seen during the course of this Chapter. For example, although Feroza used the term depression frequently her use of it was always 'objective' as opposed to 'subjective'. That is, she referred to 'depression' but not being 'depressed'. When she described her symptoms they were predominantly physical, but in her description these symptoms did not preclude her underlying awareness of her own unhappiness. Feroza was clearly aware of the many causes of her depression. She located these in her role within relationships, the pressures of being a daughter-in-law, a strained marital relationship, the pressures of having young children and housework. A further cause of Feroza's depression was lack of support, which she associated with her parents and sisters, back in Pakistan. The elaborate descriptions of kinship and hierarchy were central to her experience and expression of distress. When she talked of venting her tensions on her children, it was a reflection of the limitations of her role and particular situation bring in expressing her distress with her husband or in-laws. In her description Feroza defined herself very much in terms of function and her relationship to others. Given her clear understanding of her own state, she found it mystifying that the doctor did not recognise her depression.
Such culturally shaped conceptions of personhood, the importance of familial relationships, the connection between the psychological and the somatic, all featured in many of the respondents' descriptions of symptoms, consequences, causes and curative measures for distress / depression. It is the very shared nature of these conceptions (moreover language) that make experiences of distress, both personally and socially, meaningful. When these conceptions are not shared, as was seen in Feroza's case with her doctor, it is then that problems arise.

Using content analytic results and excerpts of respondents' descriptions the intricacies and inter-play of cultural themes which shape experiences like Feroza are discussed. An attempt is thereby made to build a Pakistani explanatory model of distress / depression and to explicate the cultural network of meaning associated with it.

8.3 NAMING THE CONDITION

The studies' one hundred and twenty respondents all recognised the vignette as a description of someone suffering distress. A breakdown of the names and terms P and BP respondents used for the condition are given in table 8.1.

The three predominant conditions identified with the vignette were depression, mental tension and distress (or a more pervasive kind of worry). Interestingly, of the three, 'depression' was always stated in English and had no Urdu equivalent. Mental tension was referred to as 'zahni daboa', and distress / worry was referred to as 'paraishani'. In terms of percentages, 45% of BP identified the vignette as depression compared with only 15% of the P respondents. In contrast, 48% of Ps identified the vignette as distress / worry, compared with 23% of the BP respondents. Ps, also identified the case relatively more frequently as mental tension (22%), than did BPs (18%). Apart from these three more 'abstract categories', the miscellaneous category consisted of more concrete names or causes, as is epitomised in 'choop lag gai hai'/'the silence has got him / her'. These did not convey the same sense of the condition being an 'illness complex'.

180
Table 8.1  Names ascribed to the condition by Ps and BPs

<table>
<thead>
<tr>
<th>NAME OF CONDITION</th>
<th>%Ps</th>
<th>%BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEPRESSION</td>
<td>15%</td>
<td>45%</td>
</tr>
<tr>
<td>MENTAL TENSION (zahni daboa)</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>DISTRESS / WORRY (paraishani)</td>
<td>48%</td>
<td>24%</td>
</tr>
<tr>
<td>MISCELLANEOUS TOTAL</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Problem / Upset</td>
<td>7</td>
</tr>
<tr>
<td>Stress</td>
<td>1</td>
</tr>
<tr>
<td>Despondency / Failure</td>
<td>1</td>
</tr>
<tr>
<td>Sadness / Loneliness</td>
<td>1</td>
</tr>
<tr>
<td>&quot;Quiet has got him&quot; (choop lag gai hai)</td>
<td>1</td>
</tr>
<tr>
<td>Family Problems</td>
<td>1</td>
</tr>
<tr>
<td>Paranoia</td>
<td>1</td>
</tr>
<tr>
<td>Illness</td>
<td>2</td>
</tr>
</tbody>
</table>

Having identified the condition respondents were asked if they knew anyone who had suffered from this condition. A breakdown of the number and percentage of respondents who identified with the condition through either themselves, a close relative or close friend, or alternatively did not identify the condition at all, are given in table 8.2. These descriptions are also categorised in terms of the amount of detail they contained, ranging from a lot of detail with reference to a specific case, or vague information and no specific case example.

Table 8.2 indicates that the vast majority of Ps and BP respondents had heard of someone who had suffered from the kind of distress described in the vignette. 42% of the BPs and 30% of the Ps, reported knowing someone who had suffered such distress intimately. 17% of informants from both groups reported experiencing similar levels of distress themselves; although, this was not necessarily always declared at the beginning of the interview. During the course of the interview or at the end of the interview, several respondents disclosed that they had in fact had a similar (if not the same) experience to that described. Interestingly, of those that identified themselves with the vignette, nine
out of ten of the BPs had identified the condition as 'depression', compared with six out of ten of the P respondents. This suggested therefore that the notion of 'depression' was more familiar in those respondents that had themselves personally experienced or been diagnosed with depression.

Table 8.2  Case examples described by Ps and BPs

<table>
<thead>
<tr>
<th>DESCRIPTION OF CASE EXAMPLE SUFFERING FROM THE CONDITION</th>
<th>%Ps</th>
<th>%BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DETAILED CASE INVOLVING THEMSELVES</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>DETAILED CASE INVOLVING CLOSE RELATIVE / FRIEND</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td>BRIEF VAGUE CASE</td>
<td>40%</td>
<td>35%</td>
</tr>
<tr>
<td>DON'T KNOW ANYONE SUFFERING THE CONDITION</td>
<td>13%</td>
<td>6%</td>
</tr>
</tbody>
</table>

In sum, it appeared that BPs were most likely to label the condition depicted in the vignette as 'depression' and were more likely to relay a detailed case of someone suffering from the kind of distress illustrated. This was hardly surprising considering that many of these respondents, in the context of British medical society, were more likely to have been exposed to information regarding depression, and consequently were more likely to have been diagnosed as depressed. Whether the BP explanatory models of depression corresponded more with Western conceptions of depression, or were still largely shaped by Pakistani cultural conceptions is yet to be seen and will be discussed later.

8.4 SYMPTOMATOLOGY
The symptoms described by the respondents were categorised into: affective symptoms, somatic symptoms and behavioural symptoms; including a sub-category of those that had more socially defined behaviours. A breakdown of the number and percentages of the specific symptoms within the four categories are given in table 8.3.
Most notably, both Ps and BPs equally implicated all four categories of symptoms in mental distress. Affective symptoms appeared to be described by both groups proportionally more than the other categories of symptoms (32% of Ps and 31% of BPs). As in the AKUADS study, this again was somewhat counter to the 'somatisation' notion of distress in Asians. Affective symptoms, however, were by no means described to the exclusion of somatic symptoms (29% in Ps and 26% in BPs), behavioural symptoms (22% in Ps and 23% in BPs) or socio-behavioural symptoms (17% in both Ps and BPs).

This clear overlap in the nature of symptomatology associated with mental distress can be understood in terms of the cultural principals of the Unani and Ayurvedic paradigms. Although, Unani Tibb and Ayurveda are no longer the sole, or even arguably, the dominant medical systems practised in Pakistan, their principals still pervade to a large extent in popular culture and are evident in explanations of distress.

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
<th>%Ps</th>
<th>%BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFFECTIVE SYMPTOMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>32%</td>
<td>31%</td>
</tr>
<tr>
<td>Crying</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Anger / Irritability</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Worry</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Despondency / sense of failure / helplessness</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Disheartened / no point ti life / hopelessness</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Sadness / loneliness</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Nervousness / anxiety</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Self reproach / self complex</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Committing suicide</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>SOMATIC SYMPTOMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>General pain in body</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Weakness / tiredness / no strength in body</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Heart sinks / heart distress / weight on heart</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Stomach problems</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 8.3 Symptomatology described by Ps and BPs
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Ps</th>
<th>Bs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney problems</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sugar / diabetes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Blood pressure increases or decreases</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Headaches</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Hands feet keep shaking / go cold</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nerve problems / nerves breakdown</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Illness / effect on health</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>BEHAVIOURAL SYMPTOMS TOTAL</strong></td>
<td>22%</td>
<td>23%</td>
</tr>
<tr>
<td>Lack of sleep / excess sleep / staying in bed all the time</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Lack of hunger / excess of hunger</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Not talking at all / or saying strange things</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Impaired / negative / excess thinking</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>No enthusiasm for life / not looking after oneself</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Out of control / loss of senses</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>SOCIAL / BEHAVIOURAL SYMPTOMS TOTAL</strong></td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Heart not feel like doing anything</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Not giving attention to / neglecting children</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Not feeling like going out or meeting people</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Withdrawn / keeping things to yourself / being distant from family</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>

These paradigms, as mentioned in Part II, have been invariably described using metaphors of 'holism' and 'ecology' (Kakar, 1982; Zimmermann, 1987). This has been due to their characteristic inter-connection of the affective, somatic, personal, social, environmental and moral realms. Each of which will be discussed later.

A brief description of the natural theory of Unani Tibb helps to explain the inter-play of these realms of human experience with health and illness. Unani Tibb is particularly tied to Islam, the dominant religion in Pakistan and of both Ps and BPs in this study. During the course of the description frequent reference will also be made to Ayuverda and the relatively larger body of research associated with it. This is justified by the quintessential
similarities between these two humoral paradigms as well as their close co-existence in the Indian sub-continent. The concepts of both are therefore inherent in Pakistani culture.

8.4.1 Unani Medicine / Tibb-Islam

Unani Tibb or Greco-Islamic medicine originates from the system of medicine that was developed during the Arab civilization (Said, 1983). Concepts of health and illness in this medical system are inextricably woven into the general body of Islam and Islamic practices, with a stress on the ethical and the holistic. In Islam the human being is viewed in the context of a larger cosmos, in which it is perceived to share essential elemental properties. The cosmos in its entirety is in turn perceived to be subject to the principal of Thawid - the concept of oneness and unity of all creation. This is clearly depicted in its linking of the macrocosm of universe with a perfectly reflected microcosm of the human being (Good & Good, 1992). The Unani model thus characteristically emphasises and uses symbolic language and analogy in its conceptualisation. Within this formulation the origin, nature and purpose of human beings is to live and function harmoniously within themselves and their surroundings. This notion of the creation of the human being is central to the philosophy of Unani medicine. Therefore Unani medicine can be seen to be a holistic perspective which views the human being as an integrated whole in a dynamic condition of balance.

The psychological component of Unani medicine resides on the concept of Nafs - the self, which in its desirable state should be in a state of unconditional tranquillity - Sakoon. Central to the Nafs is the heart, which is considered the point of union between the soma, psyche and the spirit and consequently seen as the essence of the 'self'. The heart, on the one hand, is thought to distinguish humans from other created beings and on the other symbolises the whole human being in relation to the world. It is thus considered to have

48 Although this description is structured in terms of psychological and physiological components it is in no way intended to be divisive and to detract from the holism of the paradigm. The inter-connection of the two will become apparent during the course of the description.

49 This is in contrast to the Western view of mind and rationality, which is thought to distinguish humans from other beings
predominant control over an individual's life and to be the medium for perception and interpretation of reality. It is thereby considered the seat of the mind and the reservoir for emotional processes (Obeyesekere, 1976). The functions of the heart are enabled by the *Rooh Haiwania* or vital faculty which emanates from the left ventricle of the heart, and is just one of the three faculties of the *Rooh* - vital force. The other two faculties of the vital force are the *Rooh Tabayya* - the natural faculty which is associated with the liver and the *Rooh Nafsania* - rational faculty associated with the brain (Khan, 1986). In totality the vital force is considered the guiding principal within the human organism which transcends corporeal reality. By implication it is also the primary aspect of illness. It is believed that the quantity and quality of vital force can be modified with appropriate nutrition, medication and psycho-emotional factors.

The physiological concepts underlying Unani medicine are based on a conceptualisation of the universe in terms of *Quwa* - energy, which can be delineated by four primary qualities of: hot and cold, moisture and wet and dry. Hot and cold are considered to be active qualities and wet and dry passive qualities. The entire cosmos, including humans, are regarded as a combination and interplay of these four elements. In symbolic reference these four elements relate to fire, air, water and earth; each of which is composed of particular combinations of the elements. All minerals, plants, animals and humans, in turn, are thought of as being constituted of these properties. Following the same line of correspondences these elements and their properties are extended to the *Akhlaat* - humors. The humors are conceived as originating in the liver, where chyme is converted into four primary fluids: yellow bile, black bile, phlegm and blood. Yellow bile is thought to be composed of the inherent properties of fire - hot and dry, black bile of the inherent properties of earth - cold and dry, phlegm the inherent properties of water - cold and moist, and blood the inherent properties of air - hot and moist (Khan, 1986; Said, 1983). Crucial to the understanding of humors, and indeed to the concept of body in Unani Tibb (as in Ayurveda), is the appreciation that humors are not just substances located within the body. As Langford elaborates:

"More accurately they are principals that are linked through an elaborate system of
correspondences not only to somatic processes but to processes in the natural environment" (Langford, 1995, p 336).

This fundamental link between organisms and their environment can be clarified through an understanding of the concept of 'Mizaj'. Every being is regarded to have an inherent predisposition or temperament, called - Mizaj; that is, an inherent dynamic state resulting from the interaction of the elemental qualities. Whilst to some extent Mizaj is inherited, it is also determined by climate, flora, fauna and diet, all of which have their own characteristic distribution of elements. In this system, if one or more of the elements is increased or decreased in proportion to the others this has a knock on affect. In addition to ecological factors, Mizaj is also thought to be affected by gender. Women are believed to be colder in temperament than men, due to their smaller build and more relaxed tissues and muscles. The flux of the Mizaj is further prone to stages of life and age, correspondingly temperament is believed to become colder with age. It is, thus, as a consequence of these inter-relations that: season, diet, health and well being are interlinked in Unani Tibb (Khan, 1986), and furthermore how, body, society and world are perceived as folded into one another in a convoluted way\(^5\) (Zimmermann, 1987).

Treatment and pathogenesis further indicate the convolution of body and environment. Khan (1986) has identified six essential factors which are considered to be fundamental to the health dynamic. By implication, these factors in the negative conditions are, then, pathogenic and causative of illness. These factors are:

(i ) Ecological conditions - which stress the importance of fresh air for health and the impact of seasons, climates etc...
(ii) Mental and emotional factors - which are seen as influencing the core of the person, the vital spirit
(iii) Sleep and wakefulness - which are thought to be crucial in the promotion and preservation of health and the enabling of vital functions to take place in the body
(iv) Diet and nutrition - the quantity and quality of which, in conjunction with; time of day,

\(^5\) as is in Ayuverda
year, manner of eating and psychological state, exerts a crucial effect in maintaining and restoring health

(v) Physiological movement and rest - which through the generation of heat in varying degrees facilitate the greater dispersion of humors

(vi) Retention and evacuation - an imbalance in which can lead to disease.

Treatment, in turn, (bearing in mind the inter-relations of body and environment and as mediated by the principal of mizaj), adopts natural substances, which are endowed with their own natural temperament and can thereby modify and treat the internal balance of the individual. Most notably, then, Unani Tibb stresses the importance of both internal and external balance and their joint impact on health. This notion is illustrated by a male Pakistani respondent, who explained:

"I think all these things are related to diet. Here we eat a lot of hot spicy foods, and a person who uses these more, their blood circulation shoots up causing high blood pressure. Elders say, and it is also said in a hadith, that if someone is angry give them water, and in most cases I have seen this work because running blood is slowed down and cooled by the water. I think it is also a difference in peoples natures. Some men have a hot temperament and their sins will also be eighty or ninety percent greater. These things come through family and can cause: blood pressure, nerve problems and stomach problems. From these many illnesses of the liver, heart and mind can happen. Another illness that is more in people these days is 'migraine', and this is because of stress. First their digestion becomes bad and then they get 'gas'. The gas goes straight to the brain and this causes migraine".

This respondent directly connected diet with temperament and behaviour, as well as with illness.

\[51^5\text{Teachings of the prophet Mohammed PBUH.}\]

\[52^\text{the notion of 'gas' refers to a kind of wind or current that passes through the body.}\]
These inter-relations were further elaborated upon by a Pakistani woman's description of her symptoms of distress:

"Because of these things [referring to husband's drug addiction] sleep doesn't come, (I) stay quiet and crying comes to me again and again. There is a lot of anxiety and (I) sweat a lot. My heart starts to tighten and (I) want to run away, then I often open the door and sit in the alley way. From inside the heart is not happy. No happiness has stayed in me. There is no hope. I stay lost all the time. Before I was healthy and now I have withered away. I feel more, and then I start getting a pain in my chest. A person's body becomes weak, like wood, the blood dries up. When the family see they also get worried."

Although this respondent did not make a direct reference to diet, she expressed her distress by referring to the symbolism of the heart. Through this she connected her emotions to her bodily state, which she described by drawing on a natural metaphor - "the body withering away like wood".

The convolution of the emotional, the body and the social, thus, appeared to be evident in many respondents descriptions of symptoms in line with a Unani / Ayurvedic ecological view of health and illness, in aspiring to the 'natural' state of Sakoon - unconditional tranquillity; a term often used by informants. Precisely how do these three aspects of distress (which are often disjointed in Western medical paradigms, theoretically, as well as, structurally) interplay with one another and impact on the experience of distress for Pakistanis?

In order to explicate the nature of these connections, we need to focus on the affective level and its connection with the social, followed by the connection of the affective with the somatic and finally the somatic with the social. This line of argument is not however indicative of a linear relationship. Rather, it conveys a more circular and diffuse relationship, one which relates to a conceptualisation of 'person' which is not bounded

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\(^{32}\)At least in terms of medical infra structure.
simply by a physical body; but one in which mind cannot be separated from soma and body from environment.

8.4.2 The Affective

Several researchers (Lutz, 1985; Schieffelin, 1985) have argued that it is more instructive in cross-cultural research to address 'depression' as an emotion as opposed to a syndrome. This is due to the existence of the universality of the syndrome not having yet been unequivocally established. Lutz (1985) states that the syndrome of depression is a fundamentally emotional one in nature and that theories regarding the nature of depression are also essentially theories on the nature of emotion. Furthermore, along with Schieffelin (1985), she argues that 'depression' as an emotion and cultural category stems also from more general implicit assumptions about the nature of person and emotion. That is to say, whilst emotion is to some extent experienced privately its content and expression is culturally shaped. On the one hand, emotions are subject to cognition for interpretation and on the other, they are constructed through social interaction, giving them meaning and expressive value in the presence of others. Lutz's notion that emotions are used by people to make and negotiate judgements about the meaning of events in their own and others lives, places emotion in a mediatory position between events, relationships and individuals and is therefore, central to theories of disorder like depression. Schieffelin (1985) has also similarly argued for the necessity of looking at emotions as social and behavioural systems that extend beyond personality.

In short, such an approach facilitates the cultural construction of feelings and promotes looking at the inter-relationship of affect and social action in the expression of distress / depression. Moreover, the notion of the cultural construction of emotion allows room for some diversity in the way feelings work in different cultures. In the West for example, Freud (1956) theorised 'depression' as being anger or unexpressed emotion turned inward against the 'self'. With this view, emotion is clearly confined within the individual. In contrast, emotions in many non-Western cultures do not principally belong to the self, they are conceptualised as being more reflexive and are thus the property and outcome of relationships. Such cultures correspondingly stress the social aspect of 'self'. In fact, Shweder (1985) speculates that somatisation may be more likely in those very societies in which the direct expression of
emotion may be thought to be dangerous and disruptive to social relations. Ots (1990), along similar lines suggests that cultures which legitimate emotional disorders, generally encourage an emphasis on psychological aspects of illness. Whereas cultures that stigmatise emotional disorders encourage an emphasis on somatic aspects of illness. Both these modes of thought culturally construct emotions and concept of self, and shape perception, interpretation and learning. In this scheme of things, like Kakar's (1982) analysis of Indian culture, Pakistani culture can be seen to be society orientated. It stresses an inter-dependant role over the individual and in accordance, constructs the connection and expression of affect in relation to others and social roles. This is why Feroza said:

"There is house work to do, and children's work to do - clothing them, feeding them everything. The torture of work also causes depression. But I think if a person is happy everything is happy. Then even the most work is nothing. If my husbands mood is good I feel my day has passed well, if it is bad then it all goes wrong."

This social conception of self in Pakistani culture and the expression of distress in relation to others, as opposed to being bound within the individual body, will later be developed further and given greater attention in relation to causality. For the time being the somatic aspect of distress are focused on, which respondents linked with affect.

8.4.3 The Somatic

The somatic expression of distress in conjunction with the affective can be understood in terms of the Unani conceptualisation of person, or in other words through the notion of an 'emotional body' as coined by Ots in relation to Chinese medicine (1990). Ots's notion of the 'emotional body' or the 'lived body' (Leder, 1984) refers to a phenomenological body of perceived experiences that transcends the Western dichotomy of psyche and soma. This conceptualisation accords well with the key role of the heart in Unani Tibb. In brief, the heart, is regarded as the site for both emotional and mental processes as facilitated by the vital force. An imbalance in these processes has already been implicated as one of the major factors contributing to illness. That is, negative emotions, depending on their quality and severity are believed to cause the vital force to move inwards. A
prolonged or sudden inward movement in vital force can predispose an individual to mental illness or even death. Ots' study investigating the meaning of bodily perceptions in the discourse of Chinese medicine and patients explanatory modes also showed how many somatic symptoms eg the angry liver, the anxious heart and the melancholy spleen, relate to the world of emotions.

Moreover, this connection of psyche and soma is reiterated semantically in many languages within the use of somatic idioms for distress. This connection has, however, been frequently mis-interpreted (as pointed out in Part II) and the anatomical correspondence between organs and emotions has been used as an argument for 'somatisation', propagating the notion of the somatic as a metaphor for the psychological. Porkert's (1974) postulation may help clarify the notion of 'somatisation' further. He argues that, in traditional Chinese medicine, terms such as 'heart' or 'liver' do not directly refer to anatomical substrate, rather a certain pattern of functions. This can also be applied to Unani medicine in the context of Pakistani culture. Indeed Langford (1995) in her study on Ayurvedic practice in India also suggests caution about making distinctions between signs and referents or symptoms and disease. The heart, therefore, or any other such symbol in the Unani paradigm cannot simply be taken as metaphorical, rather it is a highly polysemous symbol referring to the physical, the psychological and the social. Bal (1987) argues, in more general terms that culturally appropriate expressions of distress are encoded in symptoms that have symbolic meaning within their cultural context. The heart is such a symbol. Indeed, the polysemy of the heart has been the subject of investigation in Good & Good's study of 'heart distress in Iran' (1977) and Krause's (1989) study of 'the sinking heart' in Punjabis living in Britain.

The affective / psyche and the somatic are, thus, integrated in Unani Tibb or conception of 'emotional body', both in terms of a semantic network and in terms of communication and language. Indeed almost all informants in their description of distress / depression linked the affective with the somatic. This link was further explicated in their responses to what the "consequences of such a condition may be". As one woman said:
"It causes a hundred illnesses. From thinking and thinking it will effect the brain and you won’t stay capable of anything. If you think all the time - what shall I do, my children are like this, they are like that - then illnesses will get you. Thinking in the brain also effects the body: sleep won’t come, (you) won’t work, (you) won’t stay fit and then illnesses will get you"

8.5 CONSEQUENCES OF DISTRESS
The informants’ responses were categorised into: mental, physical and social consequences. A breakdown of both categories of effects is given for both Ps and BPs in table 8.4.

From table 8.4 it is clear that P and BPs both perceived distress / depression as having a major effect on physical health (69% of Ps and 59% of BPs) respectively. In line with the identification of the heart as a central polyseme in the connection of affective and somatic, a relatively high proportion of respondents in both groups considered distress to have a major effect on the heart (15% of Ps and 16% of BPs). A further substantial 20% of Ps identified distress specifically with blood pressure, compared with a 9% of BPs.

Physical effects, however, were not identified to the complete preclusion of mental and social effects of distress. 17% of BPs and 16% of Ps said that distress would lead to more severe effects on the brain. Interestingly, a sizeable 10% of BPs and 9% of Ps said that distress would effect the wider social network and in particular the family. The intermediary role that the wider social network can play in the course the illness takes, is illustrated by a quote from a BP respondent, who said:

"Depression doesn't become the cause of other illnesses, it is the cause of other reactions. The persons reaction with other people around them becomes difficult and harsh. From this tension blood pressure will happen, and from blood pressure other

54 Indeed, the use of the idiom of blood pressure for expressing distress may be a useful focus for future research in Pakistan.
illnesses will happen. Like these heart attacks and things, they are all because of tension.

Table 8.4 Consequences of the condition described by Ps and BPs

<table>
<thead>
<tr>
<th>EFFECT OF THE CONDITION</th>
<th>%Ps</th>
<th>%BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>17%</td>
<td>16%</td>
</tr>
<tr>
<td>Effect on brain /mind</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Self Complex</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Madness</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>SOMATIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>59%</td>
<td>69%</td>
</tr>
<tr>
<td>Effect on heart</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Blood pressure increases / decreases</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Headaches</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Effect on digestive system</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Sugar / Diabetes</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Effect on nervous system</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Body becomes weaker</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>General illness</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Miscellaneous Somatic symptoms</td>
<td>TOTAL</td>
<td>14%</td>
</tr>
<tr>
<td>Pains in body</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Effects kidney</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Effects liver</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Causes stroke</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Brain Haemorrhage</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>SOCIAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>10%</td>
<td>9%</td>
</tr>
<tr>
<td>Effect on family</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>
Attention here is again returned to the social aspect of distress; that is, how the 'emotional body' or 'lived body' is tied to the environment and social relationships. The interface of body and environment is particularly implicated in the causal discourse of explanatory models.

8.6 CAUSALITY

As in symptomatology both Ps and BP’s descriptions of causes of distress were marked by their plurality. Typically, informants viewed a number of overlapping interactive factors as being causative of distress. A breakdown of percentage causes of distress, cited by informants, is given in table 8.5. The causes of distress were categorised into: circumstantial causes (including the particular effects of living in Britain), relational (kinship) causes, personality causes and supernatural causes.

From table 8.5 it is evident that in both groups, external causes - relational, as well as, circumstantial are regarded as the predominant causes of distress; that is, a total of 74% of causes cited by Ps were external and 77% of causes cited by BPs were external (not including supernatural causes). In contrast, only 18% of indigenous Ps and 19% of BPs cited internal personality factors as the cause of distress / depression. In actual fact, where personality factors were cited they were conceptualised as being secondary to or dependant on external / environmental causes. As one male informant explained:

"People don't think too much unless such circumstances which cause thinking are created in them"
<table>
<thead>
<tr>
<th>CAUSES OF DISTRESS</th>
<th>% Ps</th>
<th>% BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIRCUMSTANCES TOTAL</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Death</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Shock / tragedy</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Illness</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Unemployment</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Financial worries / losses</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>General circumstances</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>EFFECTS OF BEING A MIGRANT TOTAL</td>
<td>2%</td>
<td>13%</td>
</tr>
<tr>
<td>Isolation / loneliness</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Cultural issues and divides</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Racism / discrimination</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Climate</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>RELATIONAL</td>
<td>31%</td>
<td>26%</td>
</tr>
<tr>
<td>Domestic atmosphere being bad / family disputes</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Marital problems in particular</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Problems with children - Cultural / marriage problems etc.</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>PERSONALITY TOTAL</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>Sensitive nature / thinks or feels too much</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Ability to cope</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Weakness in body / personality / will / faith</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Despondency / disheartened / helplessness</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SUPERNATURAL TOTAL</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Fate</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Evil eye</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Djinn</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
8.6.1 Social / Environmental Aspects

Distress / depression was therefore conceptualised by many of the informants as residing outside the 'body', consequential to circumstances or relationships. Indeed, the single most cited cause of distress was family disputes. Interestingly, when family problems were talked about the phrase "ghar ka mahool", translating as the "household atmosphere / environment" was frequently used. This literally conveyed a sense of the importance of environment and of the external in illness. As a female BP respondent said:

"The biggest cause is the mercy of circumstances and the domestic atmosphere. What else can it be? You feel you can't come out of the situation. You feel depression. You feel as if you are enclosed within your body."

Both Zimmermann (1987) and Kakar (1982) also attested to this external aspect of distress / illness, in their understanding that - Ayuverda in its symbolic correspondence between the macrocosm of Universe and the microcosm of the body\(^5\), perceives the body and the person as fluid and permeable. A relationship which is engaged in a continuous interchange between the social and natural environment. This exchange along with the permeability of boundaries of body and person extend beyond the influence of purely natural substances and energies. They also analogously render the person permeable to the influence of 'others' (including the supernatural, although only a relatively small proportion, - 8% of Ps and 4% of BPs implied supernatural factors as causes of distress, such as evil eye and the effects of Djinns\(^6\)).

From the informants descriptions, both internal and external factors (although in this study, predominantly the external factors) in accordance with the Unani paradigm can therefore be pathogenic and precipitative of distress / illness. This permeable

\(^5\) and in sharp contrast to western biomedicine

\(^6\)A Djinn is a dispossessed soul or ghost which inhabits the body of a living person or can be disembodied. In India and Pakistan they tend to have negative connotations as opposed to beneficial. The possession of a living soul is attributed to all sorts of mal-functional behaviour.
conceptualisation of body structure in Unani Tibb and the subsequent importance of environment, in conjunction with earlier associated arguments about the relational nature of emotions and illness, raises important implications regarding cultural concept, in Mauss's (1985) terms, of 'personhood' and 'selfhood'.

As Krause (1995) succinctly explains, 'personhood' refers to the aspect of an individual's existence in which he/she plays a social role as a member of a collective. 'Selfhood', on the other hand, refers to the mental and physical awareness that human beings have of their own individuality. Along similar lines with the notion of 'personhood', Shweder and Bourne (1991) and Gaines (1982) have, respectively, dichotomised the 'sociocentric' and 'indexical' self. In brief, the 'sociocentric' or 'indexical' self, refers to the unbounded permeable non-Western self that is indexed in time, in place and in a particular set of social relationships. Behaviour in this notion of 'social self' is believed to be a function of particular self/other relations. Shweder and Bourne (1991) (as already touched upon in Part II) directly linked this contextually specific conception of self with the world view and premise of 'holism' and the metaphors a society subscribes to. In the case of the Oriyan Indians that Shweder and Bourne described, as well as in the Pakistani case described in this study, the dominant social metaphor is that of 'the Body', or more accurately a 'Unani or Ayurvedic Body'. It is this premise of holism which Shweder and Bourne extended beyond conception of person to general cognition and thinking. They postulated that in such societies cognition will be primed to be contextual and descriptions will be marked by their reference to cases and specific contexts. Returning to the notion of 'holism', then, this is both a reflection and consequence of the culturally constructed view that it is not possible to understand an entity in isolation and that isolation of any unit part results in a loss of the inherent essential properties of the whole. The respondents' descriptions of distress were also notably built around a context. This context primarily related to the family and its centrality to distress and happiness, as well as the concept of self. As this male Pakistani respondent illustrated:

"Some situations a person can prevent and cure and others (he) can't. Like a man whose son wants to marry someone he doesn't want him to marry, his distress isn't born by
himself, it is born by his children. Some things, if they are born by (your)self, like if I was to take out a loan and cannot pay it back, that is created by me and I can try to cure it. But other things you cannot - those are distresses from other people."

Herzlich and Pierret (1986) argued that by evoking the social in causality we are also simultaneously expressing our relationship to it. In this sense, illness functions as a 'signifier' underlying conceptualisation of self and society. South Asian society, as Laungani (1992) argues cannot be seen in terms other than familial and communal. Consequentially, when a problem or illness arise it effects the entire family and it is seldom regarded a personalised 'private' problem. Marsella (1980) has suggested that the cultural values of a 'sociocentric' self and a focus on kin group, may in turn influence the process of self identification with dysphoric affect and bodily states. He postulates that a sociocentric self may then be protected from ego identification with the depressive state and thus depression. Marsella, however, accepts that if this is the case, it may alternatively mean that the relationally defined self is predisposed to a different set of problems.

Whilst the Asian 'extended family' may be regarded as a supportive or preventative system to depression, it is antithetically also the cause of distress. Sethi (1986), similarly found family systems and life events to be particularly relevant in the etiology of depression in indigenous Indians. Moreover, for many of the female respondents in this study, the 'home' itself became the context of distress and depression. As Feroza suggested:

"...if my husband was okay my depression would not stay. When I go out to classes or somewhere I am fine, but when I am at home it starts again".

A frequent phrase many of the female respondents used to express this connection of personal distress to the family context was: "the heart doesn't feel like staying in the house".

As was argued in Chapter 4, Shweder and Bourne (1991) suggest that cultures which
promote the belief that society is built out of status's and roles, rationalise the moral order in terms of duties. Dworkin (1977) in his dichotomy refers to these as duty based (as opposed to rights based) cultures. Nichter (1981) in his examination of sickness in Havik Brahmin women in South India understood the particular 'idioms of distress' in these women primarily in terms of their, and the wider society in which they function, perceptions of socially appropriate, 'dutiful' behaviour. Illness, thus, in many cultures, Western and non-Western (Currer, 1986; Pill & Stott, 1996) is frequently defined functionally (refer to Part II). One female informant distinctly connected her distress (and its communication) with her family and the duties of being a mother. She described:

"Sleep doesn't come, there is no tranquility [sakoon]. A weight will stay in the heart and a lot of illnesses can happen - stomach aches can happen. They will stay quiet. If there is no recognition (of it) then there won't be any care about the family or the children - there isn't any care about anything apart from about (your)self. (Your) heart won't feel like doing the housework. Crying comes again and again, there is a pain in the head, pain in the body, sweating and anxiety".

Distress was then primarily seen as a relational or family affair, in terms of cause, communication as well as its effect. This is opposed to the burden of the sole individual. As one male respondent commented:

"You can't spend your life properly, you can't do anything. It effects the whole family and children, they stay in tension and worried about him all of the time. All of the attention is diverted to him. You keep other people depressed to release your own depression".

In contrast to this description of South Asian culture, Western theories of illness predicate a cultural concept of 'selfhood' (Mauss, 1985). Herzlich & Pierret (1986), however, through analysing the influences of different philosophical traditions on social
representation of illness, show that this has not always been the case\textsuperscript{57}. They argue that, Western medicine at various times in history has operationalised a range of concepts to explain illness. These have ranged from the broader to the smaller unit, the exogenous to the indigenous, and currently the 'individual'. Indeed within the individual, mental illness is increasingly explained as residing solely in the mind. Becks' (1979) cognitive theory of depression provides an example of the current Western medical concept of the bounded individual, split by the mind and body. To elaborate, Beck's theory formulates the primary cause of depression to be cognitive; that is cognitive assumptions held by the individual are thought to intervene with the interpretation of affect. Through this conceptualising of depression as a struggle between the cognitive and emotional aspect of 'self', Beck perceives the cause of illness as internal and residing in the mind of the individual. It is at this individual self that therapy and healing is subsequently targeted. This bounded conceptualisation of body, in conjunction with earlier associated arguments about the internal nature of emotions and illness in Western cultures (although contrary to Pakistani culture), also raises important implications regarding the concept of selfhood and the subjective experience of self.

Shweder and Bourne (1991) and Gaines (1982), in the second half of their dichotomy, have respectively described the internal Western conception of self as 'egocentric' and 'referential'. In short, such a conceptualisation of 'self' perceives the individual as autonomous and the principal locus of thoughts, feelings and action. Consequently, behaviour in this notion of self is also believed to emanate from the individual. It is thus that the individual becomes open to the processes of reflection and abstraction. According to Shweder and Bourne's postulations, then (and in contrast to the contextual cognition of sociocentric societies), Western cultures can be seen to hold a physical world view and subscription to the mechanistic metaphor of the computer as brain. These premises, according to Shweder and Bourne, primes Western societies to think more abstractly. Herzlich & Pierret (1986) point out that this current connection of the mind first and foremost with illness has resulted in a distinctive relationship between the mind

\textsuperscript{57} Indeed it can be argued that this is not always the case even now. Refer to section 7.6 on sex and class differences in British explanatory models and symptoms.
and body, where the mind is conceptualised as acting as subject over body. This implicit assumption is evident in the example of the primary importance given to psychological symptoms over somatic symptoms in modern psychiatry.

Illness in such societies has thus become internalised to such an extent that it is now associated with the inner most core of the 'self' - an illness of the 'self'. In the extreme, this subjective nature of illness has lead to the somewhat peculiar position of 'illnesses' (such as depression) being awarded importance as unique to the person and a reflection of the inner person's moral position or sensitive nature. It is thereby that Sontag (1977) argues that illnesses like depression in Western cultures have become romanticised and associated with a tortured soul. The paradox of identifying the 'self' with mental illnesses like depression, yet the distancing of 'self' from diseases like cancer, is discussed further by Casell (1976) in his paper "Disease as an 'it'".

8.6.2 Language

The idea of language and symptomatology reflecting self structure and cognition, that Cassell pursues, can be further developed in cultural terms. For example, the Western cultural distinction of mind from body and it's corresponding subject / object relations can be seen to be encapsulated in the use of language, and in particular by the use of the pronoun. This is interestingly elaborated on by Phillips (1993), in his paper "Worrying And It's Discontents". Phillips describes how the use of the English word "worry" has changed as a direct reflection of current Western conceptions of mind / body.\(^58\) He points out that the English word "wyrgan" meaning to kill by strangulation, was originally a hunting term used to describe what dogs did to their prey. 'Worrying' in this sense was something that was done to you. That is, a person was the object of worry, and so one could say "I have worries". However, during the mid nineteenth century, there was a distinct change in the use of the word "worry". Phillips suggests that by this new use of the term, a person could now be the subject of worry. That is, one could worry oneself and therefore could say "I am worried". This subtle transformation of the use of the term

\(^{58}\) The Urdu term 'paraishani', which can be translated as worry or distress was frequently used by P and BP respondents.
from the external to the internal can clearly be paralleled with the philosophical split in
mind / body, and the resulting conceptualisation of an intentional mind residing over an
unintentional body. This is also portrayed in the current English use of the term
'depression' - "I am depressed".

In contrast to the English use of the word 'depression', Pakistani informants, typically used
in the terms in object relation terms. For example, they frequently used phrases such as,
"my distresses, depression happens, depression stays, became prey to depression". The
externality of these phrases can be seen to be in correspondence with contextualised
thinking (suggested by Shweder & Bourne, 1991) and a concept of 'self', which is the
object rather than the subject of 'depression'. The 'self' being the object of distress /
depression is further attested to by the notable dis-use of pronouns in conjunction with
emotions. Although in Urdu it is grammatically possible to construct a sentence which
would make the 'self' the subject of depression, it was seldom done by respondents. For
example, in Feroza's description, the term 'depression' was used eleven times, but only
twice was it used in a subjective sense. In both of these cases 'depression' was not
associated with "I", rather it was mentioned in relation to either her husband or the
collective 'you'. Thus, the use of language as well as the terminology used to convey
distress are indicative of deeper cognitions and conceptualisation of 'self'.

Moreover the Pakistani informants external conceptualisation of distress, as expressed
through language, was contextualised to such an extent that different concrete causes of
distress / depression were regarded as literally resulting in different forms of the condition.
For example, one woman whilst locating her source of distress in her children,
distinguished it from other peoples forms of distress:

"Everyone's mental distress is different. For me it is from my children, because I want
them to do as I say. For somebody else it may be to do with their husband and according
to their circumstances".

Furthermore, the notion of different forms of distress were also defined by their social
legitimacy. As one woman said:

"one type of distress is from God and that a person can bear, but another type people give, and that a person cannot bear"

A male respondent further connected the social legitimacy of the particular distress to symptom presentation:

"If there is a financial distress the person will go quiet and not talk to anyone or meet other people. If there is a death, distress in the family other people will know and will come to offer their respects. If there is a physical or mental distress then you can tell from their talks and their behaviour."

Where pronouns were not used in Urdu, the heart, once again, was frequently implicated, reflecting the Unani conceptualisation of heart being the site of the self -\textit{Nafs}, and the seat of the mind and reservoir for emotions. The heart (\textit{dil}) is, thus, used as a common word for "I", and connotes feelings of the person. A person's heart is in this sense the person. This is illustrated by common phrases such as, "heart (/I) doesn't feel like doing anything - \textit{dil nahi chahtha koch karnai ko}" or "my heart doesn't want to talk to anyone - \textit{dil nahi chahtha kisee sai bath karnai ko}". In the mediation and communication of emotion through the heart, language is tied to underlying cultural concepts. The Pakistani "I", in contrast to the Western "I"\textsuperscript{59} is thereby connected with a permeable 'emotional body', as well as, spirit. The heart in this mediatory position, consequentially, also serves to distance the 'individual self' from emotion. In this context the use of the pronoun \textit{mai} / "I" can be negatively viewed and seen to connote self-centredness. \textit{Mai}, in conjunction with distress / depression, was rarely used by the respondents.

\subsection{8.6.3 The Self}

Kleinman and Becker (1991), argue that formulating the relationship of emotion and self as a continuum of, for example sociocentric / egocentric, oversimplifies the construction

\textsuperscript{59} The western 'I' is firmly located in the mind.
of 'self', and fails to specify the situations in which 'selves' maybe constructed differently within the same culture. Indeed this discussion on notion of 'self' in Pakistanis is in no way intended to imply that Pakistanis do not have a sense of self or individuality. In fact, from the content analysis it was evident that Pakistanis identified internal personality or temperament / thabiyyath factors in the causation of mental distress / depression. However, wherever this was implicated, it was structured as secondary to and dependent on environmental, as well as, bodily factors. As Marsella & White (1982) suggest, it is not the distinction of psychological processes per se that vary across cultures, rather it is their place in explanatory models about illness and the value placed on them that varies. The 'place' of psychological processes in Pakistanis explanatory models varied in its correspondence with the integration of mind with body. Patel (1995) in a review of studies in Sub-Saharan Africa highlighted that, although many African cultures do distinguish between the mind and body, they conceptualise the mind as residing in the head, as well as the heart and abdominal region. The mind is thereby regarded as being diffuse in body. This can be understood through the principal of 'vital force' (refer to section 8.4.1).

The difference in cultural notions of 'selfhood' and 'personhood' is therefore not in absolute terms, rather it is in terms of the emphasis placed on it. As Ewing (1991) clarifies, the notion that South Asians are 'weak' in independence and autonomy, confuses the issues of 'inter-personal' and 'intra-psychic' autonomy. Building on this distinction, she presents an argument that the Pakistani woman, who are particularly regarded as inter-personally dependent, has to paradoxically show immense inter-personal autonomy when on marriage she leaves her parental home to join her husband and his family. Here Ewing demonstrates Kleinman and Beckers argument, that 'selves' can be differentially constructed within a culture.

In this study the notions of selfhood and their wider cultural connotations are hinted at through the concept of 'weakness' and 'strength'. Although these notions were only explicitly identified by 3% of the indigenous Ps and by 4% of the BPs as a cause of distress, they repeatedly arose during the course of the interviews. These dualistic notions
refer to ideas about personality, body and faith. One female respondent explained:

"If you want and your mind is so strong that you don't, then you won't build that thing up in your mind. If such a thing happens you will ignore it and it leaves your mind. For some people that thing doesn't get out of their mind, and that thing becomes a depression for them. If a person has strong faith or is a strong willed person, they won't even let this condition be made. This person will be physically strong and also mentally. But if a person takes some things too much, then they have a very quick affect on the body as well".

Thus, this woman (as did many respondents) talked about 'self' in conjunction with faith as being encapsulated in the idea of 'weakness'. This role and notion of 'self' is implicated and talked about further in the discussion around cure.

8.7 CURE

The cures advocated by Ps and BPs were split into the categories of: worship or seeking the help of a spiritual healer, a self initiated cure, family intervention and support, professional medical help, and those that believed that only a literal change in circumstances / situation / environment would cure the person. These are presented in table 8.6

Table 8.6 shows that in the case of symptomatology and causality, the cure for distress (in the view of both Ps and BPs), was pluralistic. The largest percentage of both Ps and BPs advocated the 'self' in cure. 40% of Ps and 38% of BPs advocated self help. This was through a variety of strategies: keeping oneself busy, going out and meeting people and not thinking too much or thinking positively. The Pakistanis, therefore, had a clear notion of 'selfhood' and the role this plays in distress / depression. However, in Pakistani culture the 'idealised' self should be a spiritual one. Consequently some respondents regarded depression as a 'signifier' of spiritual weakness in the 'self'. This explains 19% of indigenous Ps and 13% of BPs having advocated faith and worship in cure. Yet,
only a relatively small percentage - 3% of Ps and 2% of BPs thought it was appropriate to seek the help of a spiritual healer (pir/mulvi).

Table 8.6 Descriptions of cure by Ps and BPs

<table>
<thead>
<tr>
<th>CURE</th>
<th>Ps</th>
<th>BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religious TOTAL</td>
<td>22%</td>
<td>15%</td>
</tr>
<tr>
<td>Worship by yourself</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>Treatment from Mulvi/Pir</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Self TOTAL</td>
<td>40%</td>
<td>38%</td>
</tr>
<tr>
<td>To do self control and face it</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Keep self busy</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Don't think too much</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Go out and meet other people</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Talk to others that are close to (especially family)</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Change diet</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Family help - through improving the domestic environment TOTAL</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td>Through a change in circumstances</td>
<td>10%</td>
<td>13%</td>
</tr>
<tr>
<td>Professional help TOTAL</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>Treatment from doctors - primarily medication</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Treatment from psychiatrists/psychologists/counsellors</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Treatment from doctors of little value</td>
<td>6%</td>
<td>11%</td>
</tr>
</tbody>
</table>

8.7.1 The Role of Religion
Religion was a central theme in the respondents descriptions of distress. This British Pakistani man explained the role of religion and faith in distress in a similar way to many respondents:

"A person can only treat depression themselves. Doctors can't help you. It is in your
hands, how you take it, how you face it. If you have tried your best and something still goes wrong it is from God. But God will only put such difficulties on us that we can bear - this is our faith. If you have some distress you should thank God, as in this he may have saved you from some bigger more awful thing."

He went on to explicate the links between the role of religion in health through the principals of the Unani paradigm and the dissemination of the vital force:

"We believe in Islam and that is our faith. It is not just the pillars of Islam, by practicing faith you are actually providing the balance to your body and feeding the spiritual hunger of your soul."

This view placed man in a larger moral order over which the 'self' had limited reign. The implications, however, are not as fatalistic as has been frequently interpreted. The so called 'fatalism' of Pakistanis, has often been tied to the use of the term and concept of 'kismath' / fate. The extent of fatalism in this notion is clearly defined by one informant who explained:

"Trying is a necessity, if a person gives up trying his life is virtually finished. If a person thinks I am not doing anything - there is no point, he is completely a dead man. But if a person has sincerely tried and made the right type of effort and still that thing doesn't get done, according to our faith - this is fate."

In this sense, the role of Islam in distress / depression can be related to Obeyeskere's (1985) discussion on the role of Buddhism in Sri Lankan 'work of culture'. By drawing on this psychoanalytic notion of the 'work of culture', he argues that, the 'work' of a religious culture transforms a constellation of symptoms into a different direction than that assumed in a Western cultural context. In non-Western cultures, Obeyeskere suggests

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60 The psychoanalytic concept of the 'work of culture' refers to - the process by which painful affects and motives are transformed into publicly accepted states of meaning and symbols.
that symptoms are defined in existential terms, and through this the constellation of symptoms cease to be an illness. Rather, the unpleasant affects become associated with everyday life and are expressed and resolved through meanings provided by the religious orientation of that culture. It is the particular 'work' of a Western culture that he postulates, defines a constellation of symptoms as 'depression'.

In resolving unpleasant affects, the role of religion is described by a female British Pakistani respondent:

"In our religion it says that when you are in such a state worship God, because when you do you will know .....In the Quran it even says that a man was made for worries, and if some distress comes then it is nothing unnatural, nothing unexpected - it is a part of life. A person cannot change it with wealth or anything, it is from God. If such a problem comes you can't help it".

In fact, many of the respondents argued that if one's faith was strong, distress / depression should not happen in the first place. As one man said,

"In a Muslim depression shouldn't exist actually. It can exist of course, there are factors. But if a practising Muslim believes in God, that God is the creator he will provide, then if he reads his prayers depression will become less."

Religious language and ideas, such as kismath, thus become integrated with popular discourses on illness. They are not reflective of a literal reality, rather an ideology for giving distress meaning, social acceptance and coping with it. At the same time religious discourse also provides a culturally sanctioned way for individual motivation and interest to be expressed. In Obeyeskere's (1985) terms, in Pakistan affect "does not exist in a free floating manner, as in the west. Rather it is intrinsically locked into larger cultural and philosophical issues of existence and problems of meaning"

Religious beliefs or fatalism do not, therefore, clearly preclude the use of 'self' or other in
cure. Indeed 12% of Ps and 11% of BPs in line with an external causal conceptualisation of distress / depression, advocated family support in changing the domestic atmosphere. A further, 10% of Ps and 13% of BPs were firm that the only lasting cure was an external one that involved a change in circumstances or a solution to the problem. As one woman said,

"How can a person do prevention or cure from an emotional / psychological (nafsiyathi) problem. These are attached to your life."

Only 10% of both groups advocated seeking external (ie external to the family), professional medical advice from a doctor or psychologist / psychiatrist / counsellor. Yet, notably, 6% of Ps and 11% of BPs actually stated that they did not think that a doctor could help. This was mainly qualified by either the doctors' lack of cultural understanding, or their powerlessness to change primarily domestic situations, which respondents did not feel comfortable disclosing to them in the first place. The perceived role of doctors in some of the respondents explanatory models is illustrated by this British Pakistani woman:

"... should try and think of a solution to the problem and show tolerance. What can a doctor do if I tell him I am distressed he will not understand my domestic situation he will give me depression tablets, which won't put right the things inside me. The cure won't happen with tablets. If my children are on the wrong path I can eat tablets but I won't become alright will I. I say it is with Gods help or tolerance.

Turning to medical help, however, does not necessarily have to implicate going against ones faith. As an Imam (Islamic priest) explained:

"A person obviously has weaknesses. the Prophet P.B.U.H has also said that when you have physical or mental illnesses go to a hakim, go to a doctor. To take advantage of them and benefit is a part of Islam. He who doesn't does wrong. This is also a lack of faith - if despite this he doesn't depend on anyone and instead asks God. Because all these inherent qualities in everything are related, and God gives those qualities. Like in
antibiotics their inherent property is to kill bacteria - who gave that... God, of course. Some people, however, still don't recover with antibiotics, when this system doesn't work a person should ask from God. He is trying, he is taking antibiotics, but still they are not working - then it is Gods work to give relief. The two things should coincide - medicines and faith in God."

This thereby encapsulated both, the very unity of man with universe, and the ideology of holism central to Unani Tibb.

8.8 FROM CONCEPT TO PHENOMENA

Having constructed an explanatory model of distress / depression in Pakistanis (involving identification, symptomatology, consequences, causality and cure), the discussion can now return to the issue of concept and phenomena. From table 8.2 it was evident that, of those informants who associated the condition depicted in the vignette with themselves, a large proportion also identified it as 'depression' (nine out of ten BPs and six out of ten of the Ps). This raised the question of, whether the concept of 'depression' held by those respondents who had experienced the phenomena of depression themselves, was commensurate with that of a Western medical conceptualisation of it? An explication of this issue of concept and phenomena may shed some light on the current picture of depression (or neuroses in general) in BPs, and why they are under represented in affective disorders in Britain (Cochrane, 1977).

From the analyses, it was evident that there was a striking similarity in Ps and BPs explanatory models, including in symptomatology, causality, cure etc. This indicated the extent of maintenance of the culture of origin in first generation BPs and suggests that they draw largely on Pakistani cultural concepts of illness, as based on Unani Tibb, to explain and make meaningful concepts of distress. The most obvious points at which these concepts depart from Western conceptualisation of depression is in their emphasis on pluralism, which is in part a by product of the premise of holism and exchange between the internal and the external. Consequently, distress / depression is not seen by
Pakistanis to be internal to the same extent. Distress / depression is considered a relational issue that is not the sole property of the individual. Depression is, thus, not viewed essentially as an illness of the self. The percentage of informants that, in fact, conceptualised distress / depression as an illness or not, or the root cause of other illnesses is given in table 8.7.

Table 8.7 Conceptualisation of the condition as illness / or not by P and BPs

<table>
<thead>
<tr>
<th>ILLNESS / NOT</th>
<th>%Ps</th>
<th>%BPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes it is illness</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>Yes in some cases but depends on:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>51%</td>
<td>58%</td>
</tr>
<tr>
<td>Nature / personality</td>
<td>11%</td>
<td>28%</td>
</tr>
<tr>
<td>Circumstances</td>
<td>30%</td>
<td>23%</td>
</tr>
<tr>
<td>The stage it is at</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Root cause of other illnesses</td>
<td>20%</td>
<td>17%</td>
</tr>
<tr>
<td>Not an illness</td>
<td>11%</td>
<td>12%</td>
</tr>
</tbody>
</table>

From table 8.7 it can be seen that whilst 18% of Ps and 13% of BPs viewed the condition as an illness, the largest percentage viewed it as an illness only in certain people (51% of Ps and 58% of BPs): those that take it on their heart and had a sensitive nature (11% of Ps and 28% of BPs), those who were at the mercy of their circumstances (30% of Ps and 23% of BPs) respectively, and those in whom it had reached a serious stage or gone on for a long period of time (10% of Ps and 7% of BPs). Interestingly, the Ps and BPs differed considerably in their attribution of illness to personality factors. A larger number of BPs (28%) thought distress / depression would manifest in illness in those that took things seriously, or in the informants words "on their heart", compared to Ps (11%). A further large percentage of Ps (20%) and BPs (17%) thought that distress / depression was not an illness in itself, but rather the root cause of many other illnesses. Only a relatively small percentage (11% and 12%) completely dismissed it as not an illness.
It would, thus, appear that whilst Pakistanis do acknowledge distress / depression to have varying degrees and the potential of becoming an illness, this, to a large extent depends primarily on the external effect of circumstances, as well as on one's nature and personality. As one male informant said:

"Depression is not a disease as such, it is a cumulative response to the stresses on a person - all of these together result in a form of depression. Because of depression other illnesses can happen, but it is not an illness in itself."

As stated by the above informant, where it does become conceptualised as an illness, it is indeed perceived by many of the informants as an illness, depending on the extent to which it affects the rest of the body. This notion is described by a female British Pakistani:

"It is only an illness in those people that take it on their heart, like I have these worries...obviously on my body and mind. If I say my body aches, it won't without reason will it. It is because of mental tension that all these things started happening to me, and they start having a greater effect on the body. The mind works with the whole body, whatever is in your mind or heart is related to the whole body. If the mind doesn't work the whole body will be got. If the heart doesn't work again the whole body will be got."

Under the holistic pervasive principals of Unani Tibb, the concept of distress / depression is perceived as illness when it effects the body and general health, thus mind and body are highly inter-connected. It is in this sense that it is not an illness of the Western 'self'. Furthermore one is not subject to 'it', but rather the object of 'it'.

This is not to say, then, that Pakistanis do not recognise 'depression', rather it has different connotations for them based on underlying cultural themes. A Pakistani 'depression' therefore, typically, places an 'emotional body', which is primarily relationally defined, in a wider external context, which normally relates to kinship ties. It however, also places the person in a wider context of Islam, which render distress with meaning and
simultaneously places man in a moral order. A natural order where events happen for ethical purposes and are part and parcel of life. It is thus that, illness, in Young’s (1976) terms, serves an ontological purpose. In other words, illness in communicating and confirming important ideas about the real world reconstitutes and reconfirms cultural beliefs. In the case of BPs, how this then inter-plays and is reconciled with the concepts of Western medicine is described by a male British Pakistani respondent:

"If a man wants to make it an illness it can become. This word depression has become a fashion these days. It is a natural reaction, but since it has become defined then people are more in this state. When a person does not know about a thing, a person maybe does not focus on it. When it is defined a person says yes it has happened to me also, and fixes themselves in that category."

This respondent's view directly raised the issue of concept and phenomena. He clearly thought that once people have a concept or a definition of a condition they are more likely to suffer from it. Although this is arguably so, it has also been seen from the respondents in this study that the translation of the term and concept of 'depression' is filtered by cultural beliefs and is not simply an equivalent translation. It has been shaped and interpreted by wider Pakistani values, as is evident in the respondents' notions of presentation, causality and cure. Moreover in their linguistic use of it.

8.9 CONCLUSION

The content analytic results of this emic investigation strikingly showed the extent to which BPs explanatory models of distress matched those of indigenous Ps, despite many years of residence in a British cultural context. Where the impact of the British cultural context was evident in the BP explanatory models, however, was in their recognition of the condition in the vignette as 'depression'. Overall though cultural beliefs can be seen to play an important role in the shaping of BPs concepts of distress / depression and their illness behaviour. The cultural beliefs and concepts which appeared as recurring themes in the respondents' descriptions pertained to the perception of an 'emotional body',

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'personhood', the importance of kinship and the intrinsic role of religion in day to day life and medical beliefs.

How these themes then pervaded the conceptualisation of the disorder category 'depression' (or 'distress' / 'tension', as it was referred to by many respondents) was evident in linguistic referents by respondents and their 'objectification of depression, as opposed to 'subjectification'. To Pakistanis depression was largely an external entity located in concrete situations or relationships rather than in abstraction and the individual 'self'. Consequently depression / distress affected not just the mind but the permeable body, as well as, connected 'others'. Therefore, whilst some BPs and Ps were familiar with the term 'depression' the meaning of it changed as the social conditions and context in which it was used altered (Good, 1977). In other words, Pakistanis interpreted the term 'depression' in terms of salient Pakistani cultural themes. Although a concept could be said to exist, often it did not result in the official phenomena, as in Feroza's case, as it was not recognised by medical practitioners.

Whilst these notions may seem somewhat contrary to the majority of Western clinical theories of depression, which primarily regard depression as an internal psychological disorder residing in the mind of the individual, they do coincide with the more social theories of depression that focus on life events (Brown & Harris, 1986). This importance of the social aspect of distress / depression appears to be more of a universal one. There is some evidence to suggest that British popular understanding of depression also focus on external causes and inter-personal difficulties as the major cause of depression (Furnham & Kuyken, 1991). These findings are in line with Gilbert's (1984) argument that depression in popular culture is largely associated with person - person and person - environment interactions. Before, any definitive conclusions about similarities and differences in cross cultural explanatory models of Ps, BPs and Bs can be made a detailed interpretive investigation of British popular beliefs about distress would also be required. This requires bridging the fields of social and cross cultural representation of illness. A lead in doing this may be taken from Jodlet's (1993) suggestion that all 'lay' psychologies, irrespective of if they are Western or non-Western should be viewed as indigenous.
It is, however, suggested that the value of this investigation into Pakistani explanatory models and the vital questions this raises is not so much about similarities and differences but rather, more subtly, about the way people talk about their distress, and their subsequent behaviour. The implications of this on treatment and therapy are discussed further in Chapter 9.
PART IV
9.1 OVERALL RESULTS OF STUDY AND IMPLICATIONS

This thesis has argued for an integrated approach to the cross cultural research of mental illness. It was argued that an integrated approach is especially vital in the case of ethnic minorities who reside in the midst of a dominant culture and a health care system, that is often at variance with their beliefs. Such an approach must, on the one hand reflect the meaning of mental illness for minorities and on the other hand be meaningful to the wider medical system. It was proposed that an integrated approach would produce useful results that may help progression beyond the issue of methodology.

The drawbacks of an exclusively etic or emic approach to this kind of research were discussed with reference to cross cultural findings on depression. The influence of methodological approach on conclusions drawn were seen to be pivotal. Whilst some research concluded depression to be a universal phenomena with differential rates and presentation across cultures (Sartorious, 1986) other research argued that depression was a Western cultural response to distress (Schieffelin, 1985). In the case of ethnic minorities (especially South Asians) research based on hospital admission rates has generally indicated low levels of neuroses, including depression (Cochrane, 1977)\(^\text{61}\). Whether these statistics are accurate or artefact has been the subject of much debate. Central to this, is the validity of the concept of depression itself in Asian cultures. An understanding of this may shed light on whether Asians genuinely have low levels of depression or whether their 'depression' is not recognised by health practitioners and a Western medical system.

The first and foremost problem encountered in this research of 'depression' in Pakistanis was the absence of a linguistic or conceptually equivalent Urdu term for 'depression'. It

\[^{61}\text{Whilst these statistics have indicated low levels of neuroses they have also paradoxically indicated high levels of psychoses.}\]
was vital throughout the research, therefore, not to assume any knowledge or concept of depression; or in the words of Kleinman (1977), not to commit a 'category fallacy'. The approach consequently adopted ‘distress’ as a safe universal precursor to depression. Using a combined quantitative and qualitative approach the construct of depression and its equivalence across P, BP and B cultures was addressed through screening instruments (ie symptoms) and explanatory models (ie. meaning).

In Part II of the thesis the quantitative findings were covered and in Part III the qualitative. In the data collection phase, however, both were conducted simultaneously, and one could not help but inform the other. The results of the studies are briefly discussed below.

The GHQ, a Western standardised screening instrument, enabled an investigation of distress / depression as defined from a Western perspective. In brief, the GHQ study indicated that the P and BP samples responded differently to the B sample. Their response patterns indicated an undifferentiated factor structure consisting mainly of somatic and anxiety symptoms. The social dysfunction and depression symptoms, on the other hand, were found to be particularly inappropriate to P and BP samples. They appeared to be heavily biased by socio-cultural desirability and defensiveness factors, as was evident from the respondents reactions to these items. These socio-culturally biased responses were particularly evident in items involving the concept of 'work' in the social dysfunction sub-scale, and 'suicide' in the depression sub-scale. Comparatively, the B sample responses were more differentiated and in line with Goldberg's predicated structure. Furthermore the B samples responses (on the basis of respondents reactions and statistical analysis) did not appear to be as heavily influenced by socio-cultural factors. Whilst the comparability of the construct could not be established across the three samples, the results suggested that the P and BP samples exhibit a differential symptom profile to the B sample. In line with predictions, they appeared to somatosise their distress.

The AKUADS, a screening instrument developed in Pakistan, provided a good
juxtaposition to the GHQ. Although it too arose from a psychiatric research arena, it is based on the reported symptoms of Pakistani patients, and so enabled an investigation of distress / depression from a Pakistani perspective. It thereby addressed the issue of centicultural bias inherent in the GHQ, and raised interesting and often overlooked cultural assumptions and translation problems from a non-Western to Western direction. The difficulty of translating Urdu terms, which refer simultaneously to the somatic and psychological into English (where one or other component of psyche or soma was lost) was particularly interesting. This metonymy of psyche and soma in Urdu and the findings in the Pakistani cultural samples in this study led to a questioning of the 'somatisation' notion. Counter to predictions P and BPs, like their B counterparts, were found to score higher on the psychological sub-scale than the somatic sub-scale. It was suggested that these findings, (which were counter to previous somatisation findings) were facilitated by the isomorphic nature of the psychological items in the AKUADS. These items in comparison to the GHQ psychological items did not evoke as many social desirability and defensive issues in the Pakistani samples. Moreover this instrument also appeared to be appropriate to the B sample, and was found to be factorially equivalent in all three samples. The construct measured, therefore, could be considered comparable. Once again, however, it was unclear whether the AKUADS could measure the distinctive aspect of depression given its amorphous structure and its non differentiation of a depression sub-scale.  

Interestingly, both the GHQ and AKUADS found the same pattern of distress with Ps scoring the highest followed by B and finally BPs. In the B and BPs, however, the difference was not so marked. Despite this, caution was urged against interpreting these findings as absolute indicators of levels of distress given the normative uncertainty and highly differential study contexts. The comparability of results pertaining to cross cultural levels of distress was, thus, concluded to be limited.

The presentation and construct measured by the GHQ and AKUADS can be better understood by considering health beliefs and etiology. The MDEMQ provided an

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62 The AKUADS in its current format does not differentiate a depression sub-scale.
opportunity to combine anthropological method with epidemiology to investigate comparative explanatory models. This signified a switch in the frame of reference from symptoms to meaning, or disease to illness (Kleinman, 1977). On the basis of these results, the P and BPs were found to endorse all four causative etiologies of distress, ranging from the naturalistic to personalistic and Western to non-Western. In fact, the multidimensional scaling analysis showed that the P and BP samples drew less sharp distinctions between these categories than the B sample. This was related on the one hand to P and BPs assimilative attitude and on the other hand to the heuristic nature of distinctions such as Western / non-Western. Thus the holistic nature of P and BPs explanatory models appeared to be consistent with their unified psychological and somatic presentation of general distress. Likewise, the more compartmentalised B explanatory models appeared congruent with their primarily psychological presentation and differentiated distress structure.

In sum, due to the paucity of theory in this field, few definitive conclusions about construct or levels of distress could be drawn on the basis of the quantitative results alone. Although certain cultural themes were indeed beginning to emerge from the analysis. The inter-connection of these themes and their impact on construct was further investigated by the qualitative content analysis. The Pakistani explanatory model schedule, developed on the basis of pilot research, gave the P and BP respondents opportunity to talk about their experience of distress / depression without imposing a limiting structure on their responses. This part of the study did not assume knowledge of 'depression'. To bypass this, a vignette was used to elicit explanatory models of distress / depression. Content analysis showed that almost half the BP sample recognised the vignette as depression, and the remainder recognised it either as tension or distress. This familiarity with the term in BPs, however, did not necessarily imply a concept that corresponded to clinical definitions of depression. Indeed the descriptions of symptoms, consequences, causes and cures indicated that P and BPs placed different emphases in explanatory models to many clinical theories.

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\[63\] In comparison, only 15% of the P sample named the vignette as depression.
By considering the descriptions offered by P and BPs in conjunction with the findings of the quantitative studies, an attempt can be made to build a Pakistani cultural model of depression / distress.

In terms of symptoms, both P and BPs cited affective symptoms most frequently. This is somewhat counter to the notions that Asians somatise their mental distress. The description of P and BP affective symptoms, however, differed from Western psychiatric affective symptoms in terms of 'concreteness'. The P and BP respondents' affective descriptions were closely tied to and rooted in relationships as opposed to the individual. This external emphasis in affect was consistent with a concept of 'self' best described by Mauss' (1985) term of 'personhood'. Many respondents descriptions of depression / distress emphasised the social aspect of self and indicated how they largely defined themselves in terms of their role within the group. In this sense, affect or emotion played a mediatory role between events, relationships and the individual. Correspondingly, distress or depression itself was often linguistically referred to as an external entity. One was thus the 'object' of, rather than 'subject' to depression.

Apart from affective symptomatology, P and BP respondents also cited the somatic in terms of both symptomatology and consequences of depression / distress. The close interplay between the affective and somatic, and indeed the environmental, was understood through the Pakistani conceptualisation of an 'emotional body' (Ots, 1990), as prescribed by the indigenous medical traditions of Ayuverda and Unani Tibb. In these medical paradigms, and consistent with the P and BP sample responses, the human body is not as clearly differentiated in terms of mind / body as in modern Western medicine. This unbounded concept of body has been described as preamble and ecological by Zimmermann (1987). Whilst this was evident in the respondents descriptions of the interchange between the external and internal, it was also evident in the internal inter-change between psyche and soma.

Many respondents described emotions and somatic symptoms as being closely connected. These assertions frequently drew on the polysemous symbol of the heart. The heart in
Unani Tibb is conceived as the seat of the mind and the reservoir of emotion (Zimmermann, 1987). It is also the site of the 'self' or 'I', and so frequently respondents would attach feelings to the heart in place of 'I'. For example, as in the phrase the 'heart feels lonely'.

This concept of 'emotional body' and its inter-change (or permeability) with environment was also cited when describing the cause of distress. By far the largest percentage of causes cited for depression / distress were environmental / external. Moreover these descriptions frequently located both cause and cure in kinship ties. Where, however, internal or personality causes were mentioned, they were considered as secondary to environment and circumstance. Cure was, thus, also often located in relationships by the Pakistani respondents. This, although, did not entirely preclude a sense of 'individual self'. Respondents did also acknowledge that one could help oneself (for example by changing one's environment). Notably few respondents thought medical practitioners could assist with cures, and some literally talked of doctors not recognising or understanding their distress. Indeed many perceived the domain of the Western doctor as purely physical or somatic, and not emotional. Another theme frequently cited in cure, as well as throughout the descriptions, was faith and religious belief. It was argued that this however, did not imply fatalistic resignation in the respondents. Rather, religious beliefs and discourse gave meaning and social acceptance to the respondents' distress. In religious terms, respondents also claimed that 'depression' was not an illness but a part of everyday life. Although when respondents did recognise depression as an illness it was often connected to physical or somatic illnesses, such as blood pressure.

These inter-connections and their influence on descriptions of symptomatology and etiology can now help shed light on the quantitative results discussed earlier. The themes that were emerging in the presentation of symptoms and perception of cause on the GHQ, AKUADS and MDEMQ can be placed and understood within a wider cultural system in which they are inter-connected. To elaborate, the influence of social desirability on the GHQ and the inappropriateness of items which asked whether the respondent 'was able to enjoy his/her day to day work' can be understood in terms of the social definition of self
and personhood. In this social framework, work was regarded as ever present and a duty rather than a matter of individual choice and control. Similarly, the defensive response to suicide items can be understood in terms of the importance of religion in the discourse of distress. To express distress in terms of the religious taboo of suicide was thus not appropriate to P and BP respondents. Similarly, the AKUADS findings, refuting the somatisation hypothesis, and the psyche / soma metonymy inherent in Urdu terms such as 'gabrahat', can be understood in terms of the Unani concept of an 'emotional body'. Finally, the plurality and generality of the P and BP explanatory models highlighted by the MDEMQ can be understood in terms of the interplay between the emotional / physical and social in Pakistani experience of distress / depression.

Together the qualitative and quantitative results therefore suggest a broad model of distress / depression in Pakistanis which places emphasis on the social, somatic, affective and religious aspects of distress, as opposed to the individual or psychological. What implications do these findings then have?

9.2 THEORETICAL IMPLICATIONS

Having described an explanatory model of depression in Pakistanis the essential theoretical issue of the validity of construct can be returned to. Throughout this thesis, distress and depression have been referred to simultaneously to avoid assumptions of a concept of depression in Pakistanis that is synonymous with Western clinical theories. From the results of the qualitative and quantitative studies the P and BP symptom profiles and explanatory models can be seen to differ from the B sample, and more generally from clinical theories of depression. These differences have quintessentially been in terms of the undifferentiated, or in other words, holistic nature of P and BPs responses and descriptions. It is suggested that it is here at the level of compartmentalisation, that Pakistani's experience of depression varies most significantly to Western popular and professional medical views. Although in making this comparison it is important to note that popular and professional explanatory models also vary within Western cultures, along the lines of the disease/illness distinction proposed by Kleinman (1978). In cross cultural
terms, however, Western professional and popular explanatory models do relatively overlap, in the extent to which they share a common thread of cultural values and language which are rooted in the same historical context.

In comparison to clinical theories then, where psychiatry locates depression largely in the mind of the individual (for example, Beck's cognitive theory 1979), Pakistanis locate it in the mind and body (or more accurately emotional body) and 'others'. It is in this sense that depression in Pakistanis resembles a more general concept of distress, than the narrower definition of depression in clinical theories. In many of these clinical theories, depression refers to a specific constellation of primarily psychological symptoms that are causally connected to internal abstract individualistic notions of self esteem / self control / helplessness (Seligamn, 1975; Beck, 1979) These are notions which can be said to be distinctly Western. It is at the more general level of sociological theories, such as on life events that Pakistani concepts of depression may overlap with clinical theories.

In comparison to popular beliefs, there is likely to be a less marked difference in Pakistani and British explanatory models. Whilst in the quantitative studies there was some evidence of greater compartmentalisation in B respondents, there is also some evidence from Furnham and Kuyken's (1991) study to suggest similarities in the emphasis on the social aspect of depression. Indeed Gilbert (1984) (as already discussed) has argued in the context of Western culture, that at the popular level, person - environment and person -person interactions are thought to be the prime cause of depression. Studies also tend to show that working classes (Pill & Stott, 1986) and women place a greater emphasis on the external aspect of illness and tend to present distress somatically (Parsons & Wakley, 1991). This, to an extent, was also reflected by this study and indicates that the differences observed in P / BP and B samples are not simply absolute cultural differences. Rather the issue of similarities and differences is a more subtle one. For example it is not that Pakistanis do not have a notion of 'selfhood' or do not psychologise distress, rather the difference is in the emphasis they place in explanatory models (Marsella & White, 1982) and the way in which they verbalise their distress.
The extent of similarity in the emphasis and description of the P and BP samples explanatory models, however, was surprising. This suggested the continuance of many indigenous cultural beliefs in first generation BPs despite many years of residence in Britain. From the qualitative analysis it appeared that when BPs did use the term 'depression' of their own volition, its interpretation was heavily linked to Pakistani cultural themes. Small differences in P and BP responses were observed, which suggested some influencing of British culture. These were in terms of greater number of BPs identifying the condition in the vignette as depression and implicating proportionally more personality factors in causes than Ps.

It is thus suggested that the terminology of 'depression' needs to be carefully considered in cross cultural usage. The connotations it raises and the semantic network associated with it in clinical settings is different in emphasis to that of the P and BP samples in this study. By using such an 'exclusive' term or pathological concept, health practitioners may be limiting their openness to patients descriptions of their distress and this may in turn hinder recognition. Bal (1987) has similarly suggested that the ecological metaphors used by Asian patients (for example referring to diet and climate) may not be fully understood and valued in the highly mechanistic setting of a general practice surgery. Consequently at the theoretical and clinical levels it may be useful to refer to distress at a general undifferentiated level to avoid culturally based assumptions.

The assumptions and compartmentalisation inherent in clinical theories are also evident in the 'somatisation' notion of distress in Asians. Whilst this notion has helped widen the definition of depression and has facilitated a move away from a predominantly psychological focus, it has conversely been taken to imply that Asians are not able or do not have a sufficiently differentiated language (Leff, 1973) to express distress psychologically. From the AKUADS study and the qualitative study in this thesis this notion was clearly refuted. P and BPs did present psychological symptoms when they were culturally isomorphic. In line with the indigenous medical paradigms of Ayuverda and Unani Tibb, symptomatology is not either somatic or psychological, rather the two are inextricably linked. This was clearly evident in the respondents descriptions.
In sum, this thesis has suggested a broader concept of depression in Pakistanis, which is amenable to the influences of the social, environmental and somatic. It has suggested that the use of the terminology of depression is exclusive and reveals little about the actual experience of distress for Pakistanis. After all it is possible to talk about distress in many different ways, the use of a particular term or idiom does not cross culturally qualify the experience as being any more or less valid. In this sense suggestions of an evolutionary hierarchy of languages for expressing distress is irrelevant. Furthermore this thesis urges against the devisal of notions such as somatisation, which have often been taken to imply that Asians do not psychologise. It is perhaps because of this assumption that Asians are seldom referred for psychological treatment and are more likely to be obliged with a prescription on a visit to their general practitioner (Gill, 1996).

9.3 METHODOLOGICAL IMPLICATIONS

It was argued at the beginning of this thesis that what is concluded about depression in cross cultural research is effected by the epistemological orientation of the researcher and the methodology adopted to investigate it. In this sense the instrument used in the investigation sets the boundaries of how the research progresses. In this thesis both quantitative and qualitative approaches to research have been adopted in an attempt to address this very issue. Together the approaches, therefore, addressed the issue of validity as attested through meaning and reliability as attested through numbers. The issue of representativeness was thus diminished by the use of a relatively large sample of three hundred and sixty middle class / working class, male and female respondents; a large number of which (one hundred and twenty) were also interviewed in greater detail.

The necessity of a combined approach for meaningful analyses was evident from the bearing the findings in Part II and III had on one another. Whilst this thesis has been constructed in terms of the quantitative findings followed by the qualitative findings, the two were conducted simultaneously and helped inform the interpretation of the analyses. The quantitative results alone, without a detailed understanding of the context ie. Pakistani culture could have easily been misinterpreted. In other words the meaning of
the numbers was not so clear cut. Whilst this may be a reflection of the lack of theoretical models in the field of cross cultural psychiatry, it is also reflective of the difficulty of measuring an essentially emotional construct, such as depression as a 'thing' or entity. People feel, think and speak about emotions in many different ways, which do not always correspond with a psychiatric frame of reference, and are not always conducive to being measured by symptom checklists.

Moreover in this research the respondents talked about their emotions in a different language. This research like most other research thus involved making visible what was largely invisible, as well as, translating it across cultures and languages. It was therefore vital not to assume that absence of distressful experiences in the absence of depression terminology. Conducting the research in Urdu and using instruments that were constructed in Urdu (the AKUADS and Pakistani Explanatory Models Schedule), as well as a bilingual researcher had an important effect on this. The necessity of culturally isomorphic items in a screening instruments was attested to by the AKUADS and it's subsequent refutation of the somatisation hypothesis in Pakistanis. Had this research been based solely on a Western screening instrument, such as the GHQ or conducted in English there is little doubt that the results would have been different. The very process of the translation of the instruments was itself instructive in uncovering the cultural assumptions that items were based on. The use of interview method and its relatively little imposition of structure on the respondents responses was also more conducive to accessing contextually rich information. It enabled a demonstration of the interconnection of general themes of meaning that accompany distress. These subtleties and interconnections that are central to meaning are not so easily quantifiable.

It is thus suggested that in cross cultural research it is important to conduct a detailed enquiry into the context of the study or culture under investigation before embarking on a quantitative approach. It is only then that meaningful questions can be asked of the

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64 This is arguably often the case in general practice settings.

65 As the respondents were first generation it is important to note that Urdu was their first language and the language they felt comfortable conversing in.
data. This, however, is not to say that a quantitative approach is any less valid than a qualitative. Rather that a qualitative approach may be more fruitful for theory development and hypothesis generation, and a quantitative approach for theory testing and comparative research. Both are therefore essential in the research of ethnic minority mental health, which in the context of a multi-cultural society such as Britain inevitably becomes a comparative matter.

Qualitative research has, however, frequently been criticised for its subjective element. There is no doubt that the interview study in this thesis was also influenced by the ethnicity, age and sex of the interviewer, who was second generation female Pakistani. This however, does not necessarily only imply negative connotations. It certainly aided in accessing this difficult sample and quite often the interviews naturally took an explanatory stance, with the respondents relating to the interviewer as a younger member of the community. Conversely there was inevitably some interviewer effect. For example, it is acknowledged that culturally constructed gender roles may have inhibited some of the male respondents responses to a female interviewer. Overall though the interviewer effect was felt to exert less of a bias in responses' to the interview study than the questionnaire study, in which it was argued that BP respondents identification with the interviewer as community member may have biased their responses. In the quantitative study interviewer effect was felt to exert less of a bias for a number of reasons. Firstly, the respondents did not appear to be as offended by the questions which were open ended and culturally isomorphic by virtue of the construction process. This is in comparison for example to the suicide items in the GHQ. Secondly, talking about their distress in a context as opposed to simply responding to symptom check lists seemed to put the respondents more at ease. Finally, considering that the interviews lasted on average an hour rapport was built between the interviewer and respondent, which enabled the attainment of increasingly accurate and detailed information. All in all the interview procedure was more rewarding for both the respondent and interviewer.

It is conceded, however, that it may have been more effective to order the study so that some respondents received the interview before the questionnaires and vice versa to
control for interviewer effect. In practical terms though, during the collection of data this was not considered a suitable strategy, as it was thought that respondents would be more likely to discontinue the study after the initial, often hour long, interview.

The qualitative research study was also, however, limited in it's comparative power, as a similar detailed interview study was not conducted on the indigenous B sample. This was due to the primary concern of this thesis being to develop an understanding of the influence of culture on first generation BPs experience of psychological distress within a British medical context. The results were thus juxtaposed to clinical theories, with the intention that they may cast light on the hypothesis suggesting low levels of detection by practitioners. By setting the comparison at this level it should not be assumed (as already touched on) that the differences discussed in the Pakistanis explanatory models are relative to popular British views of depression. In this sense the study crossed not just cultures, but also the disease / illness divide proposed by Kleinman (1977) which occurs day to day in the consultation setting.

Further comparative problems in this study, which were impossible to control for, were the highly differential contexts of the study. Whilst Pakistan is a developing country Britain is, relatively speaking, developed. Within these contexts the comparability of the constructs of class and gender are also open to debate. It was clearly evident that the working classes of Pakistan were in no way comparable to the working classes of Britain. Similarly the roles and social positions of women in Pakistan are also differential to the roles and social positions of women in Britain thus predisposing them to different vulnerability factors. Indeed the statistical analysis revealed that whilst class and gender were predictors of levels of distress in Ps, they were less so in BPs and Bs.

When considering these findings it has to also be remembered that though this sample was relatively large it was inevitably not entirely representative. All samples in this study were drawn from urban cities and arguably the results from a rural non-Westernised area in Pakistan would have been notably different. Indeed the results may have also been different had this study been conducted in a tight knit Pakistani community in Britain, such
as Bradford or Slough. In the beginning of this thesis it was pointed out that the areas of Wembley and Harrow, although with a sizeable Punjabi and Muhajir Pakistani community, did not correspond to the tight knit communities of Pakistanis elsewhere in Britain. The results of this study may therefore, for example, not be entirely reflective of a Mir Puri community. Mir Puris form the largest Pakistani ethnic group in this country, and typically reside in tight knit communities that have formed following a chain migration pattern. They were, however, not chosen as the focus of this research due to linguistic difficulties and the pragmatic problems in matching the sample in Pakistan.66

Apart from these shortcomings, this study has importantly demonstrated how both frames of reference of symptomatology and meaning could be addressed together in a mutually informative way. It has highlighted the importance of using a qualitative approach for generating meaningful hypotheses before conducting quantitative research, as well as, the need to address the issue of validity of screening instrument when conducting comparative research. On the basis of the findings of this study it is suggested that the AKUADS may be a potentially appropriate instrument for detecting distress in British and Pakistani samples.

9.4 APPLICATIONS

When interpreting these results it is important to remember that cultures are far from static. Indeed, inevitably within the P and BP samples there were also individual differences. It may, therefore, help to clarify the meaning of 'culture' when considering the application of these findings. Krause (1995) description of 'culture' as consisting of both 'generative' and 'interactive aspects appears to be an informative one and particularly relevant in deciphering a way forward in the case of ethnic minorities. The 'generative' aspect refers to those aspects of culture that are passed on from generation to generation and interactive to those aspects that are open to individual reinterpretation in light of

66 Mir Puris speak the pahari dialect which was not spoken by the interviewer and it was felt that contextually rich information may be subsequently lost in a communication exchange in Urdu or through translation.
personal experiences. Such a formulation thus enables room for fluidity and change in health beliefs. In line with this Currer (1986) also argues that health and illness beliefs are dynamic processes, which are influenced by health experiences of the individual or group. On the basis of the BP explanatory models in this study it seems, however, that there has been relatively little re-interpretation of cultural themes in terms of health experiences within a British medical context. This clearly appeared to be the case on the basis of the respondents description on 'cure of the condition'. Many respondents described lack of understanding of their condition by their general practitioner. This in conjunction with the findings of this study that Asians do clearly suffer mental distress, appear to back the hypothesis of under detection by health practitioners. Although some respondents did also not consider their emotional distress to be the realm of the general practitioner. Whether lack of recognition or lack of reporting it is suggested that in some senses this is why concept in BPs (at least in those BPs that have a concept of 'depression') is not leading to phenomena, as often measured by admission rates or service use.

This is not to say that therapeutic intervention is not appropriate for Pakistanis. After all inter-personal healing has been traditionally practised in South Asian cultures for many generations within the kinship network and through the hierarchy of elders. For many BPs as was evident in many interviews, this supportive network has largely been lost with migration. Although extended families may have migrated together, in many ways their functioning has been altered by residing in another cultural system (Ballard, 1982). It is thus suggested that an approach to therapy or treatment is needed, which works at the 'interactive' level of culture. That is, at a level which would enable cultural minorities to re-interpret and reproduce cultural themes according to the circumstances of their lives in the context of Britain. In order for this to happen clinicians and health practitioners need to be increasingly aware of and sensitive to the influence of culture on their patients' experience of depression / distress. Awareness, however, would be dangerous if it meant rigid ideas of what particular cultural minorities believe and don't believe, rather it refers to curiosity and an open mindedness to exploring difference. The danger of stereotyping Asian health beliefs, is succinctly described by Bowes and Domokos (1993) in their conclusion to a study on general health beliefs of Pakistani women in Glasgow:
"If 'Asian culture' is regarded as a set of customs such as consulting a hakim, ideas of bhye bhaddi, a certain diet or family structure marked as exotic by other observers, then it seems to us a rather unimportant influence on peoples health. If, however, 'culture' is people's view of the world, a matter for investigation rather than stereotyping, then it is certainly important." p 625  Bowes and Domokos (1993)

Some therapeutic approaches, however, may be more isomorphic and appropriate for Pakistani patients than others. For example, the importance of family has been repeatedly implicated in this study, as well as, a number of other studies (Currer, 1986; Beliappa, 1991; Ineichen, 1993; Bowes & Domokos, 1993). It is suggested that a therapeutic approach, such as family therapy, which is integrative to value of family may be of greater benefit for P patients than a highly individualistic approach. Ineichen (1993) has also proposed that looking at ways in which personal conflicts resolved may be an important factor in future rates of mental illness in British Asians. At the very least an approach is required which is 'curious' about and respectful of cultural diversity, as opposed to reliant on stereotypes. Encouragingly, there is a growing literature on the development of such culturally sensitive frameworks (Kareem & Littlewood, 1992; Fernando, 1995; Falicov, 1995).

9.5 FUTURE DIRECTIONS

The first and foremost interesting extension to this research would be to conduct a similar detailed ethnographic study of representation of depression in the indigenous British sample. This would enable a comparative study at the level of illness and popular culture, as well as, an investigation of the claims that depression is largely a Western cultural construction (Judhav, 1997).

An investigation into the 'interactive' cultural aspects may also be informative. The extent of acquisition of a British cultural conception of depression could be investigated by looking at a second generation sample or a patient sample that has been diagnosed as depressed. Through research on a clinical sample the issue of concept and phenomena
could be addressed in greater detail. Indeed, considering that this study was conducted in a community sample and thus most probably addressed the more social aspect of depression, it would be interesting to investigate the cross cultural commonality or difference in experience of more biological or bipolar depressives.

In order to further understand the hypotheses of poor detection of depression by health practitioners in cultural minorities it would also be interesting to investigate medical practitioners beliefs about the role of culture in mental illness and its impact on their clients behaviour. Together this kind of research may facilitate the development of findings which can facilitate more culturally sensitive treatments.

9.6 CONCLUSION
This study through an integrated quantitative and qualitative approach to research enabled a reliable and valid approach to comparative research on the influence of culture on Pakistanis experience of distress / depression. At the symptomatic and explanatory model level subtle differences in indigenous Pakistani, British Pakistani and indigenous British presentation and perception of etiology were found. Whilst these were shown to be related to wider cultural themes and language, it was argued that differences were not absolute. It was stressed that it was important to remember when interpreting these results that cultures are in flux and are interactive as well as generative. On the basis of this study cross cultural similarities could be safely concluded in Pakistani and British samples in the general distress aspect of depression. After all, there is little doubt that people of all cultures suffer adversity and unhappiness at some point in their life, but their response and interpretation of it is largely shaped by the wider cultural system they are a part of. It is at this level of commonality that treatment can also be targeted.
REFERENCES


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Kleinman, A. (1977). Depression, somatisation and the 'new cross cultural psychiatry'. Social Science and Medicine, 11: 3-10.


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symptoms reported by anxious and depressed patients in Britain and Indo-Pakistan subcontinent. British Journal of Psychiatry, 159: 379-386.


APPENDIX 3.1
ENGLISH VERSION OF THE GHQ-28
(D. Goldberg)

We should like to know if you have had any medical complaints and how your health has been in
genral, **over the past few weeks**. Please answer ALL the questions on the following pages simply
by underlining the answer which you think most nearly applies to you. Remember that we want
to know about present and recent complaints, not those that you have had in the past.

It is important that you try and answer ALL the questions.
Thank you very much for your co-operation.

<table>
<thead>
<tr>
<th>Have you recently</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1 - been feeling perfectly well and in good health?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A2 - been feeling in need of a good tonic?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A3 - been feeling run down and out of sorts?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A4 - felt that you are ill?</td>
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<tr>
<td></td>
</tr>
<tr>
<td>A5 - been getting any pains in your head?</td>
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<tr>
<td></td>
</tr>
<tr>
<td>A6 - been getting a feeling of tightness in your head?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>A7 - been having hot or cold spells?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Have you recently**

| B1 - lost much sleep over worry? | not at | no more | rather more | much worse |
|                                 | all | than usual | than usual | than usual |

260
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Not at</th>
<th>No More</th>
<th>Rather More</th>
<th>Much Worse</th>
<th>All Than Usual</th>
<th>Than Usual</th>
<th>Than Usual</th>
<th>Than Usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>B2</td>
<td>had difficulty in staying asleep once you are off?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
<tr>
<td>B3</td>
<td>felt constituently under strain?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
<tr>
<td>B4</td>
<td>been getting edgy and bad tempered for no reason?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
<tr>
<td>B5</td>
<td>been getting scared or panicky for no good reason?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
<tr>
<td>B6</td>
<td>found everything getting on top of you?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
<tr>
<td>B7</td>
<td>been feeling nervous and strung up all of the time?</td>
<td>not at</td>
<td>no more</td>
<td>rather more</td>
<td>much worse</td>
<td>all than usual</td>
<td>than usual</td>
<td>than usual</td>
<td>than usual</td>
</tr>
</tbody>
</table>

Have you recently

|   | Question                                                                 | More So | Same As | Rather Less | Much Less | Than Usual Than Usual Than Usual Than Usual |
|---|--------------------------------------------------------------------------|---------|---------|-------------|------------|----------------|------------|------------|------------|
| C1 | been managing to keep yourself busy and occupied                        | more so | same as | rather less | much less  | than usual than usual than usual than usual |
| C2 | been taking longer over the things you do?                              | quicker | same as | longer      | much longer | than usual than usual than usual than usual |
| C3 | felt that on the whole you are doing things well?                       | better  | about   | less well   | much less  | than usual than usual less well less well |
| C4 | been satisfied with the way you have carried out your tasks?            | more    | about same | less satisfied | much less | satisfied as usual than usual than usual |
| C5 | felt that you are playing a useful part in things?                      | more so | same as | less useful | much less  | than usual than usual than usual useful |
| C6 | felt capable of making decisions about things?                          | more so | same as | less useful | much less  | than usual than usual than usual capable |
| C7 | been able to enjoy your normal day to day activities?                   | more so | same as | less so     | much less  | than usual than usual than usual than usual |

Have you recently

|   | Question                                                                 | Not at | No More | Rather More | Much More | All Than Usual Than Usual Than Usual Than Usual |
|---|--------------------------------------------------------------------------|--------|---------|-------------|-----------|----------------|------------|------------|------------|
| D1 | been thinking of yourself as a worthless person?                         | not at | no more | rather more | much more | all than usual than usual than usual than usual |

261
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>D2 - felt that life is entirely hopeless?</td>
<td>not at all</td>
<td>no more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>D3 - felt that life isn't worth living?</td>
<td>not at all</td>
<td>no more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>D4 - thought of the possibility that you might make away with yourself?</td>
<td>definitely not</td>
<td>I don't think so</td>
<td>has crossed my mind</td>
</tr>
<tr>
<td>D5 - found at times you could not do anything because your nerves were too bad?</td>
<td>not at all</td>
<td>no more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>D6 - found yourself wishing you were dead and away from it all?</td>
<td>not at all</td>
<td>no more than usual</td>
<td>rather more than usual</td>
</tr>
<tr>
<td>D7 - found that the idea of taking your own life kept coming into your head?</td>
<td>definitely not</td>
<td>I don't think so</td>
<td>has crossed my mind</td>
</tr>
</tbody>
</table>
APPENDIX 3.2

TRANSLATED URDU VERSION OF THE GHQ-28

<p>| | | | |</p>
<table>
<thead>
<tr>
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<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td>10</td>
<td>11</td>
</tr>
</tbody>
</table>

263
| ماک فوئر | نزدیک | ماک فوئر | مصرف | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر | ماک فوئر |
|----------|--------|----------|--------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| 84       | کتاب سفر با جغرافیای ریچارد             |            | 85       | کتاب المپیک فوئر در اولین سال طلایی             |            | 86       | کتاب نواب‌سلاطین زیرستی‌ای                                    |            | 87       | کتاب موسیقی مارکزی با لیلیکه ری‌یا                            |            |
| 1        | کتاب انگیزه‌های خاموش‌سالن‌های ایران             |            | 2        | کتاب در حالی که رستم‌پرست‌ها به آتش بسپارند             |            | 3        | کتاب حمایت‌های طفرینی که در برابر شیعه می‌پردازند             |            | 4        | کتاب در شهر مرزی که سبز‌هانه‌ی بود            |            |
| 5        | کتاب هم‌سایه‌ی و نمای‌سازی‌های ایران             |            | 6        | کتاب رویه‌های مدعی‌گری در عصر چهارم‌سنگ             |            | 7        | کتاب در مکان میدان بی‌شمار                       |            | 8        | کتاب در حال بی‌پیش‌بینی که نام باد را ناگهانی اندازه‌ی شیرزده‌های   |            |
| 9        | کتاب در حالی که در بی‌پیش‌بینی که نام باد را ناگهانی اندازه‌ی شیرزده‌ها    |            | 10       | کتاب در حالی که در بی‌پیش‌بینی که نام باد را ناگهانی اندازه‌ی شیرزده‌ها |            | 11       | کتاب در حالی که در بی‌پیش‌بینی که نام باد را ناگهانی اندازه‌ی شیرزده‌ها |            |
| وقت      | مفتاح | دستورالعمل | علت |
|----------|-------|------------|-----|---|
|        1 |       |            |     |   |
|        2 |       |            |     |   |
|        3 |       |            |     |   |
|        4 |       |            |     |   |
|        5 |       |            |     |   |
|        6 |       |            |     |   |
|        7 |       |            |     |   |

265
This questionnaire has been designed in order to ascertain details of different illnesses. The information obtained from his questionnaire will enable us to improve medical facilities.

In the past two weeks

<table>
<thead>
<tr>
<th>Question</th>
<th>NEVER</th>
<th>SOME TIMES</th>
<th>OFTEN</th>
<th>ALL THE TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. have you lost sleep?</td>
<td></td>
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<tr>
<td>2. has your interest in your every day activities declined?</td>
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<tr>
<td>3. has your interest in your hobbies declined?</td>
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<tr>
<td>4. have you felt anxious?</td>
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<tr>
<td>5. have you felt afraid that something bad is about to happen?</td>
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<tr>
<td>6. have you had difficulty in thinking?</td>
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<tr>
<td>7. have you wanted to be by yourself?</td>
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<tr>
<td>8. have you felt lonely?</td>
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<tr>
<td>9. have you felt hopeless?</td>
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<td>10. have you felt helpless?</td>
<td></td>
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<tr>
<td>11. have you been worried?</td>
<td></td>
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<tr>
<td>12. have you cried?</td>
<td></td>
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</tr>
<tr>
<td>13. have you thought about suicide?</td>
<td></td>
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</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Possibly</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td>14. has your appetite decreased?</td>
<td></td>
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<tr>
<td>15. have you had heartburn?</td>
<td></td>
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<tr>
<td>16. have you had indigestion?</td>
<td></td>
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<tr>
<td>17. have you had nausea?</td>
<td></td>
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<tr>
<td>18. have you had constipation?</td>
<td></td>
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<tr>
<td>19. have you had difficulty in breathing?</td>
<td></td>
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<tr>
<td>20. have your hands feet or body kept shaking?</td>
<td></td>
<td></td>
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<tr>
<td>21. have your hands or feet gone numb?</td>
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<tr>
<td>22. have you had tension in your neck or shoulders?</td>
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<tr>
<td>23. have you had headaches?</td>
<td></td>
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<tr>
<td>24. has your body ached?</td>
<td></td>
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</tr>
<tr>
<td>25. Have you had to urinate again and again?</td>
<td></td>
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</tbody>
</table>
APPENDIX 3.4

URDU VERSION OF THE AKUADS

<table>
<thead>
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<tr>
<td></td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

1. کیا آپ کا نینگ میں واقع ہوگی؟
2. کیا آپ کا مزون میں کام کا کام کیا دیگر کا کام کیا ہے؟
3. کیا آپ کا چنہ مین کا کام کیا ہے؟
4. کیا آپ کا کھانوں کے کمی بھر ہے؟
5. کیا آپ کا ہر وقت میں ہی کیا ہے؟
6. کیا آپ کا شوہر میں بارہات کیا ہے؟
7. کیا آپ کا ہوائی ناو کا بیج ہے؟
8. کیا آپ کا ہوائی ناکا برتی ہے؟
9. کیا آپ کا ہوائی ناکا برتی ہے؟
<table>
<thead>
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<th>Question</th>
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<td>Kelapip kahin kahin apna bina hai?</td>
<td>1</td>
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<td>12</td>
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<tr>
<td>24</td>
<td>Kelapip kahin apna bina hai?</td>
<td>13</td>
</tr>
<tr>
<td>25</td>
<td>Kelapip kahin apna bina hai?</td>
<td>14</td>
</tr>
</tbody>
</table>

**Total Responses:**

**TOTAL SCORE:**

**PSYCHIATRIST'S OPINION:**

**INITIALS:**

**DAYS:**

269
Many people suffer mental distress at some time in their lives. People can experience and manifest distress in many ways. Such distress can be mild or severe. Sometimes they feel sad or anxious. Sometimes they are unable to cope. Or sometimes they are out of touch with what is going on around them. They may have experiences of strange beliefs. Sometimes their behaviour becomes disorganised. They may become destructive towards themselves or others.

People explain mental distress in a variety of ways. Some are listed below. We would like to learn what you think can cause people to suffer mental distress.

How likely is it that each of the following causes could contribute. There is no right or wrong answer. Please circle the appropriate point for each item (from "not at all likely" (5) to "highly likely"). You should respond to every item even if you are not sure. Please feel free to write any comments on the dotted line alongside any item.

<table>
<thead>
<tr>
<th>Mental distress can be caused by the following:</th>
<th>not at likely</th>
<th>unlikely</th>
<th>likely</th>
<th>very likely</th>
<th>highly likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bad experiences during childhood</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Being intentionally physically harmed by another person</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Exposure to a fright or shock</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The pace of &quot;modern life&quot;</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Being hot (but not from fever or weather)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. &quot;Wind&quot; or gas or currents flowing through the persons body</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Contact with something or someone taboo</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Bad &quot;nerves&quot; in the body</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. The effects of old age</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Genetic or inherited defect

12. Being born this way (e.g. inheriting 'bad / weak / low / cold / blood')

13. Eating food which is "wrong" for that person (but not socially forbidden food)

14. The person's body being out of balance

15. Physical illness

16. Chemical imbalance in the brain

17. One or more of the person's vital organs being disrupted (e.g. liver or blood or vital fluids, or bone displacement)

18. Having had an accident

19. The person had a bad or ominous dream or sensation

20. Bad luck or chance (but not including astrologically determined fate)

21. Doing the wrong thing during pregnancy

22. Death of a relation or close friend

23. Failure to properly observe rituals after giving birth

24. Brain damage or head injury

25. Birth control against the religion or culture

26. Doing the wrong thing when menstruating

27. Astrological destiny

28. The person's karma (what happened to him/her in previous lives or incarnations)

29. A dangerous, unprovoked spirit
30. A spirit who was angry because someone did something wrong (e.g. someone failed to honour it properly) . .  1 2 3 4 5
31. The person’s soul temporarily leaving the body or becoming scattered ........................................ 1 2 3 4 5
32. Migration to a new country .................................................. 1 2 3 4 5
33. Not having enough money .................................................. 1 2 3 4 5
34. Contact with something or someone “dangerous” or “unclean” or “contaminated” or “contagious” or “polluted” ................................. 1 2 3 4 5
35. Doing something forbidden by social or cultural rules . .  1 2 3 4 5
36. Too much work or study ................................................... 1 2 3 4 5
37. Someone unwittingly casting a spell e.g. the evil eye . .  1 2 3 4 5
38. Someone wanting to hurt the person and casting a spell e.g. the evil eye ........................................... 1 2 3 4 5
39. Conflict or breakup of family / relationship ............ 1 2 3 4 5
40. Someone wanting to hurt the person and engaging a witch / shaman to cast a spell ......................... 1 2 3 4 5
41. Unemployment ......................................................... 1 2 3 4 5
42. The person seeing, hearing or feeling something ominous ......................................................... 1 2 3 4 5

Thank you for completing this questionnaire. Is there any other causes you want to tell us about?
APPENDIX 3.6

TRANSLATED URDU VERSION OF THE MDEMQ

آئزولوجی نظری کے میں معیار (مواقع بہتہ) پر دوسری دیاہا کوشنار سمجھیں ہوئی ہیں۔ دوسری دیاہا مختلف طرح سے مزیدکرمرکی پچ۔ اور مختلف طرح سے رہو کا اطمینان کرتی پچ۔ دسہارے پچ۔ دسہارے پچ۔ اور موسตาں میں اور سنہری میں۔

دیاہا دیئے گئیں جو بیچے اور پریس نے میرے کرمنار کرے پچ۔ بیاکی رفہرہ

(افروز)۔ دیئے گئے پچ کے بیچی اور پریس سے ہی ہوіاں میں سے مقابلہ بنی۔ اور

بعد کرمنار دیئے اور پریس اوہنے سے ہی فتحیہ موسیلا پچ۔ ان کو عیسی طرح

کے ضرورت آنے چلتے ہیں۔ بے پاکی سیاہی میں ہی اترا کا لوحت بھی اور رہنے

ہی تریشپ اور سب سے سا مٹچہ بٹا ہے۔ ان کا لوحت بھی اور رہنے

(سیدریا)۔ دیئے گئے کے کرمنار پچ۔ انہیں لی اور دمروں کے لیے

فتناؤ اور تلخی کا باہمے بھی بیاکی ہے۔

مرجوعہ دیئے گئے کو مختلف طرح سے میان ہرا (نباانہ ہے)

(کیو) لوحت کے اور سب سے سا مٹچہ بٹا ہے۔ ان کا لوحت بھی اور رہنے

ہی تریشپ اور سب سے سا مٹچہ بٹا ہے۔ ان کا لوحت بھی اور رہنے

(سیدریا)۔ دیئے گئے کے کرمنار پچ۔ انہیں لی اور دمروں کے لیے

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دو کسی نے سوال کیا: ہماری نوبل جوہری کا برادر ہے یا کبھی خبردار ہے؟

1. بیچنی کی نوبل جوہری نے خبردار کو تحقیق کے لئے کیا?
2. خبردار کی تحقیق نے خبردار کو تحقیق کے لئے کیا?
3. خبردار کی تحقیق نے خبردار کو تحقیق کے لئے کیا?
4. جھیلی نوبل کی تحقیق (کہا جا لگا؟)
5. جھیلی نوبل کا بچہ ہے؟
6. جھیلی نوبل کے پابندی ورثے?
7. جھیلی نوبل کے پابندی ورثے?
8. کئی علمی اخلاقی ورثے?
9. کئی علمی اخلاقی ورثے?
10. نسیی تیار کے سکھتے?
11. اضطراب کی اضطراب?
12. گوپی نوبل کی بہتر?
13. گوپی نوبل کی بہتر?
14. گوپی نوبل کی بہتر?
15. گوپی نوبل کی بہتر?
16. دیا جا کہ گوپی نوبل کی بہتر?
17. ہزاروں سے زیادہ بیچنی نوبل کی تحقیق (کہا جا لگا؟)
18. کوئی نوبل کا برادر ہے؟
19. کوئی نوبل کا برادر ہے؟
(25) موقيط بأور (ذائف واقع
(21) هل الساحت وود سإن بن ضرير ما حكرت فرا
(26) فين دار فالكريم دوست مسوم وما تلمح معا
(22) kiếmه ود رسم دو يش ترى دو سودة نسيم
(27) سر يا هانج كييفتب على
(25) مداسب بمثابرة كر ضروف صينية ولم بقنا (رُيقُي بُربانه، ربوان)
(26) مواري دو ود ناريل فام نبا
(27) تهافر صفر مون (سواراوي هايجنت نعمل)
(29) كي خوناب متروب شنگن كري دو لحص
(30) كي رهف كي آسيا دس بغينه (ampilkan ماج ترل دا نتكم دن لجب)
(31) كي خنس كي روه وهر سوري كي دا MVP دو) سرم جنبد دو دا روج منزه شو
(32) كي مسدس كي بيرت فو
(33) كي خوناب كي (مان طالب شرب مون)
(35) كي خوتاوب نابل لندن تدشنت ببري كي خصم سو داشرت بجي با
(36) كي هايجنت فا حائرت نا ليشي (مصول كي خليف مه)
(37) شاه زيدو كا كا كا برغوال نا
(38) كي خمس كي غدر إرادن دو هور نزر شت كي
(39) كي خمس كي أعضاان (تغليف) فينا لاش شور - روير مونرز "لا إيجا دو لا رماز "
(40) خانمان با تلمان مت كي ميت فأب كي "ما بومبأ "
(41) كي خمس كي (سوران) كولضانان (تغليف) فينا لاش شور - روير مونرز "لا إيجا دو لا رماز "
(42) كي خمس كي (خنوس) فينا لاش شور - روير مونرز "لا إيجا دو لا رماز "

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Many people in the world at some time or another become mentally distressed. People feel this mental distress in different ways and face it in different ways. So that we can understand this problem we would like you to help us and tell us your views about mental distress in as much detail as possible.

A woman/man for some time has been under mental pressure / mental distress. She/he appears very sad and worried and is quieter than usual. She/he has many aches and pains in her/his body and she/he does not feel like doing anything. At night she/he can’t sleep and she/he cries again and again. It is also possible that she/he is not able to do her/his work or look after her/his loved ones/family properly.

1) What would you call the condition such a person who is suffering mental distress and worries?

X

2) Do you know any such person, or have you heard of any person like this?

2a) Can you describe what happened to them.

Prompt: Reasons
Signs
Treatment
Recognition of X etc.....

3) What were the signs of this condition / X?

3a) Are there any other signs?

Prompt: Don’t feel like talking
Sleep disturbances
Loss of appetite
Anger / irritability with family
Not caring about loved ones
Out of control
Out of senses
Crying again and again
Headaches
Fits
Aches in body
Sweating
Anxiety attacks
Hopeless, helpless, worthless
Withdrawal

4) What effect does this condition / X have on their life?

5) What do you think can be the main cause of this condition / X?

5a) What other causes can there be?

Prompt: Death of a family member or close friend
Family problems
Financial situation
Loneliness
Disappointment
Personality
Thinking too much
Habit
Physical weakness / other illnesses
Fate
Evil eye / casting a spell

6) So, are circumstances more responsible for this condition or is person themselves?

7) Can this condition become the cause of anything else?

7a) Anything else?

Prompt: Physical
Mental

8) Do you think this condition / X is an illness?

8a) Yes - Does it take on the guise of an illness in everyone?

Prompt: Who / who not?

8b) No - Can it ever increase so much that it becomes an illness?

9) When / how can you tell it has become an illness?

10) Is this condition / X a physical, mental, heart or psychological condition?

11) Can one prevent this condition / X?

Prompt: More worship
Stay healthy
Take medication / eat tablets
Stay busy

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Talk to your family / friends
Get out of the house
Not think too much / think good thoughts
Treat other people well

11b) How do these things help?

12) If this condition / X becomes more serious in someone what should they do about it?

12a) Can they help / cure themselves - how?

Prompt: More worship
         Stay busy
         Talk to family / friends / someone
         Get out of the house / visit parents / friends
         Don’t think too much

12b) Can anyone else help them?

Prompt: Doctor
         Psychiatrist
         Mulvi / pir / priest / religious healer
         Hakim / homeopath

13) Do people ever completely recover from this condition / X?

13a) Who gets better and who doesn’t?

13b) Those who don’t get better , what will become of them?

14) Have you heard of any other mental illnesses?

Prompt: Which ones?

If haven’t mentioned depression in the interview

15) Have you ever heard of depression?

Prompt: What do you think it is ?
         What are the signs/symptoms?
         What are the main causes?
         What is the cure?
         Is it an illness?
         Do people recover?
APPENDIX 3.8

URDU VERSION OF THE PAKISTANI EXPLANATORY MODELS SCHEDULE

دہمہ میرے کریم بیو دیکھے میں نے رائے دیئے میرے پنی سے مثبت لمبا ہو ہوئے
دیے تلف態س فیصلہ قہرے تجسیم کرنا بہبی. اور فیصلہ قہرے سے رسالے متبادل
ہے رس تلف態س لے اچی طرح کہ کہ سے بہا کے میں سے اور رس تلف態س کہ جان
سے تفصیل سے سُبلیمین-

کوہی شخص/عورت کی خفیفیت نہیں کے دلیل دعا ہو مثبت ہے. یہ دلیل امر ہے
تورا نئی کی نظر ہے. اور مشورہ سے زیادہ چابی ہے. اس سے جسم سے طاقت
دیدہ ہے. اور بہت کہ اسی مکا نہیں کرنا ہے. راول سے ایک مذہبی
ترکی - اور بار بار دعائی ہے. اور میں میں ہے کہ دہمہ کا اگر میں داک
کی جگہ میں مذہبی ہے پہلے سرکاری

1. ٹوب سے شخص کو دیکھے دراصل پنیال اور دیدہ سے مثبت ہے. یہ دلیل کہ
کیتھا نہیں ہے.

2. ٹوب ایسے شخص کو زبان پنیال- اور دیدہ سے مثبت ہے. یہ دلیل کہ

3. بات کرنے کو کہ بیٹھ رہے -

4. خاص ان کی سادگی دوسرے کے ساتھ گریم ہے-

5. موزارپن ہے- سمجھ ہے اور بہم کرنا رہتا ہے-

6. اور بھی باہر بیٹھ کرنا

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६) \( \times \) एवं \( \div \) के समान्तर प्रेषण करके रखें।

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# DEMOGRAPHIC QUESTIONNAIRE

<table>
<thead>
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<th>Question</th>
<th>Options</th>
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</thead>
<tbody>
<tr>
<td>Sex</td>
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<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Age at marriage</td>
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</tr>
<tr>
<td>No. of children</td>
<td></td>
</tr>
<tr>
<td>Age of children</td>
<td></td>
</tr>
<tr>
<td>Occupation of children</td>
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</tr>
<tr>
<td>No of children still living at home</td>
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</tr>
<tr>
<td>Family system</td>
<td>Nuclear, Joint</td>
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<tr>
<td>Location of own family</td>
<td></td>
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<tr>
<td>Location of in laws</td>
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<tr>
<td>Where did you spend most of your childhood</td>
<td></td>
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<tr>
<td>Birth place of father</td>
<td></td>
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<tr>
<td>Birth place of mother</td>
<td></td>
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<tr>
<td>Your occupation</td>
<td></td>
</tr>
<tr>
<td>Partners occupation</td>
<td></td>
</tr>
<tr>
<td>Religious Background</td>
<td>Very, Moderate, Slightly, Not at all</td>
</tr>
<tr>
<td>How religious are you</td>
<td></td>
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<tr>
<td>How many times a day do you pray approximately</td>
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</tr>
</tbody>
</table>

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