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ABSTRACT

This thesis reviews the cultural history of western depressive symptoms and critically examines the epidemiology of Neurotic Depression worldwide. It argues that such studies and vocabularies are deeply embedded within “white British and western European” institutions; and predicated on a western epistemology. This is followed by an overview of major research methods to study folk models of mental disorders. Using established clinical anthropological methods, a clinical ethnographic instrument, the EMIC, initially developed in India, is culturally adapted for white Britons in London (the UK EMIC for Depression). 47 white Britons with a diagnosis of Neurotic Depression (ICD-9), attending psychiatric services for the first time, are interviewed for their experience of illness: presenting idioms of distress, perceived seriousness and outcome, experience of stigma, ideas of causation, and help seeking. The study also examines the relationship between such personal meaning of suffering with objective professional biomedical assessments. Results reveal that the expression of illness features, including symptoms, are governed by both popular and professional ideas of depression. Women present considerably later for help, with predominant somatic symptoms whilst men report more psychological idioms. 55 discrete models of causation are elicited. Although there is considerable stability of causal explanations over time, subjects hold multiple contradictory and overlapping ideas of causation suggesting a high degree of pluralism. These results challenge the current methodology of national public mental health campaigns. The development of a culturally sensitive stigma scale is an additional result of this study. Idioms of sadness together with psychological explanations are associated with high stigma, those of anxiety together with somatic explanations with less stigma. The thesis concludes that the concept of a universal psychopathological model for Neurotic Depression is problematic.
PREFACE

The excitement of examining a facet of white Britons and their culture was kindled several years ago when walking with Roland Littlewood through the streets of London’s West End, we discussed the absence of any research that systematically detailed the cultural psychological experience of white Britons. To be a participant observer in another culture required apart from the practicalities of access, time and money, a position of relative power and sheer confidence in locating one self as an observer. I had little of this when I first arrived in Britain, and it took time and effort to understand and unravel this through a personal journey that involved interacting with local culture at different levels: simply living and participating, earning relevant credentials, engaging in frequent dialogues and intimate experiences including personal psychotherapy with a white analyst; and above all, this piece of research.

As a trainee psychiatrist in India, I had watched several anthropologists study the local culture and often wondered why they bothered to know what seemed fairly trivial and uninteresting, and what drove them to endure such hardship. I also admired their tenacity. Several years later, in London, having stepped outside my own culture, and removed in time and space from my own country, I had the opportunity to participate in seminars on medical anthropology at Bloomsbury. I was amazed, shocked at some ethnographic observations they had made, and the conclusions they had drawn. At the time, although deeply impressed by their scholarly accounts, I had felt they violated a basic premise of empirical research: sweeping generalisations that lacked quantitative observations and hypothesis testing. Some did not even bother to examine how language skills affected major inferences they had drawn. But it took me
a while, attending the same seminars to come off my own ethnocentric position which became clearer when I began field work for this study. Just as I had initially felt uncomfortable about narratives, I gradually appreciated the limitation of ‘numbers’ and ‘hard’ data. This led to choosing a method that married numbers with narratives: I am unsure if this has indeed resolved the conflict. My greatest difficulty has been the attempt to simultaneously hold on to dual perspectives across several dimensions: the etic and emic, enumeration and meaning, psychiatric and ethnographic, and deductive and inductive reasoning. These issues are central to the concluding sections of this thesis. I also had a great worry: what if people were unwilling to speak and share their experiences with a person of non-European origin? This was dismissed at the very outset: indeed my major concern turned into managing a huge data sets, large parts of which I have yet to analyse. Nevertheless, I hope the reader will appreciate the effort to juggle the balance between the quantitative and qualitative, and empirical with theoretical.

There is one major drawback in this research. It is customary to retreat from the field to one’s own culture to theorise further and then write up the research: the process of cultural distancing. These I have not done for several reasons that I consider are a matter of pragmatics. If it were possible, I would have written this study in Hindi or Marathi, and in a manner that would have been closer to my personal style and culture. However, this is a thesis written for London University, and to the extent that it reveals a style and method acceptable and familiar to a western academic, it conceals the Other. Someday I do hope it is possible in future to do it the other way round.
And like my shock at listening to research seminars in Bloomsbury on Indian cultures, if the conclusions of this study do not ring true to native Britons, that would just go to show how impossible it is for an ‘outsider’ to know insiders (of any culture), or for that matter to decode ‘their’ syntax.

During the period of this research, Britain and Europe have undergone tremendous changes: redrawing of national boundaries, devolutions, emergence of new economic and political paradigms, violence and ethnic cleansing, changes in health services, training of health professionals, professionalisation of complementary healing systems, and the advent of newer reproductive technologies, designer drugs, spare part surgery, etc. I have no doubt all of these matters have and will continue to influence European and British peoples’ experience of health and sickness. This would also suggest that conclusions of my research are only part of a wider dynamic process and will require continuing replication over time and place, in order to better appreciate changes in folk models of Depression and other illnesses across cultures.
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I would like to thank all subjects who participated in this study and shared their experiences, and numerous English informants who gave useful tips and facilitated entry to various British social cultural institutions. Several endearing experiences with both subjects of this study and numerous colleagues have left a deep impression. If it was not for their help, patience and trust, it would have been difficult to complete this study.

My immense gratitude to Roland Littlewood, supervisor for this thesis and a key informant for this research, for his intellectually rigorous yet generous mentorship. Arthur Kleinman, whose ideas and work echo throughout this thesis, facilitated my meeting with Roland Littlewood in 1990. This work is a continuation of the spirit of that encounter. I am also indebted to the senior author of the original EMIC, Mitchell Weiss, with whom I have been through the ‘thick’ and ‘thin’ of this approach, from the time I was a trainee psychiatrist in Bangalore. His continuing assistance with both methodological problems and statistical conundrums on this study have been pivotal. Indeed this research is the beginning of a broader collaborative programme on cross-cultural research and training between the Departments of Public Health and Epidemiology, Swiss Tropical Institute, Basel, and Psychiatry and Behavioural Sciences, University College London.

I also wish to pay tributes to both my parents. They enabled me that which was historically denied to them: membership of an open society and its’ privileges. It was also through them that I first heard about the British people. Mallika Sekhar, my
companion, contributed through her immense patience and endurance throughout this research.

Stan Newman in his capacity as head of department facilitated this project and encouraged its’ completion. Stephen Stansfield, my second supervisor, and Charlotte Feinman, Clinical Tutor, gave constant support and patiently awaited completion of this thesis. A generous grant from the Central Research Development Committee Crozier Fund (1991-1994) permitted time and expense to carry out a large part of this research.
CHAPTER ONE

INTRODUCTION AND
BRIEF ETHNOPSYCHOLOGY OF WESTERN DEPRESSION

1. Introduction

Over the past two decades, a significant body of research has outlined major problems that relate to the deployment of psychiatric diagnostic classificatory systems and standardised research instruments in cross-cultural settings (Jadhav 1995, Kleinman and Good 1985, Kleinman 1987, Littlewood 1990, Murphy 1982). Amongst the diagnostic groups, depression has been singled out as the one that raises significant issues of cultural validity and which poses special problems as a universally valid disorder (Jadhav and Littlewood 1994, Kleinman and Good 1985). Fundamental problems include a) cross-cultural variations in definitions of selfhood (Heelas and Lock 1981, Marsella and White 1982), b) differing local categories of emotions (Lutz and Abu-Lughod 1990), c) cultural variations in language with attendant problems of translating emotion-related vocabulary (Littlewood 1990) and d) the absence of a universal biological specification (Kleinman and Good 1985).

1.1 An Indian problem

Despite these demonstrated concerns, medical professionals, psychiatrists included, consider depression as universal in form, with cross-cultural differences in symptomatology as a mere artefact (Kaplan and Saddock 1995, Sartorius 1983). If there are such major differences in symptomatology, it begs the question: Why do they receive the same diagnosis? And how does this contradiction arise? To illustrate
how this might have occurred and continues to take place; I will share some observations from clinical experience at several Indian rural and urban psychiatric clinics:

The majority of psychiatric assessments in India take place in national and regional languages, either in Hindi or the language spoken in a particular state. However, the recording of case notes and discussions with clinical colleagues almost always take place in English with terminology that closely mirrors the vocabulary of western psychiatry. Most urban psychiatric clinics have standardized forms and entry sheets with printed headers and guidelines derived from established psychiatric history taking and mental state schedules used in Britain. A final formulation and diagnosis of ‘the case’, together with planned interventions, take place in a manner so as to match the cannons of psychiatric theory delineated in Western psychiatric textbooks (Kaplan and Saddock, 1995). Qualifying examinations for mental health professionals require trainees to have a thorough knowledge of such texts, with merit accorded to one’s ability in espousing recent theories on mental disorders published in international journals with a high citation index. An additional requirement, the completion of a research thesis vetted by a supervisory panel ensures conformation with internationally accepted methods and instruments. Pressures of learning the idioms of Western psychiatric vocabulary with its associated ‘touch of English’, publishing in prestigious journals for acceptance by the international academic community (coupled with local association of the term ‘Western’ with progress, refinement and technological advancement) seldom allow scope for developing alternative theoretical formulations on mental distress. Further, the teaching of Western psychiatric history
as a factual set of dates, events and names is directly linked to any local psychiatric discourse, and is thus appropriated as a common academic intellectual heritage. An audience with pharmaceutical representatives armed with semiotics that reinforce western folk psychiatric images (Kleinman and Cohen 1991, Neill 1989) are regular features at out-patient clinics. Such encounters often lead to the introduction of newer pharmacological products into clinical practice, sometimes with questionable monitoring of adverse drug side-effects.

In this situation, local worlds, their core moral and cultural values, and a rich emotional vocabulary associated with bodily problems and expressed through a range of non-English languages (Lynch 1990), are often glossed over or pruned to fit into conventional psychiatric nosological systems (DSM and ICD). This process of systematically acquiring a culture-blind ability is considered credible and meritorious, both locally and internationally. The exclusion of culture then systematically abolishes the ability (and sensibility) to consider the role of major social and cultural variables such as poverty, migration, urbanisation, gender, caste, stigma and other socially oppressive situations that may well relate to depression or its local equivalent. Ironically, these are precisely the very issues cited by the international community as relevant for the health and economic development of the poorer nations (Desjerlais et al 1995). Issues of cultural validity then acquire a significance that has serious implications for, and beyond, the clinic setting. One might argue that such a selective ‘cultural cleansing’ of patient narratives takes away the opportunity for the major research questions that cultural psychiatry seeks to investigate. For example, how may local idioms of distress (currently fitted under the broad rubric of depressive or
somatisation disorders), such as *naara mein dard* (pain in the nerves), *meetha dard* (sweet pain), *sar mein garmi* (heat in the head), *tidik* (twitch), *badan mein dard* (pain in the body), or *dil mein udasi* (sorrow in the heart) etc., provide a phenomenological template to generate appropriate nosologies of distress*⁹* (Jadhav 1986). If such nosologies were to develop, they might perhaps lead to a fundamental re-conceptualization of depressive disorders (Krause 1989, Nichter 1981).

How does one proceed further? A recent line of inquiry within the ‘new cross-cultural psychiatry’ framework suggests that “western psychiatric theory” has often naturalised its own cultural distinctions, objectified them through empirical data and then received them back as if they were universal objective “natural science” categories (DSM IV 1995, Littlewood 1990). It postulates that each culture generates a local psychiatry (termed “ethnopsychiatry”) that constitutes and articulates the moral values and health concerns of that particular culture (Gaines 1992). In this schema, current psychiatric theory is just another instance of an ethnopsychiatry, embedded however in western society and developed in response to prevailing concerns at differing periods in history. Such an approach seeks to problematise existing psychiatric concepts that are otherwise considered culture-free and universally applicable; by de-constructing theory (ies) to reveal their culturally constituted foundation (Good 1994). To use a post-modern cliché, such a project is about ‘rewriting’ psychiatric history: the Others’ perspective. The remainder of this chapter will address this issue with a focus on the historical development of concepts and terminologies associated with depression in Western Europe and, in particular, in Britain. Although limited to a lexical and semantic consideration of certain
terminology, and therefore by no means an exhaustive cultural analysis, it is an attempt to provide a general overview of the ways in which some of the key concepts of depression have been culturally shaped yet are now assumed to be universal natural entities that await further scientific research and investigation.

1.2 A Brief Ethnopsychology of Western Depression

1.2.1 The mind-body distinction, concepts of self and the location of emotions

The literature of cultural psychiatry has often referred to separation of the Mind from the Body as a fundamental dualism that underpins Western psychiatric diagnostic and classificatory systems (Gaines 1992, Kleinman and Good 1985). Although the history of mind-body dichotomies dates back before the 17th century writing of René Descartes, the study of how the Western Self is culturally constituted has generated surprisingly fewer ideas. Some consider it as a bounded, unique, homogenous and autonomous entity (Marsella and White 1982), with clear boundaries and personal space; others have postulated terms such as ‘ego-centric’ (Shweder 1991) and ‘indexical’ (Gaines 1992), as opposed to the ‘socio-centric’ and ‘referential’ Self of Third World societies. Analysis of contemporary Western professional and folk psychological idioms suggest an image of an entity that generates thoughts and emotions from inside a metaphorical three-dimensional space enclosed within firm boundaries and containing a ‘substance’ (Goldman and Montagne 1986, Lakoff and Johnson 1980, Mant and Danoch 1975, Neill 1989). In this container, past experiences are stored in a vertical and linear fashion\(^10\) that can be ‘emptied’ out in cathartic sessions. The ‘pressure’ brought about by ‘life events’ and ‘traumas’ could exhaust such a culturally constituted psychological space and lead to a bursting of
protective dams (such as psychodynamic defence mechanisms) causing disintegration and disorder (Lakoff and Johnson 1980). This sort of ‘rational’ Self therefore helps keep in check its emotions (mainly anger and depression) which if let out or let in (as in anger turned inwards) could prove damaging. The worth and social estimate of this Self is then measured by achievements refracted through a self-monitoring structure (the affective apparatus). Thus, low self-esteem occurs when the affective apparatus is depressed, and an inflated self-esteem when elated. Inter-personal and social problems are restructured as a series of person-centric ‘constructs’ (Kelly 1955) that are focused on the individual viewed as an unitary active agent acting upon the natural world.

Emotions are then both a property of, and simultaneously constitutive, of the Self, but they can also acquire an impersonal form to be transacted and exchanged as commodities. Emotional pathologies are represented through four ‘primary’ emotions: depression, elation, anxiety and fear. These are enshrined in the form of affective disorders within the official diagnostic systems (DSM and ICD) as pure forms, and as mood ‘incongruent’ disorders (Schizo-affective disorders) if they occur in mixed forms (i.e. in association with thought disturbances). Psychodynamic forms of therapy invoke concepts such as ‘engagement’ and ‘disengagement’ with the affected Self that then require the ‘transfer’ of key emotions onto a ‘significant’ other, the therapist. Although this metaphorical description is a brief and simplistic account of the Self, it is derived from the discourse within western psychiatric theory. Here, depression is primarily a ‘disorder of mood’ that rests upon a pathology of key emotions considered arising from within the ‘mind’. Predominant expressions of
bodily distress are therefore situated within a separate diagnostic category: 'somatisation disorders' and are viewed to have a distinct natural history, course, diagnosis and intervention from that of 'mood [affective] disorders' (DSM IV 1995). Against this background, a range of depressive vocabularies and their cultural histories need to be examined in some more detail.

1.2.2 A lexical analysis of depression

Any attempt to examine the origin of depression and related feeling states, in an historical context, is beset with two major problems: (a) relying upon ancient written texts, their interpretations within various disciplines and the general problem of historical interpretation, and (b) the semantic and conceptual problem of retroactively employing a term or concept. There are problems of assuming 'depression' to be a constant feeling state that is merely changing in its vocabulary over time; an idiom similar to the form-content debate across cultures (Murphy 1982). If the vocabulary of emotion is itself a cultural construct, that is shaped and in turn shapes affect, then there is a clear problem of assuming constants of affective states over time. Not surprisingly, several medical historians have chosen to take acedia, sadness, melancholia and depression as a single temporally linked and successive feeling state that has simply been subject to changing labels over time (Clarke 1975, Hunter and Macalpine 1963).

The earliest use of the term “depression” in English language dates back to the 17th century. Its subsequent and ubiquitous use in describing a state of mind, the weather or economy, suggest a general state of “lowering of affairs” (Fontana Dictionary of
Modern Thought 1988). The first standard English gloss of this term was introduced by Samuel Johnson in 1755 in his dictionary (Johnson 1755), and the Oxford English Dictionary cites its etymology from Latin roots: *de primere* (to press down, Appendix A). An idiom initially developed as a spatial metaphor, represented in astronomy and architecture, later acquired gravitational properties to represent a model of mood states along a vertical axis well exemplified in the 1750s prints of William Hogarth (Littlewood 1994). How did such a metaphor arise? And what were its historical antecedents? If the current western European vocabulary of dysphoric mood states is as recent as the seventeenth century, can one claim that emotional states were less differentiated or configured in a different manner before this period?

Although earlier research argued Old English as a poor medium for emotional expression, recent work by Nicholson proposes the presence of a prolific vocabulary of emotions during the Anglo-Saxon period (Nicholson 1995). His analysis of Anglo-Saxon literature provides evidence of a rich abstract vocabulary denoting various mood states. An examination of Old English elegies revealed over 37 different emotions that serve as equivalents for Modern English terms such as sorrow, misery, grief, fear, caring at dawn, anger, sorrowful love, perpetual grief, etc. Based on this evidence, Nicholson challenges the premise that earlier societies neglected and undervalued emotional states due to a lack of emphasis on personal choice or to an undifferentiated psychological vocabulary (e.g. Leff 1973). Whilst acknowledging that Anglo-Saxon vocabularies do not directly relate to modern English words, Nicholson confirms the existence of a range of psychological states during the Anglo-Saxon period. Of particular interest is the term 'unmood' in old English which translates as
depression, but also refers to a disease state arising from the stomach (Cockayne 1865). This bears a close linguistic affinity with the Sanskrit term ‘unmada’, a generic term in ayurvedic medicine for severe mental disorders (Bhishagratna 1991), and suggests cultural transmission of concepts may have taken place during the Anglo-Saxon period (Clarke 1975). Historical evidence argues that the major source of current concepts relating to psychological disturbances in Europe derived from the Church, followed later by classical Greek and Latin texts that came via Arabic sources. The most popular of these were Acedia and Black Bile and both seemed to have had a complex relationship with a new term in English, Melancholia (Jackson 1986).

1.2.3 Acedia, black bile and melancholia

Jackson’s scholarly and exhaustive research on Melancholia in general and Acedia in particular (Jackson 1986) reveals the complexity in an historical analysis of psychiatric vocabulary and the difficulties of drawing valid conclusions. The absence of popular folk literature from such remote historical periods further complicates this issue. Historians have generally had access to surviving written documents only of the literate elite, and this poses further limitation into research on the historiography of folk concepts.

The term ‘acedia’ originated from Latin accidia which may be glossed as “heedlessness and torpor”, and later became a “favourite ecclesiastical word to describe the mental prostrations of recluses, induced by fasting” (O. E .D 1989). Black Bile is the modern English translation of the Greek term, melaine chole (Latin
atrabilis), with Melancholia in English deriving directly from Latin which in turn was derived from the Greek (Jackson 1986).

Western thought on melancholy derive from the Hippocratic corpus in the fifth century BC, systematized by Galen during the second century AD, thereafter preserved and elaborated by Arabic and other Eastern physicians between the end of the Classical period and its Arabic re-introduction into the West (Ripper 1981). When these ideas re-emerged in the late Middle Ages, they were available through Latin translations that were then adopted into academic teaching in the universities (Clarke 1975). Such a process could therefore have lead to a range of meaning systems, nomenclatures and theories. Despite such cultural transitions and reinterpretations, the term Melancholia seemed to prove a relatively durable concept and an overarching category that was later to subsume a range of dysphoric terms include Acedia and Guilt (Bright 1586).

Although religious literature of the late 4th century AD referred to Acedia as one of the major temptations with which the solitary monk had to struggle (Clarke 1975), Jackson’s translations of the writings of John Cassian, an influential monk of the period, suggests bodily metaphors such as a “weariness or distress of the heart”, “akin to dejection” and “especially trying to solitaries”. He describes:

"The condition was characterised by exhaustion, listlessness, sadness or dejection, restlessness, aversion to the cell and the ascetic life, and yearning for family and former life. The afflicted monk became restless, complained that his situation was no longer spiritually fruitful and that he was useless in it, and he thought that he would
never be well unless he left the place. In his continuing restlessness, time seemed to pass very slowly, he yearned for company and considered seeking solace in sleep. In short, he tended to either remain idle in his cell or to wander from it in restless pursuit of diversionary activities, in either case to no spiritual end.” (Jackson 1986, p. 66-67).

The term continued to be used by theologians over the next decade, and by the 12th century AD, it survived internal ecclesiastical debate to be officially accepted as one of the seven deadly temptations, the Sin of Sloth (Jackson 1986). How then did Acedia acquire folk popularity if it was confined to monks, given their reclusive lives in monasteries? In contrast to the early middle ages, when medicine was taught exclusively in monasteries, an outward diffusion of medical ideas did not occur (Clarke 1975). However, the rise of clerical power during the 12th and 13th century, led to confession being made obligatory on all by the Fourth Lateran Council (Legge 1963). This led to an extensive production of penitential literature, manuals for preachers and cathetical handbooks, resulting in a steady diffusion of religious and medical ideas and concepts into the popular culture. During the subsequent scholastic phase, a systematic analysis of theological literature resulted in the integration of Acedia with Greek theories of the passions that had started arriving into Britain, and Acedia “emerged as a disorder in man’s emotional life. At times, it came to be thought of in medical terms” (Jackson 1986, p. 70). Its status as a Sin however, continued within the Church until further developments led to its association with Black Bile and religious Guilt.
1.2.4 The Cultural History of Guilt

The word Guilt derives from the early medieval German gelt (gold or guld: to pay for an offence), a monetary penalty for commission of crime but commonly used to indicate a failure of duty (O. E. D 1989). The literature suggests that this was primarily a religious and social category that became interiorized and transformed into a secular psychology. To follow the O.E.D citations: “initially conceived as a Sin (9th century AD), later as the fact of having committed some specified moral offense (“Christ shed his blood so he might wash us from the sickness of guilt: *quarto sanguinem suum fudit, ut nos a morbo culpe lavaret*, 14th century AD, Siegfried 1989 p. 207), and then as feelings of conscience (15-16th century AD), and as a quasi-medical term, guilt-sick conscience (1625 AD), it later acquired physical characteristics such as being pent-up inside the body (1605 AD), and evolved into a more elaborate psychological category, guilt complex (1927 AD), with a further development into a plural form: guilts (1932 AD)” (O. E. D 1989).

If guilt originated as a moral and social category, how did it become incorporated within a medical psychological framework and acquire a pathological connotation (as it does in the psychiatric descriptions of contemporary depressive disorders)? To understand this, one needs to examine the changing relationship between the church and medical profession. Jackson and others have postulated that this came about as a result of key texts and teachings of eminent theologians who were to later practice medicine, or vice versa (Clarke 1975, Jackson 1986). The role of this ‘medical clergy’ in merging moral guilt with an illness concept of melancholy and its postulated cause, i.e., black bile, is succinctly illustrated in the following passage by Saint Hildegard of
Bingen, who wrote an influential medical treatise during the 11th century, titled “Causae et curae” (Delumeau 1990, p. 246):

“At the very instant when Adam disobeyed divine order, melancholy coagulated in his blood, just as clarity vanishes when the light goes out, though the still hot oakum produces malodorous smoke. And so it was with Adam, for while his own light was being put out, melancholy curdled in his blood, which filled him with sadness and despair. Indeed, when Adam fell, the devil breathed melancholy into him, that melancholy which makes man fainthearted and unbelieving”.

An influential earlier (fifth century) scholar, Saint Augustine, commented on the Christian notion of inheritance of Sin (ibid., p. 247):

“We inherit this ignorance and concupiscence, yet we are also guilty of them. For at the time of his sin, Adam formed one single man with all his posterity; all of us were contained in him. The unity of the human race within Adam explains how the first offence was also our offence”.

Almost five hundred years after Hildegarde’s teachings, Burton extended this logic in his influential Anatomy of Melancholy, beginning with a discussion on the Original Sin that transformed man, “the miracle of nature, into a miserable being subject to illness, fear, unhappiness..... : Heu tristis et lachrymosa commutatio!” (ibid., p. 246).

1.2.5 The Inheritance of Guilt: from Sin to Gene

All this suggests how Guilt simultaneously translated into a material substance (black bile) and an illness, to acquire a hereditary property. More significantly, through its association with black bile, it established a direct link with Melancholia. Thus, there
developed a situation wherein the triad of Guilt, Sin and Black Bile was firmly linked and crystallized into a robust category. This category was to become the basis for further elaboration of theories on melancholia and at the same time, considered constituting the ‘clinical’ features of Melancholia, the disease. Black Bile theories of Melancholia remained popular until the 17th century, and were variously viewed as heavy impurities that either produced noxious fumes or precipitated and blocked blood vessels, to produce Melancholia. The Spleen was considered as the site that produced Black Bile, its spongy texture serving to absorb and store this thick viscous humour. During the Renaissance, developments in medicine such as Paracelsus’s challenge to Galenic medicine and his rejection of the humoral theory, Vesalius’s work on anatomy, together with Harvey’s theories of circulation, challenged the legitimacy of the Black Bile theory for Melancholia. It was replaced by competing theories either in succession or in a mixed form. Some of the prevailing popular medical explanations include: Spiritus vitae blocking the brain\(^{13}\), Affectations of the mind\(^{14}\) and Melancholic vapours rising from the Spleen to obscure the mind\(^{15}\) together with a range of Neo-Platonic theories invoking supernatural forces, demons and spirits as causal agents\(^{16}\). In this pluralistic atmosphere, the introduction of chemical theories\(^{17}\), nerve juices\(^{18}\) and mechanical explanations were part of a paradigm shift that emphasised a primary pathology in the nerves (Jackson 1986, Porter 1991).

The cultural association of Guilt with Melancholia survived as a ‘complex’ to become symptoms of ‘Depression’. Medical historians consider this period one in which the Body underwent a process of secularisation (Delumeau 1990, Elias 1939, Porter 1991). Demons and malignant spirits of the pre-Renaissance period were objectivised
through medical theories which introduced the concept of Natural Spirits located within the nervous system (as compared to earlier Neo-Platonic daemonic spirits from the supernatural world), and with the discovery of such natural laws as those of Newton and Boyle, Depression acquired metaphors derived from physics (such as stress, fatigue and energy). The four original humours including Black Bile were replaced by neurohumours (the forerunner of neuroendocrine theories), the metaphors of balance and excess-deficit between humours retained to explain various mental disturbances and normal brain functioning. Idioms such as sluggishness and heaviness translated into psychomotor retardation and drooping body postures, whilst Darkness (derived from the shadow of black bile) retains popularity in contemporary folk vocabulary exemplified by pharmaceutical advertisements for anti-depressants, although the current metaphor “feeling blue” owes its popularity to the 18th century notion “to burn blue” (a burning candle emitting a flash without red glare, an omen of death or indicating the presence of Devils with the plural form, Blue Devils, referring to an apparition seen in delirium tremens: O. E. D 1989). Later, the psychoanalytic theories of Freud reinterpreted religious Guilt (as Guilt Sickness) into a schema that explained individual guilt as having originated from “a great traumatic event: the murder of the father of the horde” (Delumeau 1990, p. 251). In a similar manner, earlier quasi-hereditary ideas of inheriting depression (through its association with guilt) were gradually turned into a theory of heredity by Esquirol (Jackson 1986), to be later developed into the late 19th century theory of degeneration (Hunter and Macalpine 1963) and then further shaped into 20th century genetic models for depressive disorders.
1.2.6 The popularity of Melancholia

The cultural shaping and transformation of Melancholia into a fashionable folk category lasted for well over a century and involved the whole of Europe. Popular interest in Melancholia peaked in the 17th - 18th centuries during which it was dichotomised: as a disease with elaborate physiological explanations and as a sentiment cultivated by the elite (Babb 1951). Dubbed for over a century as the English Malady or the Spleen, its status as a disease of the genteel class was based on the idea that it was an attribute of superior minds, of genius (Doughty 1926). A number of medical historians suggest that this was an era in which Europe developed an immense interest in Melancholia (Babb 1951, Clarke 1975, Delumeau 1990). Its diffusion into popular literature (Legoius and Cazamian 1964) together with further developments in European society such as the developing class structure (Macfarlane 1978), the private ownership of property (Marx 1887), the advent of enclosures and the notion of a private cultural space (Johnson 1993); and an interest in psychological idioms by the elite (Elias 1939), led to a personalisation of melancholic feelings with a proliferation of terminology (Carritt 1948) - thus Melancholy was described:

as divine (*Hail, divinest Melancholy.* John Milton, II Penseroso, 1645),

as personality (*The Melancholy and pleasant humour were in him so con-tempered, that each gave advantage to the other, and made his company one of the delights of Mankind.* Isaac Walton, Life of John Donne, 1640),

as landscape (*The Parke (at Bruxelles)...so naturally is it furnish'd with whatever may render it agreeable, melancholy, and countrylike. Here is a stately herony, divers springs of water, artificial cascades, rocks, grotts.* John Evelyn, 8.9. 1640),

as folly (*...All other joy to this are folly. None so sweet as melancholy.* Robert Burton, Anatomy of Melancholy, 1622),

as a “fit” (*Wrap in a pleasing fit of melancholy. To mediate my rural minstrelsy.* John Milton, Comus, 1635),
as mood (*More, I prithee, more, I can suck melancholy out of a song, as a weasel sucks eggs...I do love it better than laughing*). William Shakespeare, *As You Like It*, 1600),

as a desirable sentiment (*A sweet melancholy my senses keeps. Drummond of Hawthronden, When 'as She Smiles, 1614*), and

as a national character (*The English are naturally Fanciful, and very often disposed by that Gloominess and Melancholy of temper, which is so frequent in our Nation...*, John Addison, *Spectator, Pleasures of the Imagination*, 1712),

that was considered as uniquely English (*The English Malady*. Babb 1951).

A close examination of the historical literature suggests that this was perhaps an unique period in the history of Western Europe when ‘melancholy’ in its mild form denoted a positive desirable and fashionable state and in its severe form, a disease state which caused suffering and stigma. Against the background of two major recognised epidemics in Europe - black death and suicide - melancholia was viewed on the one hand as a social and health problem, particularly amongst the poor and unemployed, whilst the artistic community and women of the ‘genteel class’ on the other, were expected to be of melancholic disposition (Delumeau 1990).

1.2.7 From Melancholia to Depression

Against the background of Cartesian dualism, further developments in medical and psychological theories associated with the post-Renaissance period, led to a recategorisation of melancholia into somatic and psychological types (Jackson 1986). Later, the term melancholia itself was displaced by depression that subsequently developed into a major ethnomedical category (Jadhav and Littlewood 1994, Gaines 1992). Although Guilt continued to remain a feature of Depression, it was to soon be valorized: in its excessive, pathological or inappropriate form: as a central feature of
depressive disorders, and with its absence or lack: as one of the core features of anti-social personality disorder (DSM IV 1995). This tenuous link continues into twentieth century concepts of heredity, reflected through a contemporary clinical classification that associates women suffering from early onset depression to have a high incidence of anti-social personality disorder amongst their first degree male relatives (Winokur 1973).

With the increasing popularity of physiological and chemical theories of mental disorders in an era dominated by advances in the natural sciences, depression seemed congruent with emerging natural physical science concepts that implied pressure, force, energy, motion and gravitation. By the beginning of this century, the term was deeply embedded in meteorology (high pressure and low pressure areas), stock market (The Great Depression), speech (lowering of pitch and musical notes) and lowering of vital bodily functions (depressed T wave in electrocardiograms and depressed immune system) to became a robust Western ethnopsychological construct.

As an illness concept, it acquired battle metaphors: popular public health campaigns in Britain now refer to ‘defeating’ depression, ‘battling’ with stress, ‘strengthening’ defences and ‘buffering’ vulnerabilities (Jadhav and Littlewood 1994). With this gradual interiorization of a range of dysphoric emotions that were relocated and postulated to originate from within an intra-psychic space (Lakoff and Johnson 1980), fears of losing ‘control’ over such emotions shaped the further development of contemporary psychological theories and insight questionnaires that view patients’ attribution to ‘external loci of control’ as indicative of poor ‘in-sight’ (my neologism) and an unfavourable prognosis for depression (Kaplan and Saddock 1995).
1.2.8 The Birth of Fatigue and the Category of Somatisation

Originating from the French term, *fatigue* and Spanish, *fatiga*, in English fatigue denotes ‘lassitude or weariness resulting either from bodily or mental exertion’ (O. E. D 1989). Its use in the current psychiatric vocabulary originated from several diverse sources, but unlike guilt and acedia, fatigue has had a more recent medical history; commencing around the end of the eighteenth century, and closely related to the Industrial Revolution and the discovery of labour power (Rabinbach 1990).

The prevailing Protestant concerns about the importance of work meant that idleness was a danger to be guarded against. The emergence of commercial economies underpinned by capitalism, the industrial revolution, and the birth of chronological clock time led to the development of an ethic - ‘not to waste time’- as the ‘new measure of life’. Thus a new secular remedy for the medieval Sin of Sloth evolved: the discipline of work. Soon idleness was virtually regarded as the primary crime against industry, and this was supported by influential members of the scientific and political community in Europe. In this era, a significant intellectual framework, the doctrine of materialism, developed the idea that the Body was a source of energy capable of transforming universal natural energy into mechanical work. This ability to generate energy and perform labour could then be harnessed by the State for the production of wealth and articulated in the form of a metaphor: The Body as Machine. Offray de La Mettrie's famous 18th century treatise *'L'homme machine'* , provides an example of how this powerful metaphor from France and Germany swept through Europe: one that posited the human body as analogous to “a watch-spring with unique self winding properties” (ibid. p. 51). By the turn of the century, the Body was modelled on the
thermodynamic engine and linked with physical forces in the Cosmos through a unifying category: Energy, the antithesis of fatigue. As a generalisable category, it was picked up by Freud who “juxtapose[d] two universes of discourse, that of force (or energy) and that of meaning, so that meaning relations [were] entangled with force relations” (ibid. p. 63) and developed this theme to form the basis of his thesis in “Beyond the Pleasure Principle” and a theory of “libidinal energy” (Brill 1938). This concept of energy also gained popularity amongst late nineteenth century physiologists keen to understand bodily functions through principles of physics and chemistry leading to the development of terminology such as calories and muscle proteins to explain energy production within the body.

Concerns about human fatigue within industries and power plants peaked in the nineteenth century. The traditional western proscription of idleness, which spiritualised and consecrated labour, was displaced onto the working body (or class) and recast in scientific and medical language as a natural category. A major part of these developments originated in France: Philippe Tissie, the most prolific advocate of a national policy of hygienic resistance to fatigue in fin-de-siècle France, warned that a “nation, like a fatigued individual is always prepared to obey any master which imposes itself on it brutally and with force” (Rabinbach 1990, p. 146). This threat of ‘fatigue’ led to several debates within a medical profession alarmed at the ‘mental’ fatigue of youth in France and Germany, and who expressed concerns over their exhausted state brought about by overwork and overstudy. The popular press, dubbed this period as ‘L’éducation homicide’. Several texts and monographs on Fatigue were published and a state similar to the Elizabethan melancholic era had developed. With
the invention of the ergograph, aesthesiometer and algesiometer, attempts to measure the physical consequences of mental fatigue were balanced by others which tried to establish and develop a pure psychological category of fatigue. Amongst the most notable attempts was that of Emil Kraepelin who argued for devising sophisticated psychological techniques to measure fatigue. Kraepelin differentiated between fatigue (ermüdung) and tiredness (müdigkeit) as severe and milder forms of the same experience. He measured and plotted graphs on fatigability in mental terms through monitoring psychological performances of factory workers in his laboratory. Kraepelin argued for a system in which the ‘unsuitable’ would be left behind while the energies of the more capable could develop and be enriched “so that the path would be open to a new species more capable of performance” (ibid, p. 152).

Around this time, George Miller Beard, a neuro-psychiatrist, introduced the term ‘neurasthenia’ to cover “all the forms and types of nervous exhaustion coming from the brain and from the spinal cord” (ibid. p. 153). This term was then shared and reinforced by prominent physicians and social scientists including Charcot, Simmel and Durkheim. Charcot’s student, Charles Féré became a leading proponent of a hereditary link between the ‘neuropathic family’ and its propensity to neurasthenia. Yet another set of physicians ascribed this hereditary notion to ‘Jews and the slave race’ and to a ‘kind of inverted work ethic, an ethic of resistance to work or activity in all its forms’ (ibid. p. 152). This incapacity that derived from impaired energy led Pierre Janet to develop the theory of ‘psychological tension’ that postulated a hierarchy of energies required for different types of activities. Janet argued that emotions were a ‘variety’ of fatigue and viewed the psyche as a permanent struggle between the economies of
energy and fatigue. By the end of the 19th century, the medical establishment's interest in fatigue as a biomedical disorder was highlighted by the US Surgeon General’s Index listing more than 100 studies of muscle fatigue, asthenia and spinal exhaustion, along with numerous studies of ‘nervous exhaustion’ and ‘brain exhaustion’. The search for a physiological marker spurred medical research into the chemistry of fatigue with unsuccessful attempts at discovering a ‘vaccine’ against this state. A biological origin of pathological fatigue eluded the medical establishment and the term continues as a psychiatric disorder, although controversy surrounds variants of fatigue. Nuances like Chronic Fatigue and Myalgic Encephalomyelitis reflect how their causes are contested by biological and psychological theories, whilst reified by an industry of sickness benefits and litigation. Although a cardinal feature of depressive disorder (as low energy), it retains a separate identity as Chronic Fatigue Disorder in contemporary western ethnopsychiatry (DSM IV 1995).

Somatisation followed as a logical continuation of this discourse on Fatigue. Defined as “the occurrence of bodily symptoms in consequence of or as an expression of mental disorder” (O. E. D 1989), the term was introduced into the psychiatric literature of the 1920s to validate emotional origins of bodily symptoms. It is now enshrined within the DSM IV as a disorder in itself, considered resistant to treatment and continues to preoccupy researchers who either seek a biological substrate (Goodwin and Potter 1978) or consider it prevalent amongst those who have a less differentiated psychological vocabulary (Leff 1973). Its psychological equivalent, Alexithymia, was originally defined as “an affective disorder characterized by inability to recognize or express emotions” and put forward by psychotherapists of the early
1970s (Sifnoes 1972). However, standard textbooks of psychiatry now describe it as a means of communicating affective distress through somatic language. Curiously enough, a range of psychopathologies associated with powerful somatic idiom of distress such as Body Image disorders are not considered as ‘somatisation’ and further, are deemed appropriate for psychotherapeutic interventions (Kaplan and Saddock 1995). It is not surprising that the concept of somatisation originated in an era when eugenic theories dominated academic scientific thinking. The association of high rates in non-western societies and frustration with efforts to accommodate it as an affective disorder together with a poor response to anti-depressive therapies (Kleinman and Good 1985) or psychotherapeutic interventions have lead to a not so concealed stigmatising attitude towards “somatisers”.

1.2.9 The Discovery of Stress

Originating from the Latin stricta (and thence French estrée) meaning narrowness, straitness, oppression, and Middle English distress, the term connotes hardship and adversity (O. E. D 1989). Its popular usage in current English began as a common overarching metaphor (of a natural force) principally in physics (14th-17th century), that denoted a sense of weight, pressure, strain, or a deformation upon a material object. Its introduction into psychiatric literature occurred at the end of the 19th century when it was first associated with neurasthenia (Rabinbach 1990), and was considered a general cause of mental disorders. It reached peak popularity in the 1980s following the introduction of an independent psychiatric disorder, Post-Traumatic Stress, argued by medical anthropologists as a North American ethnopsychological construct invented in order to accommodate the collective trauma
of the Vietnam war (Young 1995). This diagnostic term is therefore a good example of an aetiologically (and culturally) based disorder (trauma) within a diagnostic system that claims to be atheoretical and culture free (DSM IV).

The concept of stress assumes the existence of a ‘stressor’ and the ‘stressed’: which are built into a higher order set of theories that include notions such as (social and psychological) ‘supports’ which buffer against ‘stress’: the absence of which are viewed to be ‘vulnerabilities’. Stress then is an invisible impersonal ‘thing’ that is transmitted from the ‘stressor’ to the ‘stressed’ and which can only be empirically documented by its effect on the recipient and best judged through an objective clinical assessment by mental health professionals (DSM IV). As a generic equivalent of bacterial or viral infection of the disease model, its credibility relates to non-stigmatising qualities such as an impersonal nature, location outside the body and a semantic distancing from other emotion-related vocabulary.

1.3 Conclusions

Focusing on the British cultural vocabulary of guilt, fatigue, energy, stress and depression; this chapter argues that such vocabularies have their own unique histories and meanings; deeply embedded, in this instance, within white British and western European institutions (including their health care enterprises). If the cultural validity of depression can be taken as local experiences (of the population) that are clarified and validated on their own terms, then depression can be construed as a culturally valid concept for western settings. If this is the case, it is a fallacy to assume that depression is some real objective disease entity which can be found elsewhere or for
that matter, packaged and transported to a contrasting setting for ready use. The
debate is not about the universality of suffering or its version of a local pathology
across cultures, but whether it is the same as “western depression”. As was observed
earlier, depression for the culture-free psychiatrist in India is no more than a
consensus (of psychiatric nosology) amongst health professionals sharing a common
(western medical) epistemology. This is not the same as being culturally ‘valid’ among
the general population.

Although I do not wish to suggest that depression does not ‘exist’ elsewhere outside
of western European and north American cultures, one does need to problematise the
question: Is the indigenous Indian version of depression essentially the same as
western depression? The answer is that we do not as yet know, as current knowledge
is derived mainly through a western epistemological framework. To proceed further
entails the following:

1) A study of lived experiences of everyday suffering and recourse to help, through
local narratives and language that would identify key constructs and examine the
cultural logic of constructing illness experience in both Western and non-western
settings. The semantic illness network is one such approach that revealed local
distress models for the Punjabi community in Britain (Krause 1989) and Shiite
Muslims from Iran (Good 1994).

2) Such local models would generate popular and locally meaningful patterns of
distress to validate local experience on its own terms. These could then be
operationalised and validated against western phenomenology and psychopathology
for congruence or goodness of fit in form, content and quality. It is likely that some
patterns of distress may not fit with western descriptions of psychopathology and disorders, and may therefore need separate and distinct class category representation. Examples of these are the Japanese concept of *taijin kyofusho* in the official Japanese diagnostic system for mental disorders; the *qi-gong* (excess of vital energy) psychotic reaction and *shenjing shuairuo* (neurasthenia) as represented within the Chinese Classification of Mental Disorders, 2nd edition (DSM IV 1995). Alternatively, some patterns may well reveal common universals that would enrich the debate on cultural validity.

3) Development of instruments, both quantitative and qualitative, that would measure such distress patterns and contribute towards the development of higher order categories or syndromes. Only then can such categories be comparable with western psychiatric concepts for cross cultural equivalence and validity. For example, a study of ‘life events’ contributing to mental health problems would require at first a full picture of what a life event means to the population under study. What are its relative perceived threats to marriage, kinship ties and integrity of the community on the one hand versus economic risks or unemployment on the other? Would a western life events questionnaire be recalibrated by local members of the population who might chose to re-arrange the hierarchy of events?

Cultural validity apart, there is an additional reason that merits such an enquiry: mental health professionals, particularly from developing nations have often expressed surprise at the manner in which scholarly discourses on medical anthropology remain confined to Western academic institutions with little impact on changes in everyday clinical practice in their own settings. It is ironical that some of the reasons are similar
to both groups. These include their subordinate status within health institutions across cultures, the lack of teaching and systematic research in this area leading to a poor impact on mainstream medical disciplines including psychiatry. It is in this context that anthropologically informed methods of enquiry have potential to help establish clearer links between personal suffering and local politico-economic ideologies. Such methods can generate alternative cannons of culturally valid psychiatric theory and practice and *contextualise* them in both time and space. Although ambitious in its aims, research that will critique western psychiatric theory and practice, and reveal its ethnopsychiatric premise, also broadens the debate on cultural validity of psychiatric disorders in general. Moreover, this process might generate local interest into indigenous taxonomies and provide a meaningful framework within which both professionals and patients from non-western cultures could reclaim their local cultural and political histories.
CHAPTER TWO

THE CROSS CULTURAL EPIDEMIOLOGY OF DEPRESSIVE DISORDERS

2.0 Introduction

The World Health Organization estimates that Mood Disorders affect 340 million worldwide at any given time. Depressive disorders in particular, affect over 100 million and presents in 10% of all those seeking care at primary health care facilities. Depression is implicated in at least 60% of all suicides, which in 1990 amounted for 1.6% of world's deaths. Further, Depression ranks fifth in illness burden among women and seventh among men in developing countries. In US, Depression costs approximately US $44 billion annually, the same as heart disease and represents a third of total estimated annual cost of all mental illness.

In Britain, the prevalence of Depression in the general population is about 5 per cent, with estimated 4000 deaths from suicide each year. Concerns about its social and economic losses have prompted the Department of Health to consider reduction of suicides among psychiatric patients by 10 per cent as a key target in its “Health of the Nation” White Paper published in 1995, to be reached by 2000. General population surveys identified that only half of people suffering from depression were in fact seeking medical help and primary care studies revealed that those who eventually did seek help from general practitioners, only 50 per cent had the disorder picked up at the first interview. Based on these concerns, The Royal College of Psychiatrists launched a major five-year public health campaign in 1992 with the aim of educating
the public and professionals about Depression. Further details about the Campaign’s scientific method will be addressed in Chapter Three.

2.1 The Problem with Researching Epidemiology of Depression

There are two fundamental problems associated with researching the psychiatric concept of depression:

2.1.1 Phenomenological - nosological issues

2.1.2 Validity across cultures

2.1.1 Phenomenological - nosological issues

Depression denotes three linked concepts: (a) lay usage as every day mood state, (b) a symptom of most psychiatric disorders and (c) a syndrome in itself. Unless research questionnaires distinguish the three, it is difficult to interpret responses. Whilst the first concept, lay usage as a mood state, is part of popular folk vocabulary, the latter two are professionally derived categories. Epidemiologists usually resolve this issue through their definition of what constitutes a ‘case’ but often that distinction is arbitrary and unreliable in cross-cultural research. Further, the boundaries between psychiatric disease categories of depression, anxiety and personality disorder overlap and are blurred, and do not neatly cluster into separate entities (the symptom, depression, can be observed in all three clinical conditions). This problem is compounded when the concept ‘Depression’ is studied in a cross-cultural framework.
2.1.2 Validity across cultures

The term ‘depression’ is of western ethnopsychological origin. First popularised by Samuel Johnson in the 17th century (last chapter), it connotes a “general state of lowering of affairs”. Its pervasive use in psychiatry and indeed in teaching and practice of psychiatry in the non-western world has led to current assumption that it (depression) is some universal ‘natural’ (objective) entity that can be found across the world.

Debate on the cross-cultural validity of depression remains unresolved with current research dominated by two schools:

A. Research that assumes depression to be a universal psychiatric disease

If symptoms differ, that is because cultures modulate the expression of this disease. Systematic professional clinical evaluation using diagnostic research tools such as the Present State Examination can then unmask cultural factors (chiefly, cultural beliefs in non-western cultures) to lay bare its ubiquitous core biological features. This view is the more popular and officially legitimised one, and one that continues to guide international (epidemiological) research world wide.

B. Research that assumes each culture generates its own unique pattern of distress.

A growing body of evidence from within the ‘new cross cultural psychiatry’ framework (Kleinman 1987, Littlewood 1990) posits that each culture generates its own unique pattern of distress which may not overlap with another culture’s pattern of presentation. Little is known on how non-western cultures conceptualise an equivalent or overlapping concept of depression. Evidence so far suggest that
distressing patterns in non-western cultures do not correlate with western concepts of depression in their symptoms profile, for example: 'sinking heart' among Punjabis (Krause, 1989) and 'heart distress' among Iranians (Good, 1985). Nor do they bear a straight forward relationship with local concerns. Although such research has been gaining prominence, there is little data available that 'measures' or 'quantifies' local experience on its own terms.

These issues strike at the very basis of current psychiatric epidemiology and render cross-cultural epidemiological studies flawed. This review will therefore examine the epidemiology of depressive disorders across cultures within a restrictive framework. Studies reviewed in this section are in the true sense, 'cross-national' and not 'cross-cultural'. Methodologically sound research would be those studies that initially define local conditions that constitute and recognise a disorder in any given culture (i.e. caseness). Then they compare distribution of such disorders across groups defined by ethnic background, nationality, language, religion, degree of urbanisation and technological development, and the influence of local health care systems to measure 'rates' of a particular disorder, and follow this with attempts to explain differences (or similarities).

2.2 The review is divided into three parts:

2.2.1 Part I reviews cross-cultural studies on depression from the preceding three decades, i.e., between 1950 and 1980, and titled 'First generation of epidemiological studies'.
2.2.2 Part II reviews current epidemiological standardised research (post 1980s), that operationalise clinical concepts of depression as in the DSM III and later versions, and titled ‘Second generation of epidemiological studies’.

2.2.3 Part III outlines and amplifies “emerging methodologies based on the new cross-cultural psychiatric framework”. This part also discusses their potential in developing a culturally informed epidemiology of depressive disorders.

2.2.1 Part I: First generation of epidemiological studies (1950 to 1980)

Although there exist reports and studies on variations in depression across cultures, preceding the 1950s - such as Richard Blackmore’s proclamation on the rarity of the English Malady (spleen) among the indigenous populations of the tropics (1725), the absence of melancholia related diagnosis in the annual returns of many South Asian lunatic asylums of the 19th century, and Kraepelin’s observations of the absence of guilt and sinfulness in Java (1902) - subsequent post-war studies suggest that depressive disorders do exist in the ‘third world’ and that the rates seem to be increasing over time. What might be the reason for this sudden shift in Africa and Asia? Prince (1968) offered four reasons:

1. Depression was seldom discussed because it was more prestigious and believed to afflict only those who were “especially sensitive and intellectually aware...in the colonial era depressions should not be seen and named because Africans were not responsible; in the era of independence, depression should be seen because Africans are responsible and aware”. More recently, Nandy (1983) also argued that recognising melancholia among the native inhabitants of the colonies might have been tantamount
to acknowledging that Africans and Asians have more in common with Englishmen than the colonial assumptions would have permitted. If their “spleens” were English, who was to say that their hearts and minds were not as well? Consequently, acknowledging comparable rates and symptoms of the “English Malady” might have been tantamount to a threat to the colonial hierarchy. The prestige factor might have not only have predisposed post-colonial psychiatrists to diagnose depression more frequently, but it may also have left pre-independence colonial psychiatrists reluctant to make that diagnosis (Weiss, 1988).

2. The later identification of certain clinical presentations as ‘masked depression’, especially somatisation and neurasthenia, may have led to more frequent diagnoses of depression in the later period.

3. Patients and families may have viewed mental hospitals as inappropriate places to seek help for the kind of distress that would have been diagnosed there as depression. They were more likely to have taken to traditional healers unless too troublesome to remain in the community. Because of a selection bias against hospital based treatment for depression, psychiatrists (predominantly hospital based) may have underestimated rates of depression.

4. With Westernization and perhaps linked sociocultural processes, there may have been a ‘true’ increase in the rates for depression. Murphy (1982) argued that shifts from more mutually supportive social settings toward increased competitiveness in various societies accounted for an increased incidence of affective disorders. This view seems consistent with recent interpretation of findings in India attributing higher rates among nuclear rather than the allegedly more supportive joint families (Weiss, 1988).
The composite literature can be further sub-divided into two broad groups as proposed by Marsella (1980). The first (Group I) covers publication on depression as part of a larger review of cross-cultural psychological theory and the second (Group II) specifically addresses cross-cultural depression.

**Group I:** One of the first reviews conducted in Africa during the colonial period (Benedict and Jacks, 1954) concluded that “depressive states, in any form,...are relatively rare in the native populations studied”. Al-Issa (1970) and Kiev (1972), both present a small section on expression and prevalence of depression across cultures but omit detail discussion on differences in rates and prevalence (the latter author essentially endorses the rarity of depressive disorders in certain cultures). German (1972) reviewed depression in Africa as part of a general report on psychiatry in sub-Saharan Africa, and detailed some of the classic investigations conducted in Africa. However, the values of these reviews for elaborating cultural issues are limited. In most instances, the number of references cited is too limited to be of value for review purposes.

**Group II:** consists of major reviews by distinguished psychiatrists and social scientists. They include Prince (1968), Pfeiffer (1968), Silvermann (1968), Bagley (1973), Sartorius (1973), Fabrega (1974) and Singer (1975). Briefly, all refer to cultural factors as significant in depression but with dissimilar conclusions.

Empirical studies on local and preferred concepts of depression have broadly focussed on two issues: the presence or absence of conceptually equivalent words and on the
indigenous categories of depression. The former approach demonstrated the absence of depression-related concepts or dictionary translations of depression vocabulary through one or several methods, including interviews with subjects and showing their inability to correctly label cases of classic western depression, using word associations for the term 'depression' or its locally translated analogues, and demonstrating statistical correlation between different various emotional states (mainly anxiety and depression) and hence the lack of emotional differentiation. The latter approach, when studying indigenous categories in Malaysia, Borneo and Africa showed no local concepts that approximated to depression as either a disease symptom or syndrome. However, one major study (Murphy, 1982) needs to be singled out as it was an international survey of psychiatrists in which researchers from thirty countries were requested to report only on patients showing four classic signs of depression: depressed mood, diurnal mood variation, insomnia with early morning awakening, and loss of interest in environment. The researchers were then asked to evaluate these patients on twenty-three other symptoms. This study revealed nine countries, largely non-Western, in which this type of depression was infrequent. None of these studies took into account the implicit ethnocentric assumption when comparing other cultures’ concepts with their own. In the case of the international survey, the investigators beginning with prior notions of depression and channelling their observations into pre-set categories. As a result, most of them concluded that ‘depression’ as a term or concept was not well represented in non-western countries and then proceeded to explain these findings through then fashionable social evolutionary theories that posited non-western cultures at a primitive unsophisticated end of a linear continuum whilst western societies were at the more sophisticated end.
Tables 2-1 to 2-3 summarise point prevalence epidemiological studies of depression across the world, during the period 1950 to 1980 (Marsella (1980). Although they show dramatic variation in rates of depression, the following methodological problems make it difficult to discuss these variations:

a) rates of depression based on treated cases assume all individuals have the same access to treatment facilities and the same motivation to seek treatment.
b) problems with diagnostic reliability and the definitions of depression.
c) differences in degree of contact with the case.
d) case identification has been carried out by varied methods ranging from relatively untrained interviewers or key informants to trained psychiatrists using standard western instruments for identifying caseness.

Thus, there is no way to choose, based on these studies, a sub-group in which procedures that are more valid have been employed. But these results do offer us a source of hypotheses: Dohrenwend and Dohrenwend (1974) suggest that treated case figures are at best a source of hypotheses on cultural influences on affective disorder. Why do the percentage of patients with a diagnosis of affective disorders receiving treatment vary so greatly across cultures? Does this tell us something about the perceived status of depressed people within a culture? Does it offer clues into the patterning of depression across cultures? Or could this be resulting from culturally skewed diagnostic criteria?
Table 2-1: Community survey (Untreated) Point Prevalence Rates for Depressive Disorders (post 1950)

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Country</th>
<th>Population</th>
<th>Affective Psychosis</th>
<th>Neurotic Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eaton &amp; Weil (1955)</td>
<td>Canada &amp; USA</td>
<td>8542 Hutterites</td>
<td>0.9/1000</td>
<td></td>
</tr>
<tr>
<td>Soressen &amp; Strömgren (1961)</td>
<td>Denmark</td>
<td>6447 Danes</td>
<td>7.8/1000</td>
<td>26.5/1000</td>
</tr>
<tr>
<td>Böök (1953)</td>
<td>Sweden</td>
<td>8981 Swedes</td>
<td>0.2/1000</td>
<td></td>
</tr>
<tr>
<td>Essen-Möller (1956)</td>
<td>Sweden</td>
<td>2550 Swedes</td>
<td>2.0/1000</td>
<td></td>
</tr>
<tr>
<td>Helgason (1961)</td>
<td>Iceland</td>
<td>3843 Icelanders</td>
<td>10.4/1000</td>
<td>25.5/1000</td>
</tr>
<tr>
<td>Ivanys et al. (1964)</td>
<td>Czechoslovakia</td>
<td>66165 Czechs</td>
<td>1.5/1000</td>
<td></td>
</tr>
<tr>
<td>Fallers &amp; Fallers (1960)</td>
<td>Uganda</td>
<td></td>
<td>0.9/1000</td>
<td></td>
</tr>
<tr>
<td>Dube (1964)</td>
<td>India</td>
<td></td>
<td>2.7/1000</td>
<td></td>
</tr>
<tr>
<td>Sethi &amp; Gupta (1967)</td>
<td>India</td>
<td>300 Indian families</td>
<td>6.9/1000 urban</td>
<td></td>
</tr>
<tr>
<td>Sethi and Gupta (1972)</td>
<td>India</td>
<td>500 Indian families</td>
<td>1.5/1000 rural</td>
<td></td>
</tr>
<tr>
<td>Lin (1953)</td>
<td>P R China (Taiwan)</td>
<td>19931 Chinese/Taiwanese</td>
<td>0.7/1000</td>
<td></td>
</tr>
<tr>
<td>Rin &amp; Lin (1962)</td>
<td>P R China (Taiwan)</td>
<td>11442 Taiwanese</td>
<td>0.3/1000</td>
<td></td>
</tr>
<tr>
<td>Lin et al. (1969)</td>
<td>P R China (T)</td>
<td>29184 Chinese/Taiwanese</td>
<td>0.5/1000</td>
<td></td>
</tr>
<tr>
<td>Yoo (1961)</td>
<td>Korea</td>
<td>11974 Koreans</td>
<td>0.3/1000</td>
<td></td>
</tr>
<tr>
<td>Kato (1969)</td>
<td>Japan</td>
<td>23993 Japanese</td>
<td>0.2/1000 (1954 study)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>44092 Japanese</td>
<td>0.2/1000 (1963 study)</td>
<td></td>
</tr>
<tr>
<td>Jones &amp; Horne (1973)</td>
<td>Australia</td>
<td>2360 Aboriginals</td>
<td>1 case</td>
<td>1 case</td>
</tr>
</tbody>
</table>

Table 2-2: Clinic and Hospital Admission (Treated) Prevalence Rates for Depressive Disorders

NORTH AMERICA, CANADA & EUROPE

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Country</th>
<th>Population</th>
<th>Affective Psychosis</th>
<th>Neurotic Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schoenfeld &amp; Miller (1973)</td>
<td>USA (Southwest)</td>
<td>348 Indians</td>
<td>0.6%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Malzberg (1965)</td>
<td>USA</td>
<td>6427 Blacks</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>40221 Whites</td>
<td>2.7%</td>
<td></td>
</tr>
<tr>
<td>Vitols (1967)</td>
<td>USA</td>
<td>7 Blacks</td>
<td>2.3% Psychotic Depression</td>
<td></td>
</tr>
<tr>
<td>Hellon (1970)</td>
<td>Canada</td>
<td>168 Indians</td>
<td>4.8%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>119 Métis</td>
<td>2.3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>25 Eskimos</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Kelly et al. (1970)</td>
<td>Canada</td>
<td>337 English</td>
<td>6.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>314 French</td>
<td>4.7%</td>
<td></td>
</tr>
<tr>
<td>Terminsen &amp; Ryan (1970)</td>
<td>Canada</td>
<td>320 American Indians</td>
<td>3.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Cooper et al. (1969)</td>
<td>UK and USA</td>
<td>145 Englishmen</td>
<td>16.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>145 Americans</td>
<td>46.2%</td>
<td></td>
</tr>
<tr>
<td>Saenger (1968)</td>
<td>Netherlands &amp; USA</td>
<td>300 Dutch (Out-pt)</td>
<td>24.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>534 Americans (Out-pt)</td>
<td>53.0%</td>
<td></td>
</tr>
<tr>
<td>Rose (1964)</td>
<td>Italy</td>
<td>4965 Italians</td>
<td>31.0%</td>
<td></td>
</tr>
<tr>
<td>Hadlik &amp; Bojanovsky (1967)</td>
<td>Czechoslovakia</td>
<td>6722 Czechs</td>
<td>12.3% Primary Depression</td>
<td></td>
</tr>
<tr>
<td>Hes (1960)</td>
<td>Israel</td>
<td>2684 Israelis</td>
<td>3.7% Mainly European Jews</td>
<td></td>
</tr>
</tbody>
</table>
Table 2-3: Clinic and Hospital Admission (Treated) Prevalence Rates for Depressive Disorders

AFRICA, ASIA & FAR EAST

<table>
<thead>
<tr>
<th>Investigator</th>
<th>Country</th>
<th>Population</th>
<th>Affective Psychosis</th>
<th>Neurotic Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carothers (1953)</td>
<td>Kenya</td>
<td>160 Blacks</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>222 Whites</td>
<td>22.0%</td>
<td></td>
</tr>
<tr>
<td>Elsarrag (1968)</td>
<td>Northern Sudan</td>
<td>2160 Sudanese</td>
<td>6.0% Depression</td>
<td></td>
</tr>
<tr>
<td>Okasha, Kamel, &amp; Hassan (1968)</td>
<td>Egypt</td>
<td>1000 Egyptians</td>
<td>13.2%</td>
<td></td>
</tr>
<tr>
<td>Collomb &amp; Zwingelstein (1961)</td>
<td>Senegal</td>
<td>1600 Senegalese</td>
<td>6.3%</td>
<td></td>
</tr>
<tr>
<td>Earle &amp; Earle (1956)</td>
<td>British Guyana</td>
<td>259 Mixed Ethnic</td>
<td>7.0% Depression</td>
<td></td>
</tr>
<tr>
<td>Sathyavathy &amp; Sundararaj (1964)</td>
<td>India</td>
<td>445 Indians (Out-patient)</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Surya et al. (1964)</td>
<td>India</td>
<td>2731 Indians</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Teja &amp; Narang (1970)</td>
<td>India</td>
<td>1180 Indians</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>Sethi &amp; Gupta (1972)</td>
<td>India</td>
<td>1120 Indians (Private)</td>
<td>34.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>1000 Indians (Hospital)</td>
<td>18.1%</td>
<td></td>
</tr>
<tr>
<td>Bagadia et al. (1973)</td>
<td>India</td>
<td>2678 Indians</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>Lapuz (1972)</td>
<td>Philippines</td>
<td>419 Filipinos</td>
<td></td>
<td>13.1%</td>
</tr>
<tr>
<td>Singer (1975)</td>
<td>Hong Kong</td>
<td>? Chinese</td>
<td>7.0%</td>
<td></td>
</tr>
<tr>
<td>Taipale &amp; Taipale (1973)</td>
<td>P R China</td>
<td>? Chinese</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Sainsbury (1974)</td>
<td>P R China</td>
<td>? Chinese</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Kato (1969)</td>
<td>Japan</td>
<td>9066 Japanese</td>
<td>3.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13.4% Depression (1970)</td>
</tr>
</tbody>
</table>
Clinical studies: Clinical observation studies by reviewers before 1980 summarised the literature on the manifestation of depression across cultures. Broadly they offered one or several of the following contradicting conclusions:

1) Depression is rarer in non-western settings.

2) There is less guilt, motor retardation, self-depreciation and suicide in non-western societies, and many patients did not display depressive affect or are considered more capable of tolerating depressive phenomena.

3) Somatic symptoms including hypochondriasis are commoner in non-western settings.

4) A core depressive cluster that cuts through cultures includes sleep, libido, appetite dysfunctions and abnormal bodily sensations.

5) ‘Shame’ as opposed to ‘guilt’ is more common in non-western settings. Guilt when present was considerable more “impersonal than guilt among western patients, since the latter are likely to assume more personal responsibility for failure” (Marsella, 1980)

6) Westernised and affluent subjects from developing countries develop forms of depression more similar to depression in the west.

7) Difficulties in distinguishing ‘endogenous’ from ‘neurotic’ types in view of the local rarity of many of the symptoms that distinguish the two sub-types.

8) ‘Depressive equivalents’ in non-western cultures that are unique in pattern and form. Their uniqueness is intimately linked to cultural factors, specifically to beliefs about sickness or conflicts within the culture.
2.2.2 Part H: Second generation of epidemiological studies (post 1980s)

The impetus for a systematic study of depression - one that uses specified diagnostic criteria with standardised methods for assessment came about in the late 1970s in the US following President Carter’s Commission on Mental Health. This commission requested data on the magnitude of psychiatric illness in the community for planning mental health programmes. This led to the first study using the Diagnostic Interview Schedule to collect data on rates, risk factors and treatment patterns of major mental illness in the community. Based on over 18000 persons living in five US communities, it forms the basis of our current understanding of the epidemiology of major psychiatric disorders, depression included. Parallel developments were undertaken in different parts of the world including the UK. Table 2-4, 2-5 and 2-6 summarise lifetime prevalence rates per 100 in adults aged 18 and above in seven countries and include the Epidemiological Catchment Area (ECA) study rates. Significant findings include:

a) Prevalence of Bipolar Disorders in western nations (except Edmonton, Canada) was significantly higher compared to non-western societies, with no gender differences.

b) Major Depression was more prevalent in ‘westernised’ societies, in women and in urban rather than rural areas. Continuously married and never married people had the lowest rate and divorced people the highest.

c) Dysthymia was less prevalent than major depression with rates being about twice as high in females than in males. Variations across race, marital status and urban - rural backgrounds were similar to Major Depression. However, unlike the latter, there was a significant inverse relationship with income especially in younger persons, and, unlike
Major Depression or Bipolar Disorder, rates of Dysthymia begin to decrease around age 45.

d) Several temporal changes in rates of Major Depression. These include:

1. increase in rates of cohorts born after 1940
2. decrease in age of onset, with an increase in teenage and early adult years.
3. increase in rates for cohorts born between 1960 and 1970 with increased rates of depression for all ages, but particularly among younger age groups in that period.
4. persistent gender effect: rates two to three times higher among women than in men.
5. persistent family effect with risk of Major Depression two to three times higher in first-degree relatives of depressed patients as compared with controls.

Explanations put forward exclude genetic interpretations, as genes are considered unlikely to change in a relatively short time. Environmental factors suggested were those that evoke changes in ratio of males to females: increased urbanisation, greater geographic mobility and consequent loss of interpersonal attachments, alterations in the role of women (especially the increased number of women in the labour force), and shifts in occupational status (Kaplan and Saddock 1995).
### TABLE 2-4 (Source: Weissman and Klerman, 1992)

Lifetime prevalence rates/100 in adults aged 18+ for **Bipolar disorder**, **Major depression**, and **Dysthymia**, based on community surveys using DIS and DSM-III diagnosis

<table>
<thead>
<tr>
<th>SITE</th>
<th>YEAR</th>
<th>N</th>
<th>BIPOLAR</th>
<th>MAJOR DEPRESSION</th>
<th>DYSTHYMIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA-ECA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1980-83</td>
<td>18572</td>
<td>1.2</td>
<td>4.4</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>New Haven</td>
<td>1980</td>
<td>5034</td>
<td>1.6</td>
<td>5.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Baltimore</td>
<td>1981</td>
<td>3481</td>
<td>1.2</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.1</td>
</tr>
<tr>
<td></td>
<td>St. Louis</td>
<td>1981</td>
<td>3004</td>
<td>1.6</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>Durham</td>
<td>1982</td>
<td>3921</td>
<td>0.7</td>
<td>3.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>Los Angeles</td>
<td>1983</td>
<td>3132</td>
<td>1.1</td>
<td>5.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4.2</td>
</tr>
<tr>
<td>EDMONTON</td>
<td>1983</td>
<td>3258</td>
<td>0.6</td>
<td>8.6</td>
<td>3.7</td>
</tr>
<tr>
<td>PUERTO RICO</td>
<td>1984</td>
<td>1551</td>
<td>0.5</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>FLORENCE</td>
<td>1985</td>
<td>1000</td>
<td>1.3</td>
<td>6.2</td>
<td>2.6</td>
</tr>
<tr>
<td>SEOUL</td>
<td>1984</td>
<td>5100</td>
<td>0.4</td>
<td>3.4</td>
<td>2.2</td>
</tr>
<tr>
<td>TAIWAN</td>
<td>1982</td>
<td>11004</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>5005</td>
<td>0.16</td>
<td>0.9</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>Small Towns</td>
<td>3004</td>
<td>0.07</td>
<td>1.7</td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td>Rural Area</td>
<td>2995</td>
<td>0.10</td>
<td>1.0</td>
<td>0.9</td>
</tr>
<tr>
<td>NEW ZEALAND</td>
<td>1986</td>
<td>1498</td>
<td></td>
<td>12.6</td>
<td></td>
</tr>
</tbody>
</table>

43
Lifetime prevalence of Mood Disorders by Age & Sex


Table 2-5
### Table 2-6: Life time prevalence of some DSM IV Mood Disorders: NORTH AMERICA & EUROPE (Source: DSM IV, ed. 4. 1994)

<table>
<thead>
<tr>
<th>MOOD DISORDERS</th>
<th>LIFE TIME PREVALENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. DEPRESSIVE DISORDERS</strong></td>
<td></td>
</tr>
<tr>
<td>• Major Depressive Disorders (MDD)</td>
<td>10-25% women, 5-12% men</td>
</tr>
<tr>
<td>\hspace{2em} Recurrent with full inter-episode recovery, superimposed on dysthymic disorder</td>
<td>Approx. 3% of persons with MDD</td>
</tr>
<tr>
<td>\hspace{2em} Recurrent without full inter-episode recovery, superimposed on dysthymic disorder</td>
<td>Approx. 25% of persons with MDD</td>
</tr>
<tr>
<td>• Dysthymic Disorder</td>
<td>Approx. 6%</td>
</tr>
<tr>
<td><strong>2. BIPOLAR DISORDERS</strong></td>
<td></td>
</tr>
<tr>
<td>• Bipolar I disorder</td>
<td>0.4 - 1.6%</td>
</tr>
<tr>
<td>• Bipolar II disorder</td>
<td>Approx. 0.5%</td>
</tr>
<tr>
<td>• Bipolar I or II with rapid cycling</td>
<td>5 - 15% of persons with bipolar disorder</td>
</tr>
<tr>
<td>• Cyclothymic disorder</td>
<td>0.4 - 1.0%</td>
</tr>
</tbody>
</table>
These studies were designed and built upon an axiom discussed earlier in this chapter: depression is an objective independent culture-free disorder that can be operationalised and measured with the help of systematic diagnostic instruments. Such studies therefore did not tease out cultural epidemiological factors nor were they designed to do so. Further, there is little data available from countries other than the seven listed in Table 2-4 (US, UK, Canada, Italy, Korea, Taiwan, and New Zealand) where identical methods have been used. Finally, controversies over the independent status of Dysthymia and its overlap with Major Depression, Personality traits and Depressive symptoms not meeting criteria for Dysthymia or Major Depression, preclude further discussion on the role of cultural factors that might influence rates and prevalence of Depressive disorders. In the absence of more epidemiological data and findings from yet unpublished DIS based community studies in other countries, it is premature to comment on cultural variations of rates and prevalence.

The only other major international study on depressive disorders was carried out by the WHO in 1972 and published in 1983 with a 10 year follow up reported in 1993. Major objectives of this study were (a) development and use of simple reliable and valid instruments for assessment of depressive states in different cultures, and (b) to use these instruments to obtain descriptions in form of depression in different cultures. Data was collected from psychiatric centres in Montreal, Tehran, Basel, Nagasaki, and Tokyo by trained psychiatrists. Unfortunately, the principal researchers de-emphasised cultural variation because it seemed too complex to consider at the outset, even though numerous centre (or cultural) differences are to be found in the tables summarising their research findings in 1983 and in their follow up report. Symptoms
found in 76% - 100% of depressed patients at each centre included sadness, 'joylessness', anxiety, tension, lack of energy, decreased interest and concentration, inadequacy, and worthlessness. One third had hypochondriacal ideas and pre-occupations, and 40% had 'other' symptoms, including somatic complaints, obsessions, phobic symptoms etc. Suicidal ideas were reported in 70% of the Canadian sample but only 40% of the Japanese sample; somatization was reported in 57% of the Iranian sample but in only 27% of the Canadian sample. More personality abnormalities were detected in Basel and Montreal, that is, Western centres where personality disorder may not fit with Western diagnostic categories as well. Although psychomotor agitation was more frequent in Tehran, and symptoms of guilt and self-reproach were higher in Europe - 68% in Basel and 32% in Tehran-researchers found the absence of more centre-specific symptoms to be even more remarkable (Sartorius, 1980, Thornicroft, 1993).

2.2.3 Part III: Emerging methodologies and the new cross cultural psychiatry

It is apparent that there are several fundamental problems in universalising the concept of depression:

A) Mind - Body dichotomy: A salient feature of diagnostic criteria of mood disorders is a distinction between mind and body. Criteria that reflect physical features of depression are relatively easy to ascertain across cultures, though their elicitation poses challenges which until recently were assumed to be non-problematic.
B) Problems in determining the presence of psychological symptoms (especially dysphoria), as defined by western experience: There is continuing debate on the universality of dysphoria as a cross-culturally valid emotion. To the extent that this emotion is shared by diverse cultural groups lends support to a universal human experience (Ekman 1982, Izard 1977, Wierzbicka 1986); whilst others argue that dysphoria are essentially cultural artifacts (Geertz 1973, Rosaldo 1984), or those that compromise the two schools such as Myers (1984) who suggests it “plausible that culture to some degree [my italics] organises the stimulus, manifestation and interpretation of emotions like dysphoria”. Numerous researchers now suggest that key elements to understand this variation involves definitions of selfhood, indigenous categories of emotions, emphasis on particular aspects of emotional life, patterning of relationships among emotions, precipitating social situations and ethnopsychological accounts of bodily experience of emotions (Jenkins 1985, Kleinman and Good 1985, Gaines 1993). More recently, cross-cultural researchers have specifically shown how cultural notions of self and loci of emotion (egocentric and sociocentric: Shweder and Bourne 1984), variations in the affect lexicon (ethnosemantic network: Good 1992), selective elaboration and encouragement or discouragement of emotional experiences by cultural factors (such as anger: Jenkins 1990, Good 1982), assignment of unique attributions to intensity of both experience and expression of emotions (Kinzie, Geertz 1973 and Chagnon 1977) render the notion of depression as a unidimensional, linear, additive and universal emotion problematic.
Sartorius (1975) and Marsella (1978) suggest that future cross-cultural epidemiological studies follow a four step procedure:

Step 1: Consider relevant anthropological and ethnographic literature before designing the study

Step 2: Develop glossaries and operational definitions for symptoms and diagnostic categories to be studied

Step 3: Use multivariate analytic techniques such as factor analysis to derive symptom patterns rather than relying exclusively on apriori diagnostic categories

Step 4: Use similar research methods in cross-cultural studies

Such a prescription seems formidable to operationalise and there seems to be no simple way to resolve this issue. Over two decades ago, a group of influential researchers suggested that

"cultural differences in modes of expressing distress are interesting in their own right. They also pose serious measurement difficulties when the research problem is to compare groups that differ in social and cultural background - a methodological problem that has received very little systematic attention. Our own efforts to deal with this problem of valid cross-group comparison yielded a strategy so complex that it is reminiscent of a Rube Goldberg. Perhaps as more attention is focussed
on this issue a simpler solution will develop” (Dohrenwend and Dohrenwend, 1974)

Although this predicted ‘simpler solution’ has yet to emerge, the following chapter will detail methods that have potential to clarify cultural differences in some depth.
CHAPTER THREE

METHODS FOR THE STUDY OF FOLK MODELS OF MENTAL ILLNESS

A certain Chinese encyclopaedia states that animals are divided into: a) belonging to the Emperor, b) embalmed, c) tame, d) sucking pigs, e) sirens, f) fabulous, g) stray dogs, h) included in the present classification, i) frenzied, j) innumerable, k) drawn with a very fine camelhair brush, l) et cetera, m) having just broken the water pitcher, n) that from a long way off look like flies.

In the wonderment of this taxonomy, the thing we apprehend in one great leap, the thing that, by means of the fable, is demonstrated as the exotic charm of another system of thought, is the limitation of our own, the stark impossibility of thinking that.

Jorge Luis Borges
Cited in Foucault, M (1966, page xv)

3.0 Introduction

The organisation of knowledge in any society takes place through an ordering and classification that reflects the cardinal ways in which ‘reality’, is structured, perceived and generated. Such organised bodies of knowledge are embedded within the culture and have a reflexive relationship with the prevailing social institutions that produce and sustain it. What has been termed ‘ethnoscience’ concerns itself with such local or folk epistemology. This chapter deals with ways of studying a particular aspect of this organised body of cultural knowledge: its ordering and classification with specific reference to sickness and in particular, mental illness. Studying folk notions of ‘sickness’- a locally perceived intrusive disruption of the body, the person and the community which requires explanation and correction leads to folk explanations as a basis for interpreting or making sense of that experience. Professional study of such explanations attempt at ‘discovering’ underlying conceptual models which are tied in with cultural understanding of personhood and social behaviour, and thereby facilitate a better appreciation of a wider folk epistemology within that culture.
Table 3.1

MAJOR APPROACHES FOR THE STUDY OF FOLK MODELS

<table>
<thead>
<tr>
<th>PSYCHOLOGICALLY ALIGNED COGNITIVE APPROACH</th>
<th>ANTHROPOLOGICALLY ALIGNED SYMBOLIC APPROACH</th>
<th>INTEGRATED APPROACH EMIC &amp; ETIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attitudinal</td>
<td>• Propositional</td>
<td>• The EMIC</td>
</tr>
<tr>
<td>• Lay Models</td>
<td>• Narrative</td>
<td></td>
</tr>
<tr>
<td>• Health Beliefs</td>
<td>• Grounded Theory</td>
<td></td>
</tr>
<tr>
<td>• Illness Representation</td>
<td>• Ethnographic</td>
<td></td>
</tr>
<tr>
<td>• Categorical</td>
<td>• Semantic Network</td>
<td></td>
</tr>
<tr>
<td>• Prototypical</td>
<td>• Inferential</td>
<td></td>
</tr>
</tbody>
</table>

3.1 Major approaches for the study of folk models

Two broad approaches to the study of cultural knowledge about illness and the natural world, have been described: the symbolic and the cognitive (White, 1982) and illustrated in Table 3.1

3.1.1 Cognitive - Psychological approach

The cognitive method, closely allied to psychology, and usually termed simply ‘ethnoscience’ involves the use of formal methods to “systematically explore the
organisation of abstract conceptual models that structure cultural understandings about illness - frequently by eliciting individual judgements about meanings of indigenous terms and their appropriate use in describing illness” (White, 1982). Cognitive research posits that it is the personal and social implication of illness, rather than its diagnostic features that comprise cultural knowledge about a specific illness.

The emphasis is on what people say when asked about illness terms, and the approach emphasises the eliciting of ‘internal’ mental models - that are assumed to guide their actions.

3.1.2 Symbolic - Anthropological approach

The symbolic or interpretative approach, closely allied to anthropology, focuses on actual or reported illness episodes and recorded common-sense interpretations of illness as expressed and negotiated in actual social situations. Here there is an indirect attempt to distill symbolic representations of cultural beliefs through behavioural and social observations. This approach, associated with ‘hermeneutic analysis’, assumes that texts and natural discourse express multiple overlapping meanings and social contexts determine the expression and acceptance of illness interpretations. The emphasis is on what people actually do when ill and the approach focuses on relationships as they are constructed with the outside world.

Some (Geertz 1973), place these two styles of research in opposition, others argue that they are overlapping and complimentary (White, 1982). The former (psychological-cognitive) represents inferences derived from abstract conceptual models and the latter
(anthropological-symbolic) attempts to situate explanations within a live cultural context and demonstrate how and why certain meanings are selected over others. Both approaches have their limitations: cognitive methods yield hard data, can be empirically validated and statistically analysed but do not capture ‘thick’ cultural descriptions nor do they explain or successfully predict why certain decisions about illness actually occur. Symbolic methods on the other hand report rich contextualised description of illness episodes and live narratives from field work, and are more qualitative, but limited in specifying how illness models are constructed or could be empirically validated. White (1982) cautions against concern with “semantic and cognitive structures”, as these are “but one piece of a larger picture, where “discourse about illness are also influenced by a great many contextual variables, including the nature of social institutions, the relationship among interactants and rules of verbal and non-verbal communication”.

3.2 Folk Models of Mental Disorder

Most psychiatric studies have attempted to indirectly assess folk models by conducting or examining comparative epidemiological research that have generally relied on fixed standardised elicitation technique. Here, cultural beliefs about psychiatric disorders are derived by interpreting variations in epidemiological data and using factor analysis to explore the interrelation of psychiatric constructs (White, 1982: IPSS). This research, confusing the variation in the disorder across cultures with differences in the interpretations of questions on symptom checklists, has been criticised by anthropologists (Kleinman, 1987) as a “category error” through “data attenuation” (Marsella, 1980). Moreover, the use of prestructured questionnaires standardised in the West may not be relevant to indigenous interpretations of symptomatology although some have attempted to incorporate culture
specific constructs in their inventories (Beiser, 1976). A similar criticism (Littlewood and Jadhav, 1992; Jadhav and Littlewood, 1994) is applicable to a range of “Attitude studies” and “Lay model” research (Furnham, 1988; Rippiere, 1981; and Weinman et al., 1996) that will be now be examined in more detail.

3.3 Folk Models: Psychologically Aligned Approaches

3.3.1 Attitudinal, Lay Models, Health Beliefs and Illness Representation approaches

Over the past few decades, mental health professionals, chiefly psychologists have documented a range of approaches that empirically measure and quantify beliefs and attitudes of psychiatric and medical illnesses. They include a range of Attitude Questionnaires (Bhugra, 1990) and more formal theoretically overlapping approaches to elicit illness beliefs such as the “Health Belief Model” (Rosenstock and Becker, 1988), “Lay Models” (Furnham, 1988) and more recently, “Cognitive Representation” of Illness (Illness Perception Questionnaire, Weinman et al., 1996).

Such approaches owe their popularity to the ease with which large data set can be generated within a relatively short time and on a low budget. A recent example is the Royal College of Psychiatrist’s Defeat Depression Campaign (1992). In order to understand how ‘depression’ is popularly conceived, a MORI telephone poll was conducted to elicit Likert style responses towards a checklist of discreet propositions that were centered around the word ‘depression’. Responses elicited were then taken to be subject’s concepts about depression, not a function of the proposition which was framed in a manner understood by psychiatrists. Further, statistically analysed responses towards ‘depression’ and its treatment were then considered evidence to justify the
launch of a major national educational programme to help the public re-label their experiences (which were not elicited in full to know whether it connoted an everyday experience, a symptom or a syndrome) as a disorder for which suitable treatment facilities and interventions were made available, largely through training GPs in the detection of this disorder. Such an approach does not capture the full complexity of folk models on depression: its conceptualisation, ideas and actions, involving nomenclature, causation, agency, recognition and recourse to treatment (Jadhav and Littlewood, 1994).

These approaches have largely focused on static and discreet units of analysis, in the form of set propositions to which respondents are rated as Yes/ No, or Likert scales that allow for a degree of agreement or disagreement. Apart from multivariate analysis, there is little scope to examine the complex network of relationships between individual attitude items, particularly since these individual propositions are themselves dynamic and influenced by a variety of social and moral forces. A related method, that of using standardised vignettes, is flawed by similar difficulties. Moreover, the attitudinal sets elicited from both the above methods are actually responses to decontextualised statements or accounts having little resemblance to live social situations, particularly when viewed in the context of a significant discrepancy between reported attitudes and observed behaviour. Taken together, these approaches also offer little to assess the stability of ideas or concepts over time, and across cultures.
3.3.2 Categorical approach

This approach attempts to discover the structure of indigenous illness categories by analysing the meaning of a disease terminology. Frake's (1961) study on the “diagnosis of disease” among the Subanum was one of the first significant attempts to provide a systematic account of folk medical knowledge based on linguistic data. For example, the degree of penetration differentiated Subanum categories for different types of ulcers. This approach is based on the view that the ‘disease world’, like the ‘plant world’, is exhaustively divided into a set of mutually exclusive categories, therefore illness either fits into one category or overlaps with several categories. However recent research in cognitive anthropology clarifies folk categorisation as generally neither discreet nor exclusive. Unlike classical set theory, which requires that any given object either is or is not a member of a given category, the categories of ordinary language admit degrees of membership. One type of object or folk category may be a ‘prototype’ of a certain category whilst other members of that category may be “sort of” like that category. For example, sadness may be a good example or prototype of a certain category “depression”, while other members of that category e.g. ‘low self-esteem’ may only be a sort of ‘like that’ category.

3.3.3 Prototypical approach

An extension of the ‘categorical method’; in this approach, basic categorical structures are analysed in terms of relations of contrast and inclusion, although these relations may be fuzzy rather than discreet. Psychological research applying this approach (Tversky 1977, Szolovits and Pauker 1978) reveals differences in judgements about degrees of membership of a higher order category that are highly predictable, and based on the extent of overlapping or intersecting semantic features. Such fuzzy sets or ‘prototypes’ provide a
more refined and better way of representing folk knowledge as compared to the ‘categorical’ approach. One of the appeals of this taxonomic model is its ability in describing a conceptual structure in terms of subset-superset relations. Taxonomic relations also provide an economical way of organising, storing and retrieving complex knowledge from memory, which people use to talk about and discriminate a large variety of illnesses. Consequently, this has been a persuasive model in ethnographic accounts of disease concepts. However, D’Andrade (1976), who himself used this method describes its shortcomings which include the cross-cutting, non-exhaustive and shallow nature of categories that did not fit into a neat taxonomy. Also, informant’s responses tended to be idiosyncratic and individuals frequently changed their responses from one session to another. D’Andrade (1976) suggests that responses forming the core of different belief clusters or categories are consequences and preconditions of the illness rather than features that define them. This also highlights more a difference between the informant’s and ethnographer’s notion of definition rather than an inherent problem with the taxonomic model approach. Sontag (1978) provides an example from research on American concepts about tuberculosis, where her informants had knowledge about contagion and seriousness but little understanding of the bacterial pathogen that biomedically distinguishes it from other infections.

3.4 Anthropologically Aligned Approaches

3.4.1 Propositional approach

This approach simply indicates the extension and expansion of an ethnolinguistic model to include the socio-cultural meanings of illness concepts. Rather than specifying words and terms that designate categories, ethnographers include whatever salient
propositions their informants state about illnesses; and then examine the way in which such cognitive structures interrelate to form coherent systems of cultural knowledge.

Good (1977) has developed this notion further to construct “semantic illness networks” that describe interconnected propositions specifically associated with key illness categories and will be discussed under its own heading (‘Semantic Network’) later in this section. However, unlike Good, whose models were derived from actual case studies of illnesses, others have directly elicited informants’ judgements over salient propositions associated with specific types of illnesses. This has been achieved by deriving sets of statements regarded as culturally relevant attributes of illness, and then mapped onto various types of illness, by asking a sample of informants to judge which propositions are characteristic of which illness. This produces a matrix as illustrated in Figure 3.2.

When informants are interviewed, the same becomes a data matrix that can be used to analyse:

a) the relationship of propositions to illness categories

b) the relationship among propositions

c) the relationship between different types of illness categories

The extent to which any two propositions are predicative of the same illness provide a measure of implicit similarity between them. This can be derived by an analysis of two by two tables, as illustrated in Figure 3.3.
FIGURE 3.2

PROPOSITIONAL APPROACH

<table>
<thead>
<tr>
<th>CULTURAL PROPOSITIONS</th>
<th>ILLNESS CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DEPRESSION</td>
</tr>
<tr>
<td>Caused by stress</td>
<td>yes</td>
</tr>
<tr>
<td>Makes you tense</td>
<td>no</td>
</tr>
<tr>
<td>Cured by going out</td>
<td>yes</td>
</tr>
<tr>
<td>Lead to loss of job</td>
<td>no</td>
</tr>
</tbody>
</table>

FIGURE 3.3

ILLNESSES IDENTIFIED FOR TWO PROPOSITIONS

<table>
<thead>
<tr>
<th>PROPOSITIONS</th>
<th>MAKES YOU TENSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>YES</td>
</tr>
<tr>
<td>LEAD TO LOSS OF JOB</td>
<td>Anxiety</td>
</tr>
</tbody>
</table>
The similarities and differences between the propositions provide folk categories about the illnesses, and each box in Figure 3.2 can then provide a measure that could be represented in visual models with multivariate techniques, such as hierarchical clustering and multidimensional scaling.

Such a visual model can:

a) reveal clusters or group propositions that are separated in terms of represented distance in graphic space (D’Andrade 1976, Clement 1974, Young 1976, Eisenbruch 1990).

b) produce a map of salient attributes with illness types (Eisenbruch, 1990)

c) provide information about the cultural distribution of folk knowledge in a given population (Clement 1974)

d) Examine specific hypotheses such as the degree to which medical knowledge overlaps or is shared by healers and lay persons (Fabrega 1977, Young 1976), through quantitative analysis of the distribution of cultural knowledge about a set of illnesses.

The advantage of this method is its ability to lend itself for standardised comparative research within and across cultures. However, it is constrained by the use of fixed sets of illness categories and proposition frames especially when obtained from only a few informants and the consequent exclusion of social and contextual variables which influence everyday thinking. Critics of the propositional model argue that any model of conceptual organisation of illness categories will be a product of the particular items that are chosen and would change in unforeseen ways by the deletion or addition of
further items or propositions. Studies that have taken an open ended approach, asking informants for synonyms or word associations to illness terms demonstrate this by showing the wide variety of potential propositions which may be obtained (Micklin et al 1974, Tanaka-Matsumi and Marsella 1976), although it is possible that post-hoc categorisation of responses could resolve this difficulty to some extent.

Clement (1974) highlights yet another serious difficulty: that of situational skewing, where respondents are influenced by the ethnographer’s background. Thus, Samoans in their study avoided referring to possession by spirits, when discussing explanations of mental disorder, as they considered it an unacceptable explanation for Europeans. When such survey type questions were replaced by extended case studies and multiple other causes were included, respondents also attributed causation to the weather in addition to a general proliferation of responses. Thus, data collected on such propositional models is influenced by the nature of the questions asked, the extent to which attributions are referred to in the proposition set, as well as the background and nature of the relationship and attitude between ethnographer and the respondent.

Summarising the problem, Frake (1977) suggest this approach tends to treat “questions and responses as chunks of verbiage isolated from their settings and speakers which then omits significant information about the social context that influences everyday thinking about illness”.

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3.4.2 Narrative approach

This approach is derived from the field of literary studies, mainly the biographical novel, literary realism and realist fiction (Atkinson, 1990 & 1992; Cappetti, 1993). A genre of authoritative reportage, and a stylistic literary device, such realist writing is familiar in the construction of factual authoritative accounts in which the dominant mode of representation involves an impersonal, all but invisible narrator as impartial author (Coffrey et al, 1996). Typically, this approach involves representing “accounts of health and illness (that) are embedded in life stories, or stories whose purpose is to find a biographical, metaphysical and in some cases a socio-historical meaning” (Skultans, 1995). However, third person accounts of illness histories are vulnerable to distortion to suit the (transformed) language and power of the narrator, which raise issues of authorship and control. Narrative approach therefore involves an active and constant awareness about construction of co-authorship of a text that can be successful in ‘giving a voice’ and retaining fidelity to the original.

Examples of narrative approach include Gareth Williams (1984) and Michael Bury’s (1982) narration of chronic illness and the ways in which they compensate for a disruptive biography; Paul Farmer’s ethnography which shows the ways through which narratives give birth to new cultural representations (Farmer, 1992) and Good’s attempt to borrow literary theory in order to reveal the richness of narrative content (Good, 1993).

3.4.3 Grounded Theory approach

This is synonymous with ethnographic approach that follows later. The difference between grounded and ethnographic is merely a reflection of the disciplines that came up with
concepts that were essentially similar. ‘Grounded theory’ (Glaser and Strauss 1967) is a term coined by sociologists as opposed to ‘ethnographic’ coined by anthropologists, to refer to a procedure that involves starting from a bottom up perspective using a qualitative approach and allowing for theory to develop (or be ‘grounded’) within or from emerging data. The proponents of this approach at the time took no note of its applicability to medical practice. They did however suggest that grounded theory was tested by four criteria: its fitness and adequacy in explaining all the data, its acceptability as an explanation to the people studied, its generalisability to other instances, and its usefulness for application and change. In summarising their approach, Hunter (1991) suggests that the method “relies upon the investigator as the principal research instrument and employs a constant comparative method of analysis in which all statements, explanations, and views of phenomena are regarded as data themselves”.

3.4.4 Ethnographic in-depth approaches

Ethnographic in-depth studies of psychiatric disorders tend to present rich descriptions of specific cases or illness episodes with little comparative significance; are therefore difficult to replicate or apply elsewhere, are derived from interviews organised according to the interest of the researcher and hence neither easily testable nor replicable.

Three major published ethnographies illustrate this approach. In all three, the researchers have lived for extended periods within the culture or community studied, and adopted a participant-observation method to describe the local culture in an exhaustive manner, taking into account political economy, kinship systems, religion,
occupation, gender and linguistic issues together with an analysis of local health care institutions and its impact on the lived experience of the sickness:

1. Margaret Field studied rural Ghanaians in the 1950s (Field 1960). She outlined in detail their beliefs on spirits and how these relate to western psychiatric disorders such as Schizophrenia, Affective Disorders and Neuroses. Although this work is dated, it is considered a classic and has never been replicated nor extended in the subsequent three decades. However, her case histories are written in a dry and universalising style thus limiting scope for a fuller understanding of the relationship between local meanings and psychiatric disorders.

2. Vieda Skultan studied women attending a Manubhava temple in Pune district, Maharashtra State, India in the early 1980s (Skultans 1991). Interviewing and understanding ‘healthy’ women who got ‘possessed’ whilst attending the Manubhava shrine, she teased out the relationship between these women, who ‘took on’ their (alcoholic) husbands’ sickness and a range of complex culture specific intra-familial and inter-personal conflicts ‘acted out’ through their possession experience.

3. Roland Littlewood amongst Afro-Caribbeans in Trinidad in the early 1980s explicated a local version of depression (Tabanka) resulting from love-sickness, which is neither pathologised nor viewed as a psychiatric disorder by the local culture (Littlewood 1993). Tabanka, affecting the jilted male lover, is a culturally determined way of sanctioning a painful experience of loss in an inter-personal context.

Ethnographic studies lack consensus on cultural conceptions of mental disorders but this is just a reflection of inadequate methods for standardised (ethnographic)
descriptions across cultures. Fabrega suggests that the problem area for ethnomedical research are the symbolic characteristics of beliefs about illness, non illness and medical treatment; a view also expressed by Kleinman (1977) who suggests attending explicitly to cultural definitions of illness and medicine. Nevertheless, despite this general agreement on a need to attend to culture-specific modes of conceptualising and talking about illness, there is little agreement about an agreed standardised method for accomplishing this.

3.4.5 Semantic Network approach

Causal reasoning is an important inference that has emerged from the generative model approach. For example, Good’s semantic network analysis of Iranian concepts of “heart distress” produced an entire clustering of folk etiological constructs. The recognition of causal influence as a fundamental and universal aspect of folk knowledge also provides a framework for comparative analysis. White (1982) used a query about causality to elicit open-ended explanations of several symptom complaints from American and Hong Kong Chinese to compare causal influence in the two cultures.

Figure 3.4 reveals the causal chains elicited. The Chinese tended to use situationally oriented causal explanations compared to the American counterparts, who made greater use of psychological and affective constructs.

The advantages of using a known relevant inferential relation (i.e. causality), as an elicitation procedure, produces responses that are not constrained by predetermined fixed list of
propositions. However, such inferences elicited need to be coded further for relevant elements of meaning if such data has to be used for qualitative or direct comparative analysis. A limitation of the causal reasoning approach is its assumption of the rational orientation of cognition. This may well be supported by a universal preoccupation with making sense, or giving meaning to illness events; but this is very different from folk theories about illness which provide the symbolic means to accomplish that task.
FIGURE 3.4

COMPARISON OF CAUSAL INFERENCES ABOUT ILLNESS COMPLAINTS AMONG AMERICAN AND HONG KONG CHINESE
(Source: Marsella and White 1984)

USA CAUSES  PROBLEM  HONG KONG CAUSES

BODY  ↓  ↓  ↓  BODY

APETITE  ↔  WEAK

EMOTION  ↔  SLEEPING  ↔  EMOTION

SITUATIONAL PRESSURES

dotted lines indicate p < 0.05, Fischer's Exact Test
3.4.6 Inferential approach

Whilst the propositional method attempts to construct local illness categories in a static manner, the generative-inferential approach tries to represent the dynamic quality of cultural knowledge through a path model.

D'Andrade (1976) developed a procedure to examine various ways in which illness propositions may be combined in American common sense reasoning about illness. He developed a model to specify the nature of logical relations between propositions. Such as implication (i.e. A implies B), exclusion (A contrasts with B) and equivalence (A equals B). Further, a diagram of implicational structures could be generated if informants, given some information about illness, might infer additional properties, causes or consequences of that illness. The diagram thus generated represents “culturally appropriate” or “grammatical paths” in common sense reasoning. (Figure 3.5).

This approach suggests that interpretations constituted by thought processes extend beyond mere identification or categorisation of symptomatology in some form of diagnosis. If one has to answer these additional questions, e.g. what type of person is likely to be affected, what are the causes, what behavioural consequences may result, what are appropriate treatments etc, then this complexity is addressed with recourse to “necessary”, “contingent” and “sufficient” causes of illness which in turn reflect multiple interacting conditions.
FIGURE 3.5

INFERENCES IN NORTH AMERICAN BELIEFS ABOUT ILLNESS
(Source: D'Andrade 1976)

Bad Weather

Fatigue

Lack of resistance

Germs

Parasites

Contagious

Infection

Fever

Running Nose

Sore throat

Antibodies

Can't Catch Again

Vaccination

Allergy

Cold Weather

Irritation

Temporary Resistance

Permanent Resistance

Children's Disease

X ➔ Y Condition X can potentially cause condition Y

X ➔ Y Condition X always causes condition Y

X ➔ Y Condition X can contribute to some condition which can cause Y but X cannot cause Y by itself
Very little is known about how cultures organise explanations of illness as a conceptual task. Most approaches provide typologies, like Foster’s (1976) “Personalistic versus Naturalistic” idioms which White (1982) argues are abstract and which do not specify either the structuring of multiple causal factors nor the significance of causal reasoning with behavioural consequences such as help seeking. There are four exceptions to these:

1) Young’s discrimination of 4 types of etiological information in cross-cultural explanations of illness (Young, 1976).

2) D’Andrade’s differentiation of “potential”, “sufficient” and “contributory” causal relations discussed earlier (D’Andrade 1976).

3) Fabrega’s distinction between “Why” (causation) and “How” (mechanism), questions in cultural explanations (Fabrega 1977).

4) Kleinman’s formulation of the Explanatory Model approach, consisting of a series of interlinked questions that aim to elicit folk explanatory models (Kleinman 1980).

An innovative approach is that of Colson’s attempt to explore the internal organisation of causal reasoning and constructing an explicit model of the structure of indigenous explanations (Colson 1971). Colson’s work, based on Malay data reveals a complex reticulum, in which influences about causes of illness are linked through an intricate grid with possible explanations, symptoms and treatment choices. His model (Figure 3.6) makes explicit the culturally appropriate inferences about the causes of illness in a way that can be checked and revised as additional interpretations of illness episodes are recorded. This also allows for a certain generative capacity, in that it
FIGURE 3.6

MALAYSIAN THEORIES OF ILLNESS CAUSATION
(Source: Marsella and White, 1984)

- Indicates those points at which illness episodes may begin.
describes 717 possible explanations of illness. His model describes several varieties of “immediate” and “ultimate” causes which in turn constitute 4 major types: Natural, Supernatural, Unethical behaviour and Inappropriate behaviour; and represents their inter-relationship among various causal constructs. However, it excludes any connection between these constructs and additional conceptual factors such as type of symptoms, illness or treatment choice. White points out that “it would be surprising if Colson’s Malay informants normally ponder over the full range of 717 possible causal sequences in explaining a given pattern of symptoms”.

3.5 Integrated approaches

Limitations with use of either symbolic or cognitive approach stimulated development of methods that attempt combining the two with differing emphasis to suit the researcher’s background, aim(s) and convenience of gathering data. Is it possible to combine the two approaches linking narratives with epidemiology, the quantitative with qualitative or the emic with the etic? To date there has been only one such promising approach: the Explanatory Model approach.

3.5.1 Explanatory Model Approach

Theoretical developments during the 1970s, largely within North American psychiatry clarified and detailed subjective experience of sickness that lead to the articulation of Illness/Disease concept and Emic/Etic views. A chief proponent of this school, Kleinman (1977) developed the notion of “Explanatory Model” which Weiss (1997) developed as “The Explanatory Model Interview Catalogue” (The EMIC). As the current study utilised an adapted version of the EMIC, a detailed discussion follows:
3.5.2 Explanatory Model Approach: Theory, Practice and Research

The terms ‘Emic’ and ‘Etic’ were first coined by Pike in 1954 (Pike, 1967) and derived from the terms ‘phonemic’ and ‘phonetic’ to include “both verbal and non-verbal behaviour” (Pike, 1990 in Headland, 1990). Over the subsequent four decades, there were extensive debates on the ‘meaning’ of these terms across a range of disciplines and for widely divergent purposes. By 1989, the terms were cited in 278 titles of published articles and books including 14 dictionaries, often in ‘inadequate ways’ (Headland 1990). These disciplines include Anthropology (local and universal), Archaeology, Psychology (as in anthropology but emphasising behaviour), Philosophy (ideas and things), Linguistics (phonemic and phonetic), Education, Management, English Literature and Religion (Headland et al 1990). Although salient issues around these terminologies continue to be guided by the views of Pike and Harris, this section will limit discussion to the meaning, application and purpose within the field of cross-cultural psychiatry.

Etic perspectives refer to professional formulation and constructs derived from an objectification of phenomenon within any culture in a universal language. In other words, etic concepts and related terminology are ‘experience distant’ derivatives (outsider’s views). The ICD and DSM versions, which use a universal (professional) language and are derived through a culture - free frame could be considered examples of etic categories.

Emic perspectives on the other hand refer to indigenous local formulations: subjective experiences and meaning systems within any culture and thus framed in a culture specific vocabulary. In other words, Emic concepts and related terminology are ‘experience near’ derivatives (insider’s views). Ethnographic studies that yield concepts like ‘Tabanka’, ‘Sinking heart’ and ‘Dhatu’ could be considered emic categories.
Figure 3.7 illustrates one of the central problem in cross-cultural research which is termed the ‘category fallacy’ (Kleinman 1977, Littlewood, 1990). Current psychiatric research that examines the prevalence and manifestation of mental health problems across ethnic and cultural divides begins with a set of criteria developed primarily in Western European settings (Culture A: Emic A) and attempts of measure its goodness of fit in another culture (Culture B) and assumes that the ‘discovery’ of constructs yielded in Culture B as evidence of universal category (Emic A). Several researchers (Berry, 1990; Kleinman, 1980; Littlewood, 1990; and Marsella, 1980) have clarified that this ‘discovery’ is in fact merely a function of the lens (or concepts) originally developed in Culture A and that the resulting ‘data’ from Culture B is in fact an imposed etic (an outsider’s view) and not an emic construct from Culture B. They suggest that in order for cross-cultural comparison to be truly valid, the researcher must begin from each end thus resulting in two emics (of Culture A and B) and then attempt comparison (steps 1 and 4). Such a comparison could then yield a ‘derived etic’ (step 5-2) which would share elements common to Emic A and B. In situations where comparison is not possible (if emics from each culture generate divergent concepts), then that should be accepted as valid rather than attempting to predicate one (emic A) on the other (emic B) as has taken place in the majority of cross-cultural research, epidemiology in particular and discussed in detail earlier in Chapter 2.

Berry (1990) cites an example of cross-cultural research on concepts of intelligence. He suggests that western view as “quick, analytic and purely cognitive” is not shared in Latin America, sub-Saharan Africa and East Asia. In such a situation, a cross-cultural study on intelligence could lead to imposed etic if the western construct (of quick, analytic and cognitive ability) were to be applied to Latin American, African and Asian cultures.
Figure 3.7
Problems in cross-cultural research (adapted from Headland et al, 1980)

<table>
<thead>
<tr>
<th>Steps</th>
<th>Research Activity</th>
<th>Culture A (Kannada)</th>
<th>Culture B (English)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>begin research in own culture</td>
<td>emic A</td>
<td>imposed etic</td>
</tr>
<tr>
<td>II</td>
<td>transport to other culture</td>
<td>imposed etic</td>
<td>emic B</td>
</tr>
<tr>
<td>III</td>
<td>discover other culture</td>
<td>emic A</td>
<td>emic B</td>
</tr>
<tr>
<td>IV</td>
<td>compare two cultures</td>
<td>emic A</td>
<td>emic B</td>
</tr>
<tr>
<td>V-1</td>
<td>comparison not possible (no shared features)</td>
<td>emic A</td>
<td>emic B</td>
</tr>
<tr>
<td>V-2</td>
<td>comparison possible (some shared features) leading to: DERIVED ETIC</td>
<td>emic A</td>
<td>emic B</td>
</tr>
</tbody>
</table>
Thus, if in Culture A, one concept of intelligence includes being quick in responding, but Culture B does not mention it, then speed of responding cannot be a dimension on which the two groups can be compared. However, if Culture B mentions being slow and deliberate as an element of intelligence, then speed of responding could be a valid dimension for comparison, but scoring would have to be in opposite directions in the two cultures. In a related domain, hunters and gatherers, known to value spatial ability and who generally attain high scores in this domain, would not be comparable with another group which does not value spatial ability and a similar veto would apply.

Although the Emic-Etic dichotomy might appear superficially neat and complementary, it is not. First, etic concepts influence emic ones such as when professional ideas diffuse out into the local culture. Second, local professional healing systems such as Ayurveda in India “are so deeply rooted in popular culture(s) and formal medical traditions that it is impossible to associate them with one or the other exclusively. Although explanatory model interviews based on the emic framework aim to elicit explanatory models of subjects in their own terms, which emphasises the emic component, this emphasis can only be relative, not absolute” (Weiss, 1997). Third, emic and etic, like disease and illness, do not have a one to one relationship, although they may overlap. For example, the disease category ‘depression’ may have a range of associated ‘illness’ categories; the etic category ‘depressive disorders’ might correspond to several local conceptualisations (emic models).

Explanatory models (EMs) and associated theory (Explanatory Model Theory) were first articulated by Kleinman (Kleinman, 1980). He suggested that just as physicians hold
professional views and ideas derived from a scientific construction of the patient’s problem (disease model), patients too hold their own views but do not usually volunteer them for fear of being “ridiculed, criticised, or intimidated because their beliefs appear mistaken or nonsensical from the professional medical viewpoint” (Kleinman, 1980), supposedly more ‘educated’ and ‘scientific’. Further, he and others suggested that the failure of western biomedicine, and in particular, high non-compliance rates for psychiatric clinic attendance related to professionals not paying sufficient attention to patient’s explanation. In order to elicit patients’ EMs, Kleinman (1980) put forward a series of eight key related questions that are analogous to the disease model (symptoms, signs, pathophysiology, diagnosis, aetiology, management and prognosis). These are detailed below:

### Questions that elicit an Explanatory Model (from Kleinman 1980)

1. **What do you call your problem? What name does it have?**
2. **What do you think has caused your problem?**
3. **Why do you think it started when it did?**
4. **What does your sickness do to you? How does it work?**
5. **How severe is it? Will it have a short or long course?**
6. **What do you fear most about your sickness?**
7. **What are the chief problems your sickness has caused for you?**
8. **What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?**

Although the questions are open ended, attempts to further operationalise these questions to a certain degree of ‘preciseness’ (Weiss, 1997) and quantification were difficult as
answers needed careful and systematic pre-coding and rating without loosing the narrative content of (subjects) response.

The EMIC (Explanatory Model Interview Catalogue) developed in response to these challenges through a series of research projects developed by Weiss and his colleagues (Weiss et al, 1986; Jadhav, 1986; Weiss et al, 1988; Weiss et al, 1992; Weiss et al, 1995; Raguram et al, 1996; and Weiss, 1997) in several countries including India, North America, Canada, Hong Kong, Thailand, and in the UK for the present study. The next two pages summarise the broad operational formulation and structure of the EMIC, and Table 3.8 details the topic, site, and collaborating researchers participating in ongoing EMIC studies world wide. Appendix C details the adapted UK EMIC version for depression for white Britons.

3.5.3 Findings from author’s past research in India

The author of this thesis completed his MD thesis at the National Institute of Mental Health and Neurosciences, Bangalore, India utilising a preliminary version of the current Indian EMIC for Depression (Jadhav, 1986). Keeping in mind that the EMIC is not a generic instrument that can be utilised for any site or study, this earlier preliminary version was developed to elicit explanatory models among patients at the two outpatient (psychiatry and neurology) walk-in clinics (N=100, age range 18 – 65 years, first presentation) regardless of diagnosis. The psychiatry sample generated six major explanatory models: psychosocial, hot-cold ideas, taboo-violation, possession and sorcery, astrology and fate, and western ideas. The neurology sample generated three major explanatory models: psychosocial, hot-cold ideas, and organic
explanations. Psychiatric illnesses that were acute in onset and progressive in their course were significantly associated with less number of non-allopathic consultations irrespective of the models that patients held. Psychiatric patients were more likely to resort to allopathic consultations if they held organic explanatory models. Analysis of past treatment consultation patterns suggested general practitioners as most popular resort for help in both groups. Most patients resorted to non-allopathic healers in both groups and the psychiatric sample did so significantly more often than the neurology sample. Qualitative in-depth case histories illustrated the role of explanatory models and their influence on choice of healers in the context of help seeking within the Indian culture. Clinical implications of the explanatory model approach including strategies for promoting early help seeking and ensuring compliance with bio-medical care without conflicting with non-allopathic modes of reasoning utilising explanatory model approach were detailed. Although this early Indian version of the EMIC did not allow for a more sophisticated analysis of data, the experience and insight generated informed the further development of later EMIC versions that are now in use across several centres detailed in Table 3.8.
Operational Formulation of Illness Explanatory Model for EMIC Interviews (Source: Weiss 1997)

Patterns of distress

- Illness-related problems and concerns
- Name of illness, symptoms, anticipated outcome
- Psychological, social, and economic impact
- Stigma, disclosure, and self-esteem
- Marriage prospects and marital relations

Perceived causes

- Foods
- Psychological factors, psychosocial stressors and victimization
- Sanitation, hygiene, contamination, and health habits
- Infection, prior illness, constitutional factors
- Humoral imbalance
- Magico-religious forces
- Heredity
- Sexual experience, retribution for previous deeds

Help seeking and treatment

- Family support and home remedies
- Private practitioners and public clinics
- Western-styled health professionals, paraprofessionals, and specialists
- Traditional healers of various types
- Past experience and current preferences

General illness beliefs

- Explanatory models of illnesses other than current problem
- Focus on illnesses with a range of cultural meanings
- Relationship between mind and body

Disease-specific queries

- Ideas about the illness affecting the subject, but distinct from personal experience of presenting problems
Structure of EMIC Interviews
(Source: Weiss 1997)

Empowering introduction

Explain the nature of the queries that follow and assure the respondent that responses will not be a source of humiliation.

Open-ended queries

By imposing minimal structure, enable the respondent to refer to what is most prominent in personal experience.

Screening queries focused on categories of interest

A relatively more structured section of the inquiry minimises errors of omission. Respondents may not mention important aspects of illness experience in response to open-ended queries for various reasons. Without inquiring about specific categories of interest, one cannot assume that failure to mention a particular aspect of distress, perceived cause, or help-seeking experience means that these play no role in this person's experience.

Summary judgement comparing multiple responses

Since multiple responses are common, it is useful to weigh their relative significance, asking the respondent to identify which among them is most important, first in time (i.e., first symptom, first perceived cause, first help seeking), and how aspects of the explanatory model have changed over time.

Prose elaboration

Most questions in EMIC interviews elicit responses in the context of a narrative account of illness experience. This prose elaboration of various aspects of illness experience may be the principal interest for qualitative analysis of thematic content, or it may be consulted to clarify the meaning of coded categories. In either case, qualitative data constitutes an integral component of the dataset.
<table>
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*Translation and adaptation from English
CHAPTER FOUR

PRESENT STUDY: THE BRITISH EMIC

4.1 Objectives

4.1.1 To develop an EMIC, the UK EMIC for Depression, for white Britons suffering from clinical neurotic depression (ICD-9).

4.1.2 To interview subjects on this British EMIC in order to:

a) Systematically detail lived experience of depression along the following EMIC dimensions:
   i) Socio-cultural characteristics
   ii) Patterns of distress
   iii) Stigmatising notions
   iv) Perceived causes, and
   v) Help seeking behaviour

b) Examine the relationship between these emic dimensions (i.e. patterns of distress, stigmatising notions, perceived causes, and help seeking behaviour) with etic models of psychopathology measured through a clinical rating instrument, the Hamilton Depression Rating Scale (HDRS).

4.1.3 Translate results into hypotheses for local clinical and health planning initiatives including compliance and public health education programmes

4.2 Rationale

Psychiatric illnesses differ from other medical categories in that the social context and the patients’ own beliefs shape the very pathology to a great extent, and this is particularly so for minor psychiatric disorders. However, Western psychiatric assessments have been
criticised as they disregard the cultural dimensions of illness, including the local and personal meanings that shape psychological distress in any patient group (Paul 1955, Korsch 1968, Hunt 1989, Kleinman 1978).

In recent years, clinical anthropology has developed models to explain the interplay of biological ('disease' related) and social ('illness' related) data (Kleinman 1980, Littlewood 1990). Medical anthropology, which emphasises the hermeneutic meanings of illness, has however focused either on the developing world or exclusively on ethnic minorities (Korsch 1968, Marsella and White 1982, Sartorius et al 1983). This assumes that the “white majority” culture is “culture-free”, experience illness, which are simple expressions of the underlying pathology. Medical anthropologists argue that patient constructions in any particular society are no less culturally constructed than in another (Gaines Hahn and Gaines 1985, Littlewood 1990). Indeed this proposition is a core feature of the ‘new cross cultural psychiatry’ framework articulated by Kleinman and Littlewood over two decades ago. There are yet no studies in Europe or the United States that have examined lay concepts and explanations of psychiatric disorders among the majority population nor which evaluate their clinical significance. While attempts have been made to study lay beliefs and popular ideas among patients suffering from a range of medical diseases such as diabetes, hypertension and AIDS (Helman 1990, Fitzpatrick 1984, Blumhagen 1980, Hunt 1990), there are no studies on lay models of depression among white Britons excepting psychologically oriented attitudinal studies (such as Furnham’s, 1991) nor research that seeks to integrate both qualitative and quantitative data. Such studies suggest that attention to patients’ interpretations is clinically essential.
and can be successfully integrated into the practice of health care. This approach is
known as clinical anthropology (Littlewood 1990, Chrisman and Maretzki 1982).

Lay concepts include attitudes and notions that could be considered to ‘stigmatisate’ the
psychiatric patient. In addition, stigma is known to be directed towards certain chronic
illnesses like leprosy and AIDS, is associated with low self-esteem and helplessness, thus
complicating the management of such disorders (Fitzpatrick et al 1984, Weiss 1990).
Mental health professionals have so far been unable to tackle the problem of stigma
among psychiatric patients. We lack basic clinical data on stigmatising attitudes within
Western culture, its influence on the outcome of psychiatric disorders or indeed the
effects of psychiatric services in shaping stigmatising attitudes. The previous chapter
discussed Kleinman’s framework, which devised an approach that now guides a large
body of research in clinical anthropology: the “Explanatory Model” framework. To
recapitulate, this suggests that people hold ideas and concepts (Explanatory Models or
Cultural Models), which provide meaning for their distress, help them to express and,
shape their illness’ experience and choose a particular form of treatment. These models
are usually not volunteered, but they are analogous to explanatory (‘biomedical’) models
of disease (aetiology/why, pathology/mechanism, signs/recognition, diagnosis/name,
treatment/care, and prognosis/fears over future consequences, etc) held by physicians.
Often, this creates a communication gap between health professionals and patients,
leading to premature termination of treatment, poor compliance and resort to alternative
medicine (Kleinman 1978, Helman 1990). Estimates of poor compliance and non­
adherence to treatment offered in psychiatric out-patient clinics range from 29% to 65%
(Foulks et al 1986). Current attempts to develop powerful and effective treatments for
psychiatric disorders would therefore be inappropriate if patients do not comply with these treatments and this is particularly the case for depressive disorders for which effective pharmacological treatments are now available.

This study will therefore seek to establish and develop an approach that is responsive both to patients' perception of their illness and to professional theories of disease, and will set up for the first time a data base on indigenous concepts of neurotic depression among the white British population. The elicitation of such beliefs will ideally enable clinicians to understand the language of their patients, recognise areas of divergence and help to maximise adherence to treatment. It follows that if health professionals understand patients' ideas and concepts, and communicate using a language and idiom that the patient is able to share, then considerable progress could be achieved in dealing with resistance to medications and other treatments. It is evident that we need to know much more about the ways in which these ideas are constructed and shaped, including their internal logic and the manner in which they are articulated. Considerable progress has already been achieved by earlier researchers who developed the EMIC, which identifies explanatory models and facilitates analysis of the relationship between the models and outcome measures of interest to the clinician (Weiss 1992, 1995, 1997). By using clinical outcome parameters (see 'Method' section below), the study will establish a relationship between beliefs on one hand with clinical psychopathological measures. The data from the present study will also be suitable for cross-cultural comparison with findings from ongoing EMIC based research on depression in India, other centres detailed in chapter three, and future studies in Britain.
4.3 Method

The study was carried out in three stages:

4.3.1 Stage I

This researcher adopted a qualitative ethnographic approach to formulate pilot questions, proceeding from the outline of previous EMICS detailed in chapter three, and utilised the existing structure of a specific EMIC (used to study depression in India). This stage took 24 months to complete and is detailed in the following chapter (Chapter Five).

4.3.2 Stage II

50 semi-randomly chosen depressed subjects of white British origin and nationality (i.e. those born in the United Kingdom and were British citizens), of equal sex distribution, attending out-patient and in-patient NHS psychiatry clinics serving the Camden and Islington community with clinic diagnosis of ICD-9 Neurotic Depression (see final section of this chapter for definition) were selected and administered the British EMIC, followed by a clinical assessment of their diagnosis based on the ICD-9, and subsequently rated on the Hamilton Depression Rating Scale (HDRS, Appendix B). Patients with organic brain disorder and functional psychoses including manic depressive disorder were excluded. Similarly, those subjects born outside United Kingdom were excluded.

4.3.3 Stage III

All interviews were tape recorded (following informed consent), transcribed and numerically coded based on the pre-coded British EMIC developed in Stage I. Quantitative data was entered into a database (DataEase) whilst qualitative prose data was ‘reformatted’, entered into a word processing format (word perfect 5.1 DOS
version), and subsequently imported into a computer assisted qualitative data analysis software for retrieval analysis sessions (Text based Beta). A linked computer software programme, DBMS Copy, was used to import numerical data from DataEase into SAS and SPSS for statistical analysis. The total time taken from interview to data entry was approximately 18 hours (3 hours for the EMIC and HDRS interview, 8 hours for transcribing, 4 hours for coding and 3 hours for data ‘cleaning’ and data entry).

Training for administering EMIC interviews, coding responses, data base construction and management, and software skills was provided by Professor Mitchell Weiss, senior author of the EMICs. This involved continuing discussions and meetings in London, Boston and Basel over the full period of this research. Formal inter-rater reliability exercises were not done as, unlike other EMIC sites, all interviews were conducted solely by this researcher. Additionally, in view of this researcher’s extensive experience with earlier EMIC interviews, a formal inter-rater reliability exercise was considered unnecessary. Professor Weiss participated in pilot interviews and with Professor Roland Littlewood in subsequent discussions on coding narrative responses during Stage I of this research.

ICD-9 criteria for Neurotic Depression (WHO 1980)

A neurotic disorder characterised by disproportionate depression which has usually recognizably ensued on a distressing experience, it does not include among its features delusions or hallucinations, and there is often preoccupation with the psychic trauma which preceded the illness, e.g., loss of a cherished person or possession. Anxiety is also frequently present and mixed states of anxiety and depression should be included here. The distinction between depressive neurosis and psychosis should be made not only upon the degree of depression but also on the presence or absence of other neurotic and psychotic characteristics and upon the degree of disturbance of the patients behaviour.
CHAPTER FIVE
DEVELOPING THE BRITISH EXPLANATORY MODEL INTERVIEW FOR CLASSIFICATION
(THE BRITISH EMIC)

5.0 Introduction

Results of the first objective of this study (Chapter Four: 4.01) are presented here. In contrast to adapting quantitative research questionnaires, adaptation of an ethnographic instrument requires fundamental restructuring to ground the instrument within the culture to be studied. The EMIC adaptation underwent three stages over a period of two years (1991 to 1993).

Stage I: Field Work
Stage II: Restructuring
Stage III: Field testing

5.1 The Indian EMIC: Background and structure

Cross-cultural psychiatrists have extensively debated problems in developing instrument for research across cultures (discussed in Chapter 1). The procedure adopted to develop an instrument was made easier by the availability of such an instrument developed for India (Weiss, 1997). This raised an important challenge: the majority of research in cross-cultural settings have been criticised for adapting instruments developed in western settings and applied to generate data and test hypotheses in non-western settings. The EMIC was developed in a non-western setting and its application in a western setting for eliciting folk ideas from a white British sample in London, posed similar problems. In order to overcome these problems, I had to generate questions based on local white folk concepts. However, I felt it would also
be interesting to retain questions asked of Indian subjects to explore the possibility of some cultural universals, as well as to empirically test for Obeyesekere's hypothesis on the 'reverse category error'. Items that were borrowed from the Indian EMIC into the British EMIC version included specific perceived causal categories for depression: supernatural, humoral, and semen regulation explanatory models. The latter item, on semen regulation, was incorporated following field work experience and media scanning that suggested such ideas were indeed prevalent among contemporary white Britons.

The existing structure of the EMIC for studying depression in south India was adopted as a starting point for various reasons: convenience, availability and permission from Professor Weiss to use the Indian EMIC, personal experience and familiarity in developing the Indian EMIC (with Professor Weiss for my MD thesis in 1986 and subsequently for the study on depression in Bangalore in 1989), and finally, in order to ensure compatibility with other EMICs for later cross-cultural comparison.

5.2 Stage I: Field work

The first step involved asking open-ended questions to get baseline information and starting from the premise of turning the familiar into the unfamiliar. Doing field work or studying another culture has the advantage of being in a culture where everything is strange. There is no short cut to this. Why do people cry differently in Britain? Why do they apologise so much? Why are they so obsessed with their body shape and image? Why do they eat what they do, and how? How do they express intimacy of feelings and
thoughts? What are their codes of interpersonal relationship? What are their ideas about the body (anatomical and physiological functioning)?

Of course, such questions are never ending, and therefore focusing on important issues was necessary. In studying depression, this meant asking how emotions in British culture are conceived, experienced, expressed, resolved etc. This often involved suspending my own judgement, and asking what may appear to an informed person as rather stupid or obvious. Often, a good substitute to mere asking is participating in local community life, for example, living with a family, attending important cultural events including births, marriages, deaths and funerals. The latter two I never managed to attend but watched on television and read in popular press. However, I did attend a hospital based funeral service for one of my study subjects. In the language of anthropology, this is “participant-observation”.

My field work therefore entailed working as a psychiatrist in London hospitals and participating in the professional and social life of my colleagues and related British social institutions. Listening and watching colleagues, including nurses, psychologists and social workers, interview depressed patients and discuss their management was as useful as their personal opinion about health services and illness meanings outside work hours in the pub. I spent extended hours mostly during evenings and nights with patients, and visited hostels and homes. I also spent time sitting at out-patient clinics observing patients, medical secretaries, general architecture and access. During this period, I was training to qualify as a psychiatrist in Britain and that provided a unique opportunity to understand the construction of professional psychiatric identity.
5.2 Sources

It was important not to be too concerned at the outset about specific questions, their framing and other technical matters. These were to emerge as I began enquiring the issues outlined in the earlier section of this chapter. In developing the EMIC, apart from working and participating in the role as a psychiatrist, I found the following formal sources useful:

5.2.1 Radio

There were frequent programmes on counselling. People ring in to a counsellor, state their problem and seek advice. These are live broadcasts, and provide opportunity to know more about popular patterns of distress, local ideas of causation and ways of seeking help. Transcript of Radio counselling programmes and horoscope advice on LBC Radio were scanned for this purpose.

5.2.2 Television

Similar to the radio programmes, these shows include psychiatrists interviewing volunteers with psychological problems, soap operas which often centre around key emotional events and comedy shows which articulate popular brands of humour within the culture. Here, it was useful to know how certain emotions were expressed and this enabled calibration of feelings and emotions by visual examination of the data. For example, stand up comedy shows popular for dead pan humour, and the popular series on 'Inspector Morse' for a brand of British wit through understatement.

5.2.3 Newspapers

Most British newspapers (broadsheet and tabloid) feature health columns. The one I found most useful was the Agony Aunt column, similar to the question and answer slot in popular Indian magazines and newspapers. Again, the nature of letters written, the
manner in which they are framed and the experts’ advice gave vital clues about folk
categories around depression. Ideas about semen loss and retention, stress, nerves,
pressure etc were to be found in such columns. Here I found local tabloids such as
Evening Standard far more informative and rich with local knowledge compared to
national broadsheet newspapers. Newspapers often feature advertisements on public
health and other popular health campaigns that were similarly useful.

5.2.4 Support Groups and Other Voluntary Organisations

A wide range of such groups exists in Britain. These include Mind, AA, Overdose
Anonymous, Bereavement and Phobia Societies. Staffed and run by ex-patients, they
are key places where important concerns about depression and other emotional
problems are discussed, and in lay terminology.

5.2.5 Academic textbooks and research journals

Academic texts, in this context, mirror important cultural concerns articulated through
scientific metaphors. Looking for chapters on depression that discuss everything
aetiology to treatment, and examining research journals provide vital clues about how
and why certain ideas are privileged and the manner in which they diffuse outwards
into the culture and from the culture into professional texts. I tried to imitate a Western
anthropologist attempting to relate Ayurvedic texts in India as a reflection of popular
folk ideas on humoral theory.

5.2.6 Lay panel

I set up an informal ‘lay panel’ of native informants. These included colleagues at
work (patients, psychiatrists, nurses, social workers, hospital receptionists, secretaries,
porters) and outside of work (parents, teachers, bar tenders, cabbies). I would often
consult them to help understand the Why and How of popular theories about
depression. This is not a prescription but a suggestion of simplifying a ‘snowballing’ process that could otherwise be complex, daunting and never ending. There are no criteria for selection of informants other than willingness on their part to help you. Anthropological literature details the classic problem about informants: they might tell you what you want to hear, or conversely not tell you something crucial. Some may not be reliable, in that they might change their stories often or offer information in return for material or other rewards. One could argue that ‘changing stories’ or providing information in exchange for some gain is expected and needs to be included rather than viewed as contaminating ‘data’.

5.2.7 Other sources

Tape recorded transcripts of personal experiences, flyers and brochures, visits to local folk practitioners, in the case of London including a range of complementary healers. Careful and detailed notes of visits to such places and filing away material was crucial. During this phase, I visited several complementary healers at Drummond Street and hairdressers on Goodge Street (who offered complementary healing) attended annual New Age Events such as Glastonbury folk festival and Mind-Body-Spirit exhibitions. I also scanned notice boards at local council offices, Fitzrovia neighbourhood help centres on Goodge Lane, and the social services offices on Cleveland Street. I visited betting parlours and car pound centres to learn more about intense emotional expressions.

5.3 Stage II: Restructuring (and departures from the Indian EMIC)

By this stage, I had already formulated questions that were crucial to the study. The next stage involved re-structuring the EMIC. The broad outline of the British EMIC, is
shown on the next page. Each item allows both numerical coding and recording prose responses of subjects in narrative format). The full UK EMIC for Depression version 2.3 is enclosed as Appendix C.
5.3.1 Broad Outline of the UK EMIC for Depression

A Informed Consent Form comprising expected benefits, potential risks, confidentiality and signatures of both subject and researcher

B. I Socio-cultural characteristics

Cultural significance of name

Age, date of birth, sex, religion, ethnicity, address

Migration history to London (if relevant)

Living conditions

Neighbours and neighbourhood

Marital status, family and household details including

Family interaction

Pets and their influence on health

Influence of media and health literature

Hobbies and leisure

Community supports

Home remedies

Education

Statutory benefits

Income

Languages spoken.

B II Patterns of distress

Spontaneously elicited in response to open ended questions

Screened specifically for somatic and psychological idioms

Onset and duration
Name of problem
Impact on body, mind and society
Perceived seriousness including most troubling problem
Anticipated outcome with and without treatment
Impact on personal and household income
Self esteem and stigma disclosure
Self regard and community response
Effect on subject’s and relative’s marriage.

B III Perceived causes
Spontaneously elicited perceived causes
Screened with 58 perceived causes
Most important perceived cause
Changes in perceived cause over time

B IV Help seeking
Spontaneously elicited help seeking
Screened help seeking
First help seeking
Most important help seeking
This clinic

B V Mind-Body-Soul Beliefs
Relationship between mind and body
Place of mind and soul

C. Open ended field notes
It was not enough to ask the right question but also the appropriate context. Thus, items such as Neighbourhood needed to be placed following queries on Housing and Social Supports. Similarly, appropriate introductory remarks shift the process of interview in a direction that then allows subsequent questions to be meaningful and engaging. Other issues include wording, syntax, length and layout. Subsidiary probes are often useful when the subject is unable to understand the main question.

I did a content analysis of the material gathered in Stages 1 and 2, to extract key concepts, which were then tested out repeatedly to exclude some and retain others. This was done with the assistance of Professors Littlewood and Weiss.

5.4 Stage III: Field testing

This was relevant if I wished to analyse data quantitatively. Anthropologists would not be particularly concerned about precoding as their analysis is based upon reading and picking up themes embedded within their field notes. In this study, as outlined earlier, I planned to analyse data both quantitatively and qualitatively. This was done after reading several responses to each question and generating categories that were then coded with a numeric.

5.4.1 An example illustrating how data is managed on the demographic section of the UK EMIC

In the introductory section enquiring about cultural significance of name, subjects were asked the following two principal questions (A) and (B), their responses recorded verbatim and then coded as illustrated overleaf.
(A) What does your GIVEN NAME mean to you? Do you like your GIVEN NAME?

(Vertabim record of prose narrative below):

Jas Kali. I gave myself this name. It means feminine power. Yes.

(B) What are the origins of your FAMILY NAME? Do you like your FAMILY NAME?"

(Vertabim record of prose narrative below):

My family name was Karen Anne Brown. I hate it, it is one of the most common names in England.

Subsidiary probes

(i) Where do your ancestors come from?
Scotland, Celtic, Kali is also a Celtic Goddess, and I am actually from that line Celtic, I think probably Vikings, they say.

(ii) Do you like your family name?
No.

(iii) Why is it you don't like it?
Well I changed it when my father kicked me out of my house, so it was kind of like saying 'No' to my father, because it was my father's name, because we take the father's name in England, so that's why I had to get rid of it, because I didn't get on with my father, and I wanted to get rid of it.

(Numerical coding based on categories below derived from pilot interviews):

(A) [2]

(B) [2]

Coding guide for cultural significance of name

No Meaning/Likes Name [1] Yes Meaning/Likes Name [4]

As the nature of questions and responses got more complex, such as in the Perceived Causes section of the EMIC, newer ways of coding needed to be developed. If one is doing a quantitative study, the prose data is often discarded; but in qualitative research, such data is the very essence that serves to amplify the coded categories.
Because I was keen to examine how perceived causes related to other causes and the manner in which subjects elaborated, associated and constructed a web of causation, the coding strategy was adapted to capture responses in numerical format. The example below illustrates this section followed by guidelines for coding.

5.4.2 An example illustrating how data is managed on the perceived causes section of the UK EMIC

Example of interview question (I), subject response in narrative form S) and coding (C) in section on Perceived Causes

I: Do you believe your problem is caused by germs, viruses, dirt, or contact with an infected person? Is it a result of not taking care of yourself or keeping yourself clean enough, poor housing or environmental pollution?
S: I certainly worry about Aids, and I don’t have sex without condoms, and I do worry about especially being raped. I worry when they say you could contact it after 10 years, I do worry.
I: Did you get yourself tested then?
S: Yea, I've been tested a couple of times.
I: And you've been safe?
S: Yea.
I: Is it a result of not taking care of yourself or keeping yourself clean enough, poor housing or environmental pollution?" S: I get asthma from the traffic, which um is made both by stress and things. Err, What was the other thing?
I: Um not taking care of yourself or keeping yourself clean enough, poor housing or environmental pollution?
S: Poor housing, I developed asthma from poor housing.
I: And that would translate into depression?
S: Um, poor housing is definitely a main thing in my depression.

TABLE 5.1
CODING FOR PERCEIVED CAUSES
(see next page for coding guidelines)

<table>
<thead>
<tr>
<th>Perceived Causes</th>
<th>Status</th>
<th>Artefact</th>
<th>Influence</th>
<th>Linkage</th>
<th>Code Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>32) Sanitation/ Living Conditions</td>
<td>B</td>
<td>B</td>
<td>SE</td>
<td>R</td>
<td>Stress-loss</td>
</tr>
<tr>
<td>33) Personal Hygiene</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34) Germs/ Inf./ Contam/ Contact</td>
<td>B</td>
<td>B</td>
<td>SE</td>
<td>R</td>
<td>Sexual abuse</td>
</tr>
<tr>
<td>35) Environmental Pollution</td>
<td>B</td>
<td>B</td>
<td>SE</td>
<td>R</td>
<td>Sant/lvng conditions</td>
</tr>
</tbody>
</table>
Guidelines for rating questions relating to perceived causes. All alphabets were reassigned a value label (numerical digit) prior to data entry into Data ease

(1) **(S) Status:** Rate the status of each Perceived Cause (PC) with respect to the significance the subject attaches to it.
- Clearly a cause ........................................................................ [B]
- Possible or less significant cause ................................................ [C]
- Not a cause .................................................................................. [D]
- Role not clear .............................................................................. [E]
- Subject states unknown concept ................................................. [F]

(2) **(A) Artifact:** Specify whether this idea is an artifact by asking whether the subject considered it prior to the interview or only afterwards.
- Artifact .................................................................................... [A]
- Previously Held Belief ................................................................. [B]
- Uncertain .................................................................................... [C]

(3) **(I) Influence:** Specify the most important influence or source of this belief for each of the Perceived Causes rated with status B or C. For example, if own idea and not influenced by others, code SE [Self]. See Appendix C, UK EMIC for Depression, final section, for detail coding schema for this section.

(4) **(L) Linkage:** codes indicate how this idea may be linked to other Perceived Causes. Record "I" if it is an independent Perceived Cause. Also, if several ideas are linked together in a complex model, code the most prominent as "I" and others linked to it as "R" for related or "D" for dependent. Specify related or dependent based on the nature of the link between the two Perceived Causes. If one is related to another, but makes sense in the narrative on its own, code it "R". If the meaning of the Perceived Cause for this patient, however, makes no sense without considering the link to another Perceived Cause, code it "D".

(5) **(CR) Code Reference:** If this Perceived Cause is related to or dependent upon another, specify the category to which it is linked by referring to the Perceived Cause option codes detailed under (7) below. If it is linked to several, specify the one that it is linked to most prominently and indicate any others in the prose elaboration.

(6) **Narrative:** Elaborate narrative details in the space provided, as the patient presents them.

**Perceived Cause Option Codes:** Each of the 59 perceived causal categories have a fixed numerical code shown on the next page. This code is used for the code reference column. The same codes are denoted in the column for perceived causes. See Appendix C for full coding of the perceived cause codes for the UK EMIC for Depression.
### Perceived causes for white Britons suffering from Neurotic Depression

<table>
<thead>
<tr>
<th>Cause</th>
<th>[Reference]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food-Water</td>
<td>[1]</td>
</tr>
<tr>
<td>Alcohol</td>
<td>[2]</td>
</tr>
<tr>
<td>Smoking</td>
<td>[3]</td>
</tr>
<tr>
<td>Abused Drug</td>
<td>[4]</td>
</tr>
<tr>
<td>Prescribed Med</td>
<td>[5]</td>
</tr>
<tr>
<td>Injury, Accident</td>
<td>[6]</td>
</tr>
<tr>
<td>Prior-Existing Illness</td>
<td>[7]</td>
</tr>
<tr>
<td>Pregnancy-Childbirth</td>
<td>[8]</td>
</tr>
<tr>
<td>Congen-not Heredity</td>
<td>[9]</td>
</tr>
<tr>
<td>Anatomical-Phys Prob</td>
<td>[10]</td>
</tr>
<tr>
<td>Weakness</td>
<td>[11]</td>
</tr>
<tr>
<td>Body Image</td>
<td>[12]</td>
</tr>
<tr>
<td>Family problems</td>
<td>[13]</td>
</tr>
<tr>
<td>Marital problems</td>
<td>[14]</td>
</tr>
<tr>
<td>Failure to marry</td>
<td>[15]</td>
</tr>
<tr>
<td>Other Interpersonal</td>
<td>[16]</td>
</tr>
<tr>
<td>Global Concerns</td>
<td>[17]</td>
</tr>
<tr>
<td>Bereavement</td>
<td>[18]</td>
</tr>
<tr>
<td>Stress-Loss-Shock</td>
<td>[19]</td>
</tr>
<tr>
<td>Physical Abuse (Adult)</td>
<td>[20]</td>
</tr>
<tr>
<td>Sexual Abuse (Adult)</td>
<td>[21]</td>
</tr>
<tr>
<td>Racism</td>
<td>[22]</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>[23]</td>
</tr>
<tr>
<td>Other Injustice</td>
<td>[24]</td>
</tr>
<tr>
<td>Other Victimization</td>
<td>[25]</td>
</tr>
<tr>
<td>Mind-Thoughts-Worries</td>
<td>[26]</td>
</tr>
<tr>
<td>Nerves</td>
<td>[27]</td>
</tr>
<tr>
<td>Personality</td>
<td>[28]</td>
</tr>
<tr>
<td>Work Problem</td>
<td>[29]</td>
</tr>
<tr>
<td>Financial Stress</td>
<td>[30]</td>
</tr>
<tr>
<td>Heredity</td>
<td>[31]</td>
</tr>
<tr>
<td>Sanitmat/Living Condtsns</td>
<td>[32]</td>
</tr>
<tr>
<td>Personal Hygiene</td>
<td>[33]</td>
</tr>
<tr>
<td>Grms-Inf-Contam-Contact</td>
<td>[34]</td>
</tr>
<tr>
<td>Environment-Pollution</td>
<td>[35]</td>
</tr>
<tr>
<td>Living w/Emotnly Disturbed</td>
<td>[36]</td>
</tr>
<tr>
<td>Disclosure Problem</td>
<td>[37]</td>
</tr>
<tr>
<td>Loneliness</td>
<td>[38]</td>
</tr>
<tr>
<td>Boredom</td>
<td>[39]</td>
</tr>
<tr>
<td>Life Meaningless</td>
<td>[40]</td>
</tr>
<tr>
<td>Spiritual Deficit</td>
<td>[41]</td>
</tr>
<tr>
<td>Semen-Vaginal Fluid</td>
<td>[42]</td>
</tr>
<tr>
<td>Masturbation</td>
<td>[43]</td>
</tr>
<tr>
<td>Sexual Experience</td>
<td>[44]</td>
</tr>
<tr>
<td>Sexual Identity</td>
<td>[45]</td>
</tr>
<tr>
<td>Heat-Cold in Body</td>
<td>[46]</td>
</tr>
<tr>
<td>Climate: Heat-Cold</td>
<td>[47]</td>
</tr>
<tr>
<td>Wind-Bile-Phlegm</td>
<td>[48]</td>
</tr>
<tr>
<td>Astrology</td>
<td>[49]</td>
</tr>
<tr>
<td>Fate-Chance</td>
<td>[50]</td>
</tr>
<tr>
<td>Will of God</td>
<td>[51]</td>
</tr>
<tr>
<td>Bad Deeds</td>
<td>[52]</td>
</tr>
<tr>
<td>Karma</td>
<td>[53]</td>
</tr>
<tr>
<td>Religious</td>
<td>[54]</td>
</tr>
<tr>
<td>Other Supernatural Spirits</td>
<td>[55]</td>
</tr>
<tr>
<td>Evil Eye</td>
<td>[56]</td>
</tr>
<tr>
<td>Other Sorcery</td>
<td>[57]</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td>[58]</td>
</tr>
<tr>
<td>Cannot Say</td>
<td>[59]</td>
</tr>
</tbody>
</table>
5.5 Final UK EMIC for Depression, version 2.3

After assessing the face and content validity of questions, checking codes, adding or deleting questions, and general tidying up; the instrument was frozen. Field testing took 18 months to generate 15 versions. Each version was given a specific number and used as draft version for the subsequent EMIC, until we were satisfied that we had reached a stage at which no further developments were necessary. The final version UK EMIC Version 2.3 (Appendix C) was frozen in 1993, and the UK EMIC for Depression was ready for data collection.

As the data generated on the EMIC interviewed was enormous, only those results relevant to objectives of this study, and outlined in Chapter Four are presented in a tabular format in Chapter Six.
CHAPTER SIX

RESULTS

6.1 Demographic features: Hospital status, age, gender, ethnicity, religion, marital status, income, education, occupation, employment and housing (Table 6.01)

All subjects were of white British origin (see Chapter Five for sampling and other details on criteria for ethnicity) and lived in the borough of Camden and Islington at the time of interview. 58 subjects were interviewed and 47 were included in the analysis of this study. Seven did not fulfil inclusion criteria. This emerged during the early part of the EMIC interview and these subjects were dropped from the study. Data on additional four interviews was lost on audio-tape.

The age ranged from 22 to 65 years, mean 39 years (Figure 6.01). 46% were females and 54% males. 48% were single, 24% divorced, 14% separated, 12% married and remainder either widowed or cohabiting.

Among the total sample, 40% were Roman Catholics, 21% atheists, 17% Protestants, and the remainder comprising agnostic, Jewish and other denomination. 70% of the sample were of white English background, 20% Irish, and the remainder Scottish. 30% had completed some secondary schooling, mostly with O levels, 25% had either a diploma or professional degree, and the remainder had only primary school education. 60% were unemployed. Among those in employment, 30% were in working class occupation such as manual labour, artisans, clerks or vendors, etc.
### Treatment Status & Demographic features of the study sample (%)

<table>
<thead>
<tr>
<th></th>
<th>In-patient n=27</th>
<th>Out-patient n=20</th>
<th>Total n=47</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td>59.3</td>
<td>50.0</td>
<td>54.0</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td>40.7</td>
<td>50.0</td>
<td>46.0</td>
</tr>
<tr>
<td><strong>Age (mean)</strong></td>
<td>39.9 years</td>
<td>38.4 years</td>
<td>39 years</td>
</tr>
<tr>
<td><strong>Duration of Illness</strong></td>
<td>12.2 months</td>
<td>13.8 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Std. dev. 13</td>
<td>Std. dev. 22</td>
<td></td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scottish</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irish</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholics</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atheists</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestants</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agnostics</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>48</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohabiting</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mean Income</strong></td>
<td></td>
<td></td>
<td>£571.27 month</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma/ Degree</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-manual</td>
<td>70</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Council</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self rental</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self mortgage</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 6.01**
Mean income for the total sample (£571.27 per month). This did not significantly differ between out-patient and in-patient subjects (£593.46 and £549.09 respectively). Over half of the sample (55%) perceived either moderate or severe strain on their finances. 73% of the sample lived in council accommodation, 21% in their own rental homes, and only 6% owned their home (on mortgage). 60% felt their living conditions might adversely affect their health and a similar percentage (60%) did not get on with their neighbours. Further, the majority (80%) did not discuss their problems with neighbours and almost two-thirds of the total sample had no confidants.

6.2 Clinical characteristics

6.2.1 Hospital status

Fifty-seven percent of the sample were in-patients (mean age 39.9 years), and 43% were out-patients (mean age 38.4 years). There was little age-related gender difference both for the entire study sample and on their hospital status.

6.2.2 Diagnosis

All subjects fulfilled the ICD-9 criteria for Neurotic Depression, as this was an inclusion criterion for the study. Two patients died during the study period but after completing the interviews (one subject committed suicide and one died of AIDS).

Although the study design aimed at sampling first presentations to NHS psychiatry clinics, many subjects had a past history of depressive episodes, including consultations with mental health professionals. This information emerged when subjects were systematically screened in the final help seeking section of the EMIC.
interview and were therefore retained within this study. The implication of this will be discussed in section 7.7.1, Chapter Seven.

6.2.3 Hamilton Depression Rating Scale (HDRS) scores

The Hamilton Depression Rating Scale (HDRS) (Appendix B) was administered to 46 out of the 47 subjects. One subject did not participate initially in this rating due to time constraints, and later refused. The total time taken to administer the HDRS ranged from 30 to 45 minutes. All ratings on the HDRS were carried out after subjects were interviewed on the UK EMIC for Depression. HDRS scores are illustrated in Figures 6.02 and 6.03. Mean depression and anxiety scores for the 24 item HDRS scale were 28.1 and 17.5 respectively. As scores were not normally distributed, statistical analysis involving this variable was non-parametric in nature.
Hamilton depression rating scale 24 item score

FIGURE 6.02

Hamilton anxiety rating scale scores

FIGURE 6.03
6.3 The EMIC Stigma measures

The EMIC sub-section (‘Patterns of Distress’) contained 11 questions relating to stigma (item 35.0 to 37.3, see Appendix C: UK Depression EMIC version 2.3) under the heading ‘Self esteem, Stigma and Community response’. Table 6.17 in this chapter also detail these 11 questions. Responses (yes, no, possibly, and uncertain) to each question on this 11 item sub-section were computed in a manner that yielded a total score for each subject. This score was additive and linear, permitting further analysis.

Mean Hamilton Depression and EMIC Stigma section scores for in-patient and out-patient subjects are illustrated in Table 6.04. Further details on computing EMIC stigma scale and scores are reported in section 6.6.

A 2-tailed t test between in-patient and out-patient groups for both HDRS and EMIC stigma scores showed no significant difference (Table 6.04). In view of this, subjects within the two groups (in-patient and out-patient) were not separated for further statistical analysis involving HDRS ratings and EMIC Stigma scores.

### Mean scores for Hamilton Depression Rating Scale & EMIC Stigma scale

<table>
<thead>
<tr>
<th></th>
<th>Out-patient N=20</th>
<th>In-patient N=27</th>
<th>2 tailed t test</th>
<th>Total N=47</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hamilton Depression Rating Scale scores</strong></td>
<td>27</td>
<td>28.89</td>
<td>not sig.</td>
<td>28.11</td>
</tr>
<tr>
<td><strong>EMIC Stigma scores</strong></td>
<td>12.05</td>
<td>11.40</td>
<td>not sig.</td>
<td>11.68</td>
</tr>
</tbody>
</table>

**TABLE 6.04**
6.4 Patterns of Distress: How Subjects Reported Presenting Problems
(Figures 6.05 and Table 6.06)

6.4.1 Coding strategy

Responses to this section were computed to yield an additive score represented in a bar chart that distinguished prominence ranking for 10 pre-coded symptom categories. This ranking results in a semi-quantitative scale that enables examination of relationship between distress patterns and other variables on the EMIC. The prominence was ranked in a manner that identified whether symptoms were reported spontaneously or after probing, and in both contexts, whether they were emphasised, or just mentioned. The response values assigned were as follows:

- Spontaneous Emphasised: 4
- Spontaneous Mention: 3
- After Probe Emphasised: 2
- After Probe Mention: 1
- Not reported: 0

(See Appendix C, UK EMIC for Depression, items 26.0 to 26.2 for questions and coding response).

Bar chart (Figure 6.05) details symptom response (i.e. patterns of distress) depicting four broad categories: whether they were spontaneously reported (either emphasised or mentioned), or elicited on probing (either emphasised or mentioned). The legend within this bar chart clarifies their sequence.
FIGURE 6.05

Patterns of Distress: How subjects reported their symptoms

- Other
- Functional
- Cognitive
- Fears
- Anxiety
- Sadness
- Somatic
- Libido
- Appetite
- Sleep

Spontaneously emphasised
Spontaneously mentioned
Emphasised on probe
Mentioned on probe
6.4.2 Patterns of distress: quantitative results (Table 6.06)

Table 6.06 below specifies the frequency percentage of symptoms reported in graphic format in Figure 6.05. It indicates how many respondents emphasised or mentioned each symptom spontaneously in response to an open ended question. Patients who did not report these symptoms spontaneously were probed further. The table also reports these symptoms in response to probes.

Patterns of Distress: how symptoms were reported

<table>
<thead>
<tr>
<th>SYMPTOM CATEGORY</th>
<th>Spontaneous %</th>
<th>On Probing %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emphasised</td>
<td>Mentioned</td>
</tr>
<tr>
<td>SLEEP</td>
<td>4.3</td>
<td>4.3</td>
</tr>
<tr>
<td>APPETITE</td>
<td>6.4</td>
<td>2.1</td>
</tr>
<tr>
<td>LIBIDO</td>
<td>6.4</td>
<td>0.0</td>
</tr>
<tr>
<td>SOMATIC</td>
<td>8.5</td>
<td>2.1</td>
</tr>
<tr>
<td>SADNESS</td>
<td>78.7</td>
<td>8.5</td>
</tr>
<tr>
<td>ANXIETY</td>
<td>31.9</td>
<td>8.5</td>
</tr>
<tr>
<td>FEARS</td>
<td>12.8</td>
<td>2.1</td>
</tr>
<tr>
<td>COGNITIVE</td>
<td>14.9</td>
<td>2.1</td>
</tr>
<tr>
<td>FUNCTIONAL</td>
<td>2.1</td>
<td>0.0</td>
</tr>
<tr>
<td>OTHER</td>
<td>27.7</td>
<td>6.4</td>
</tr>
</tbody>
</table>

**TABLE 6.06**

The figures in the first two columns added together for the symptom **sadness** indicate a frequency of 87.2% spontaneous response as a presenting problem, 78.7%
emphasising and 8.5% mentioning them. This is in contrast with 10.6% of the total sample spontaneously reporting somatic symptoms, and only 2.1% placing emphasis on such symptoms. Similarly, 40.4% of the sample spontaneously reported anxiety symptoms but only 8.6% reported them on further probing.

When these three symptom categories (i.e. sadness, anxiety and somatic) were probed, 6.4% reported further symptoms of sadness with 4.3% placing emphasis and 2.1% mentioning them. Similarly, 8.6% of the total sample reported further symptoms of anxiety. This contrasts with 76.6% reporting further symptoms of somatic nature, with 63.8% emphasising them and 12.8% mentioning them.

In summary, psychological complaints, in particular mood symptoms (sadness and anxiety), were most commonly reported spontaneously; further probing generated fewer responses. Somatic symptoms were however infrequently reported spontaneously but reported extensively on specific probing.

6.4.3 Patterns of distress: qualitative themes (Table 6.07)

Table 6.07 illustrates examples from prose response of subjects who emphasised either psychological (sadness or anxiety) or somatic symptoms before or after probe.
<table>
<thead>
<tr>
<th>Pattern of distress elicited spontaneously emphasising sadness</th>
<th>Pattern of distress elicited after probing for somatic symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male, 39 years</strong>&lt;br&gt;Um, I think it was my mum’s death that was the biggest single factor. I got so fed up with feeling down all the time.</td>
<td>I get headaches a lot, yeah and my stomach gets quite acidity and I have got physical symptoms as well.</td>
</tr>
<tr>
<td><strong>Female, 32 years</strong>&lt;br&gt;I began to get very suicidal. Fairly depressed and having quite bad nightmares.</td>
<td>Yes I have an irritable bowel from the age of 17.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern of distress elicited spontaneously emphasising anxiety</th>
<th>Pattern of distress elicited after probing for somatic symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male, 38 years</strong>&lt;br&gt;The major problem I am having is one of acute anxiety.</td>
<td>I have had problems. Pains in my upper limbs ..in the mornings.</td>
</tr>
<tr>
<td><strong>Female, 31 years</strong>&lt;br&gt;Anxiety. Um, well, panic attacks.</td>
<td>It is sometimes my ears, sometimes my tummy, sometimes I feel nauseous.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pattern of distress elicited spontaneously emphasising somatic symptoms</th>
<th>Pattern of distress elicited after probing for psychological symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female, 35 years</strong>&lt;br&gt;It is the problems with my head. I feel a lot of tension, a lot of discomfort. Sometimes the scalp feels very tight and tingling.</td>
<td>Well, depressed you know</td>
</tr>
<tr>
<td><strong>Male, 26 years</strong>&lt;br&gt;I kept getting headaches, real severe headaches in my head. I couldn’t stand no more of it.</td>
<td>Depressed, I feel even more depressed now ‘cos I am in a worse position now</td>
</tr>
</tbody>
</table>

**TABLE 6.07**
Examples of how subjects reported their complaints: spontaneously and after probing
6.4.4 Gender difference on presenting symptoms (Tables 6.08A and B)

Table 6.08A shows differences between male and female subjects on their presenting patterns of distress. The distress patterns have been computed in three different ways: (a) overall degree of definiteness of symptoms based on the prominence of a particular symptom throughout the EMIC interview (b) reporting style of symptoms based on response to an open ended question to subjects asking what they thought was the main problem for consulting a psychiatrist, and (c) most troubling symptom in response to a specific question asking subjects what troubled them most. In addition the table shows HDRS and EMIC Stigma scores for the two sexes.

2-tailed t tests in Table 6.08A show that male subjects presented with significantly more sadness regardless of how these scores were computed (p<0.02, 0.07, 0.08, Table 6.08A). Women scored higher on the overall prominence symptom of anxiety although this was statistically not significant (p<0.09). Male subjects also scored high on the 24 item HDRS (p<0.05). There were no gender difference on EMIC Stigma scores.

Table 6.08B is a correlation between reporting priority of symptoms and EMIC Stigma scores separated by gender. Symptom reporting priority rather than overall symptom prominence or most troubling symptom was chosen for this analysis as published literature suggests perceived stigma influences symptom presentation. This is discussed in more detail in Chapter Seven. Results show EMIC Stigma measures correlate inversely with somatic and anxiety symptoms within the female sub-set of the sample (p<0.07 and 0.007 respectively).
<table>
<thead>
<tr>
<th>Variables</th>
<th>Sex</th>
<th>Mean scores</th>
<th>Sig. 2 tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Prominence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic</td>
<td>Male</td>
<td>2.26</td>
<td>0.38</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.71</td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>Male</td>
<td>5.84</td>
<td><strong>0.02</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.95</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Male</td>
<td>1.34</td>
<td><strong>0.09</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.33</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting style</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic</td>
<td>Male</td>
<td>2.26</td>
<td><strong>0.93</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2.23</td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>Male</td>
<td>3.73</td>
<td><strong>0.07</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Male</td>
<td>1.15</td>
<td><strong>0.20</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1.85</td>
<td></td>
</tr>
<tr>
<td><strong>Most troubling symptom</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic</td>
<td>Male</td>
<td>0.00</td>
<td><strong>0.16</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.47</td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>Male</td>
<td>2.11</td>
<td><strong>0.08</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>Male</td>
<td>0.19</td>
<td><strong>0.46</strong></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0.47</td>
<td></td>
</tr>
<tr>
<td><strong>Hamilton Depression scores</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>29.73</td>
<td><strong>0.05</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>26.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hamilton Anxiety scores</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17.27</td>
<td><strong>0.68</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>17.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EMIC Stigma scores</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11.96</td>
<td><strong>0.45</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>11.19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 6.08A**

Gender differences on Patterns of Distress, HDRS and EMIC Stigma scores. Patterns of Distress have been calculated in three different ways: (a) Overall prominence throughout the EMIC interview, (b) Reporting style, and (c) Most troubling symptom.

<table>
<thead>
<tr>
<th>REPORTING PRIORITY OF SYMPTOMS</th>
<th>EMIC STIGMA SCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Males (n = 26)</strong></td>
</tr>
<tr>
<td>SOMATIC</td>
<td>R 0.08, Sig. 0.7</td>
</tr>
<tr>
<td>SADNESS</td>
<td>R 0.29, Sig. 0.15</td>
</tr>
<tr>
<td>ANXIETY</td>
<td>R -0.23, Sig. 0.25</td>
</tr>
</tbody>
</table>

**TABLE 6.08B**

Correlation of reporting priority of symptoms with EMIC Stigma scores within male and female subjects (R=Spearman’s coefficient, non-parametric analysis)
6.4.5 Correlation between Patterns of Distress and Hamilton Depression Rating Scale scores (Tables 6.09A, 6.09B, and 6.09C)

Tables 6.09A, 6.09B, and 6.09C show the result of non-parametric correlation between subjective patterns of distress elicited on the EMIC with HDRS scores. The note below main title of this table explains how scores for distress patterns were computed. This three way calculation for distress patterns was necessary in order to allow for the possibility that spontaneous presentations of symptoms could well be superficial 'reporting styles'. Utilising this score alone for analysis may ignore more serious concerns (or symptoms) that subjects might have to report. And such troubling symptoms are more likely to emerge during the course of the EMIC interview rather than in response to an initial open ended question on their problems. Therefore, the degree of prominence of all elicited symptoms throughout the EMIC interview were calculated by giving weightage to both spontaneous distress patterns and symptoms that were considered most troubling to subjects. The latter were elicited on specific questioning in a later section of the EMIC interview.

Subjective reports of sadness significantly positively correlate with HDRS scores (Tables 6.09A and C), but other mood symptoms such as anxiety and fear, and somatic symptoms, although not statistically significant, score in the opposite direction (Tables 6.09A, B and C).
TABLES 6.09A, B AND C

CORRELATION BETWEEN PATTERNS OF DISTRESS AND HAMILTON DEPRESSION RATING SCALE SCORES

Patterns of distress have been computed in three different ways: Table 6.09A depicts Reporting style: based on response to open ended question or after probe, Table 6.09B depicts Most troubling pattern of distress, and Table 6.09C depicts Overall Prominence resulting in a symptom prominence score. Numbers in bold indicate statistical significance (R: Spearman’s correlation coefficient, non-parametric analysis)

**TABLE 6.09A**

<table>
<thead>
<tr>
<th></th>
<th>sleep</th>
<th>appetite</th>
<th>libido</th>
<th>somatic</th>
<th>sadness</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>-0.136</td>
<td>-0.228</td>
<td>0.037</td>
<td>0.074</td>
<td>0.451</td>
</tr>
<tr>
<td>Sig.</td>
<td>0.367</td>
<td>0.128</td>
<td>0.809</td>
<td>0.625</td>
<td>0.002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>anxiety</th>
<th>fears</th>
<th>loneliness</th>
<th>stigma</th>
<th>cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>-0.143</td>
<td>-0.216</td>
<td>0.113</td>
<td>0.042</td>
<td>0.056</td>
</tr>
<tr>
<td>Sig.</td>
<td>0.343</td>
<td>0.150</td>
<td>0.457</td>
<td>0.781</td>
<td>0.710</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>functional</th>
<th>not troubled</th>
<th>other</th>
<th>cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>-0.045</td>
<td>0.011</td>
<td>0.274</td>
<td></td>
</tr>
<tr>
<td>Sig.</td>
<td>0.765</td>
<td>0.941</td>
<td>0.066</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 6.09B**

<table>
<thead>
<tr>
<th></th>
<th>sleep</th>
<th>appetite</th>
<th>libido</th>
<th>somatic</th>
<th>sadness</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>.</td>
<td>-0.028</td>
<td>.</td>
<td>-0.241</td>
<td>0.196</td>
</tr>
<tr>
<td>Sig.</td>
<td>.</td>
<td>0.853</td>
<td>.</td>
<td>0.106</td>
<td>0.191</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>anxiety</th>
<th>fears</th>
<th>loneliness</th>
<th>stigma</th>
<th>cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>-0.100</td>
<td>0.197</td>
<td>.</td>
<td>0.083</td>
<td>0.083</td>
</tr>
<tr>
<td>Sig.</td>
<td>0.510</td>
<td>0.189</td>
<td>.</td>
<td>0.583</td>
<td>0.583</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>functional</th>
<th>not troubled</th>
<th>other</th>
<th>cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>-0.031</td>
<td>-0.191</td>
<td>-0.113</td>
<td>-0.036</td>
</tr>
<tr>
<td>Sig.</td>
<td>0.838</td>
<td>0.203</td>
<td>0.456</td>
<td>0.811</td>
</tr>
</tbody>
</table>
### TABLE 6.09C

**OVERALL PROMINENCE PATTERNS OF DISTRESS & HDRS SCORES**

(How reported + Most troubling)

<table>
<thead>
<tr>
<th></th>
<th>sleep</th>
<th>appetite</th>
<th>libido</th>
<th>somatic</th>
<th>sadness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>-0.136</td>
<td>-0.230</td>
<td>0.037</td>
<td>-0.019</td>
<td>0.363</td>
</tr>
<tr>
<td><strong>Sig.</strong></td>
<td>0.367</td>
<td>0.125</td>
<td>0.809</td>
<td>0.899</td>
<td>0.013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>anxiety</th>
<th>fears</th>
<th>loneliness</th>
<th>stigma</th>
<th>cognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>-0.197</td>
<td>-0.075</td>
<td>0.113</td>
<td>0.117</td>
<td>0.102</td>
</tr>
<tr>
<td><strong>Sig.</strong></td>
<td>0.191</td>
<td>0.622</td>
<td>0.457</td>
<td>0.439</td>
<td>0.502</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>functional</th>
<th>not troubled</th>
<th>other</th>
<th>cannot say</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>R</strong></td>
<td>-0.029</td>
<td>-0.132</td>
<td>0.214</td>
<td>-0.036</td>
</tr>
<tr>
<td><strong>Sig.</strong></td>
<td>0.846</td>
<td>0.382</td>
<td>0.153</td>
<td>0.811</td>
</tr>
</tbody>
</table>

#### 6.4.6 Hospital status and perception of illness (No figures or tables)

Following open ended queries on the nature of presenting problem(s), the section on patterns of distress in the UK EMIC for Depression enquired about their illness perception (see Appendix C for questions and pre-coded response). They included the following items:

1. Most troubling symptom
2. Perceived seriousness of illness
3. Expectation from treatment,
4. History of deliberate self harm, and
5. Impact of current or future income as a result of their illness

Regardless of whether subjects were admitted or receiving out-patient care at the time of interview, the two groups (out-patients and in-patients) did not show significant differences on their response to the above items.
6.5 Perceived Causes (Figures and Tables 6.10 to 6.16)

6.5.1 Coding strategy

The stacked bar charts (Figure 6.10), illustrate the frequency of 59 perceived causes. The four stacks within each bar represent weighted frequency for each perceived cause depending upon whether that particular cause was spontaneously offered, elicited on screening as a definite or possible cause, or if the causal concept was unknown to the subject. As in section 6.4.1, response were ranked and values assigned as follows:

- Spontaneously elicited cause 4
- Cause elicited on screening 3
- Possibly a cause 2
- Cause uncertain 1
- Cause not elicited 0
Perceived Causes for Depression
How they are reported

FIGURE 6.10
6.5.2 Perceived causes: tables and charts

Table 6.11 outlines the grouping strategy for Figure 6.12 in which the 59 perceived causes have been collapsed into 13 major causal groups. It is important to note there is no ideal way of collapsing individual perceived causal categories. Grouping in this study was done by the researcher and based on the face validity of causal categories that held together to fit with particular higher order themes.

Pie charts in Figures 6.13 and 6.14 detail perceived causes that were reported as first perceived and most important perceived cause. Table 6.15 outlines changes over time for the principal grouped causal categories. Table 6.16 shows that causes were both independent and linked, and illustrate causal linkage for the most common explanations elicited.
<table>
<thead>
<tr>
<th>GROUPINGS</th>
<th>INDIVIDUAL PERCEIVED CAUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>INGESTION</td>
<td>Food-Water</td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
</tr>
<tr>
<td>MEDICAL SOMATIC</td>
<td>Prescribed medicine</td>
</tr>
<tr>
<td></td>
<td>Injury-accident</td>
</tr>
<tr>
<td></td>
<td>Prior-existing illness</td>
</tr>
<tr>
<td></td>
<td>Pregnancy-childbirth</td>
</tr>
<tr>
<td>PSYCHOLOGICAL</td>
<td>Body image</td>
</tr>
<tr>
<td></td>
<td>Stress-loss-shock</td>
</tr>
<tr>
<td></td>
<td>Mind-thoughts-worry</td>
</tr>
<tr>
<td></td>
<td>Nerves</td>
</tr>
<tr>
<td></td>
<td>Personality</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>Family problem</td>
</tr>
<tr>
<td></td>
<td>Marital problem</td>
</tr>
<tr>
<td></td>
<td>Failure to marry</td>
</tr>
<tr>
<td></td>
<td>Other interpersonal</td>
</tr>
<tr>
<td></td>
<td>Global concerns</td>
</tr>
<tr>
<td>VICTIM-ABUSE</td>
<td>Physical abuse-adult</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse-adult</td>
</tr>
<tr>
<td></td>
<td>Racism</td>
</tr>
<tr>
<td>HEREDITY</td>
<td>Heredity</td>
</tr>
<tr>
<td>TOXICITY-SANIT-</td>
<td>Sanitation-living conditions</td>
</tr>
<tr>
<td>HYGIENE</td>
<td>Personal hygiene</td>
</tr>
<tr>
<td>SEXUAL</td>
<td>Semen-vaginal fluid</td>
</tr>
<tr>
<td></td>
<td>Masturbation</td>
</tr>
<tr>
<td>SUPERNATURAL</td>
<td>Astrology</td>
</tr>
<tr>
<td></td>
<td>Will of God</td>
</tr>
<tr>
<td></td>
<td>Bad Deeds</td>
</tr>
<tr>
<td></td>
<td>Other supernatural</td>
</tr>
<tr>
<td>FATE &amp; CHANCE</td>
<td>Karma</td>
</tr>
<tr>
<td>HUMORAL</td>
<td>Heat-cold in the body</td>
</tr>
<tr>
<td></td>
<td>Climate: heat-cold</td>
</tr>
<tr>
<td>OTHERS</td>
<td>Other (specify)</td>
</tr>
<tr>
<td>CANNOT SAY</td>
<td>Cannot say</td>
</tr>
</tbody>
</table>
FIGURE 6.12

Perceived Causes (Grouped)
Most Important Cause

First Reported Cause

FIGURE 6.13 & 6.14
<table>
<thead>
<tr>
<th>CAUSAL GROUP</th>
<th>SPONTANEOUSLY PROVIDED CAUSE</th>
<th>FIRST REPORTED CAUSE</th>
<th>MOST IMPORTANT CAUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>INGESTION</td>
<td>0.0</td>
<td>2.2</td>
<td>4.4</td>
</tr>
<tr>
<td>MEDICAL</td>
<td>8.8</td>
<td>11.0</td>
<td>9.0</td>
</tr>
<tr>
<td>PSYCHOLOGICAL</td>
<td>32.2</td>
<td>19.6</td>
<td>20.0</td>
</tr>
<tr>
<td>SOCIAL</td>
<td>30.4</td>
<td>26.0</td>
<td>31.0</td>
</tr>
<tr>
<td>VICTIM - ABUSE</td>
<td>11.0</td>
<td>13.0</td>
<td>13.4</td>
</tr>
<tr>
<td>HEREDITY</td>
<td>2.2</td>
<td>0.0</td>
<td>2.2</td>
</tr>
<tr>
<td>TOXICITY- SANITATION - HYGIENE</td>
<td>4.4</td>
<td>4.4</td>
<td>4.4</td>
</tr>
<tr>
<td>SEXUAL</td>
<td>2.2</td>
<td>0.0</td>
<td>2.2</td>
</tr>
<tr>
<td>FATE &amp; CHANCE</td>
<td>0.0</td>
<td>4.2</td>
<td>2.2</td>
</tr>
<tr>
<td>SUPERNATURAL</td>
<td>0.0</td>
<td>8.8</td>
<td>2.2</td>
</tr>
<tr>
<td>OTHER</td>
<td>4.6</td>
<td>4.2</td>
<td>2.2</td>
</tr>
<tr>
<td>CANNOT SAY</td>
<td>4.2</td>
<td>6.6</td>
<td>6.8</td>
</tr>
<tr>
<td>PRINCIPAL PERCEIVED CAUSES</td>
<td>LINKAGES OF PRINCIPAL CAUSES WITH OTHER RELATED CAUSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mind-Thoughts-Worry</td>
<td>Anatomy-Physiology (1) Body image (1) Family problem (1) Global concerns (1) Alcohol (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (16)</td>
<td>Child abuse (1) Nerves (8) Personality (14) Heredity (1) Prescribed medicines (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked (31)</td>
<td></td>
<td></td>
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<tr>
<td>Stress-Loss-Shock</td>
<td>Anatomy-Physiology (1) Family problem (3) Interpersonal (1) Bereavement (4) Physical abuse (1) Child abuse (2)</td>
<td></td>
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<tr>
<td>Linked (21)</td>
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<tr>
<td>Family problem</td>
<td>Anatomy-Physiology (1) Marital problem (6) Interpersonal (4) Child abuse (1)</td>
<td></td>
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<tr>
<td>Independent (29)</td>
<td>Personality (1) Living with emotly. dist. (2) Disclosure problem (1) Sexual identity (1)</td>
<td></td>
<td></td>
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<tr>
<td>Linked (18)</td>
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<td></td>
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<tr>
<td>Body image</td>
<td>Food-Water (4) Interpersonal (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (38)</td>
<td>Mind-Thoughts-Worries (1)</td>
<td></td>
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<tr>
<td>Linked (9)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fate-Chance</td>
<td>Anatomy-Physiology (1) Family problem (1) Marital problem (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (19)</td>
<td>Will of God (2) Bad deeds (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked (8)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerves</td>
<td>Injury-Accident (1) Personality (8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (34)</td>
<td>Family problems (1) Mind-Thoughts-Worries (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked: (13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality</td>
<td>Anatomy-Physiology (1) Family problem (1) Stress-Loss-Shock (1) Child abuse (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked (26)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heredity</td>
<td>Mind-Thoughts-Worries (1) Nerves (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent (43)</td>
<td>Personality (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linked (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 6.16**

PRINCIPAL CAUSES: INDEPENDENT AND LINKED
(Numerical in parenthesis indicate number of subjects. Only the most frequent principal perceived causes have been selected to illustrate this finding)
6.5.3 Perceived Causes: summary results

The following key results summarise findings on this section of the EMIC:

1. 55 distinct explanations for Neurotic Depression were elicited. (Figure 6.10) Explanations provided by subjects were not always independent. Frequently, they were linked with other explanations. In such situations, prose data guided coding for the linkages as illustrated in the example provided in Chapter Five, Figure 5.1. Table 6.16 illustrates the way in which some of the most common explanations elicited were linked with other explanations.

2. The most frequently reported explanations (as most important) for depression were social (31%), psychological (20%), and victim-abuse (13%) (Figure 6.13).

3. Medical explanations were offered by about 10% of the sample, and seldom spontaneously. About 35% offered medical explanations on specific screening. Similarly, explanations relating to fate and chance, and supernatural forces, were not offered spontaneously but were considered by some as most important causes (Table 6.15).

4. The following explanations were elicited only when specifically screened (Figure 6.10):
   - Food-water, alcohol, smoking, abused drugs, prescribed medicines, pregnancy-childbirth, global concerns, racism, nerves, personal hygiene, germs-contamination-contact, environmental pollution, living with emotionally disturbed, disclosure problems, boredom, spiritual deficit, sexual identity, heat cold in the body or the weather, astrology, fate-chance, bad deeds, and karma.
5. Failure to marry, evil eye, and congenital non-hereditary explanations were not elicited from any of the study subjects (Figure 6.10). 3 subjects who initially reported explanations coded as 'other' (Figure 6.10) were subsequently recoded as 'other interpersonal conflicts'.

6. All of the perceived causes offered spontaneously were also elicited on specific screening (Figure 6.10).

7. Frequencies for 'first reported' and 'most important' causes were remarkably constant excepting supernatural explanations which although offered spontaneously, dropped three-fold when comparing first reported cause with whether or not they were considered most important (Figures 6.13 and 6.14, and Table 6.15).

8. Ideas relating semen regulation with 'psychological problems' were also elicited and are reported separately under section 6.8.
6.6 EMIC Stigma scale: content and calculation of internal consistency
(Tables 6.17 & 6.18)

6.6.1 Internal consistency (Cronbach’s Alpha)

An internal consistency calculation provides information about the relationships between individual items on a scale. It determines the extent to which items in a questionnaire are related to each other, identify problem items that should be excluded from a scale, and helps obtain an overall index of the internal consistency of the scale as a whole. This overall index, known as Cronbach’s Alpha, is the value obtained from inter-average correlation between all items on a scale. A value of 1 indicates perfect correlation, 0 as no correlation.

In this study, the Cronbach’s Alpha was calculated to establish the internal consistency of eleven questions (referred to as ‘items’ in statistical analysis) relating to ‘disclosure and stigma’. These questions were a sub-section of the ‘Patterns of Distress’ section of the UK EMIC for Depression (detailed in Table 6.17, next page). The alpha value for the ‘raw’ 11 items was 0.49. This improved to 0.61 when 6 out of the 11 items were dropped (Table 6.18). The 6 ‘problem’ items that were dropped are:

1. TOLD SOMEONE WHOM YOU WANT TO KNOW
2. NOT YET TOLD SOMEONE YOU WANT TO KNOW
3. SOMEONE KNOWS, BUT NO MATTER
4. ABILITY TO MARRY
5. EFFECTS ON ONGOING MARRIAGE
6. EFFECTS ON A RELATIVE’S MARRIAGE
TABLE 6.17

<table>
<thead>
<tr>
<th>RAW 11 ITEM EMIC STIGMA QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRONBACH’S ALPHA 0.49</td>
</tr>
</tbody>
</table>

1. SOMEONE KNOWS WHOM YOU PREFER DID NOT KNOW  
   Does anyone else know about this problem, anyone whom you might not want to know about it?

2. THINK LESS OF YOURSELF  
   Do you think less of yourself because of your problem?

3. BURDEN TO OTHERS  
   Do you feel that your problem is a burden to others?

4. EMOTIONS UPSETTING TO OTHERS  
   Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?

5. OTHERS WOULD THINK LESS OF YOU  
   If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?

6. TOLD SOMEONE WHOM YOU WANT TO KNOW  
   Is there anyone whom you told about this problem, because you wanted them to know, perhaps because you thought they should know, or they might help, or for some other reason?

7. NOT YET TOLD SOMEONE YOU WANT TO KNOW  
   Is there someone you would like to tell about your problem whom you have not yet told?

8. SOMEONE KNOWS, BUT NO MATTER  
   Does anyone else know about this problem, someone whose knowing or not knowing makes no difference to you?

9. ABILITY TO MARRY  
   IF UNMARRIED  
   If people knew about it, might this problem make it more difficult for you to get married?  
   IF MARRIED  
   Suppose you were not married. If people knew about it, would this problem make it more difficult for you to get married?

10. EFFECTS ON ONGOING MARRIAGE  
    IF UNMARRIED  
    After you get married, do you think this problem might cause you trouble in your marital life?  
    IF MARRIED  
    Might this problem cause trouble of any kind in your marital life?

11. EFFECTS ON A RELATIVE’S MARRIAGE  
    Could this problem make it more difficult for someone in your family to get married?

This resulted in a final **EMIC Stigma scale for Depression** consisting of 5 items (Table 6.18). Subsequent analysis to examine relationships between EMIC Stigma and variables such as patterns of distress, perceived causes and HDRS scores utilised the 5-item EMIC Stigma scores.
TABLE 6.18

VALIDATED 5 ITEM EMIC STIGMA SCALE FOR NEUROTIC DEPRESSION AMONG WHITE BRITONS IN LONDON

(CRONBACH'S ALPHA 0.6)

1 SOMEONE KNOWS WHOM YOU PREFER DID NOT KNOW
Does anyone else know about this problem, anyone whom you might not want to know about it?

2. THINK LESS OF YOURSELF
Do you think less of yourself because of your problem?

3. BURDEN TO OTHERS
Do you feel that your problem is a burden to others?

4. EMOTIONS UPSETTING TO OTHERS
Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?

5. OTHERS WOULD THINK LESS OF YOU
If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?

6.6.2 Correlation of EMIC Stigma scores with patterns of distress (Table 6.19)

Table 6.19 shows correlation analysis between patterns of distress and EMIC Stigma scores. Patterns of distress were ranked in two ways: (a) based on degree of definiteness for each symptom throughout the EMIC interview, and (b) based on whether symptoms were reported spontaneously or after probing (see footnote in Table 6.19).
TABLE 6.19
Correlation Analysis between Patterns of Distress and EMIC Stigma scores
R = Spearman's coefficient, non-parametric

<table>
<thead>
<tr>
<th>HOW DISTRESS WAS REPORTED</th>
<th>EMIC Stigma scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
</tr>
<tr>
<td>Degree of definiteness</td>
<td></td>
</tr>
<tr>
<td>DF ANXIETY</td>
<td>-0.400</td>
</tr>
<tr>
<td>DF SADNESS</td>
<td>0.330</td>
</tr>
<tr>
<td>DF SOMATIC</td>
<td>-0.089</td>
</tr>
<tr>
<td>DF APPETITE</td>
<td>0.057</td>
</tr>
<tr>
<td>DF CAN'T SAY</td>
<td></td>
</tr>
<tr>
<td>DF COGNITIVE</td>
<td>0.185</td>
</tr>
<tr>
<td>DF FEAR-PHOBIA</td>
<td>-0.221</td>
</tr>
<tr>
<td>DF FUNCTIONAL IMPAIR.</td>
<td>0.170</td>
</tr>
<tr>
<td>DF LIBIDO</td>
<td>-0.056</td>
</tr>
<tr>
<td>DF LONELINESS</td>
<td>0.067</td>
</tr>
<tr>
<td>DF NOT TROUBLED</td>
<td>0.095</td>
</tr>
<tr>
<td>DF OTHER</td>
<td>0.102</td>
</tr>
<tr>
<td>DF SLEEP</td>
<td>0.017</td>
</tr>
<tr>
<td>DF STIGMA</td>
<td>0.159</td>
</tr>
</tbody>
</table>

Reporting priority
RF ANXIETY               | -0.401             | 0.005         |
RF SADNESS               | 0.333              | 0.022         |
RF SOMATIC               | -0.130             | 0.383         |
RF APPETITE              | 0.049              | 0.744         |
RF CAN'T SAY             |                    |               |
RF COGNITIVE             | 0.185              | 0.214         |
RF FEAR-PHOBIA           | -0.223             | 0.132         |
RF FUNCTIONAL IMPAIR.    | 0.160              | 0.282         |
RF LIBIDO                | -0.056             | 0.708         |
RF LONELINESS            | 0.067              | 0.654         |
RF NOT TROUBLED          | 0.095              | 0.525         |
RF OTHER                 | 0.096              | 0.519         |
RF SLEEP                 | 0.017              | 0.912         |
RF STIGMA                | 0.159              | 0.285         |

Degree of definiteness: Prefix DF. This is according to whether subjects rated symptoms as definite spontaneous (highest score), definite probe (next highest), possibly spontaneous (next highest), and possibly on probe (next...). These variables have DF first and then a descriptive name for the symptom (e.g., DFSADNESS for sadness and DFSOMATIC for somatic).

Reporting priority: Prefix RF. Whether the symptom was reported as spontaneous versus probe as criterion for priority. That is, spontaneous definite (highest score), spontaneous possibly (next highest), probe definite (next highest), and probe possibly (next...). These variables have names with the first two letters RP, such as RPSADNESS, RPSOMATIC, and so forth.
Significant results include:

1) The symptom, sadness, was significantly associated with high EMIC Stigma scores.

2) The symptom, anxiety, was significantly associated with low EMIC Stigma scores.

3) Symptoms of somatic nature were inversely associated with EMIC Stigma scores but not statistically significant.

4) Narratives of subjects who scored presented with sadness as a spontaneous pattern of distress and had high EMIC Stigma scores (upper quartile) were compared with narratives of those subjects who presented with anxiety symptoms and had low EMIC Stigma scores (lower quartile). These are presented in Tables 6.20A and 6.20B. The prose reveals the ease with which subjects who reported anxiety as a presenting problem speak about their problem. This contrasts with the difficulty disclosing problems for those who reported sadness as a presenting problem.
TABLE 6.20A
Narratives of subjects who presented with **sadness** as spontaneous pattern of distress and had **high** EMIC Stigma scores

<table>
<thead>
<tr>
<th><strong>PATTERN OF DISTRESS</strong></th>
<th><strong>EXPERIENCE OF STIGMA</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Terrible. Very depressed. Um it started a month ago, it just felt that I was being swallowed by a big wave.</td>
<td>I don’t want people to know. Um you know kind of semi-professional people and people who could hire me as a dancer, people who could do this as soon as you think oh there depressed, unreliable, there this that and the other. So yeah, really I don’t want too many people to know. It does make a difference people knowing.</td>
</tr>
<tr>
<td>2. Well, erm, I was real depressed. I just went up to see my sister and said I am gonna jump off this building ‘cos I am depressed, and that’s it. I jumped off</td>
<td>I think less of myself. It affects my brother and sister ‘cos they don’t like seeing me depressed all the time, they don’t like to be around depressed people do they? ‘Cos it brings them down as well. It will affect my marriage prospects ‘cos a girl don’t want to be going out with a depressed person does she?</td>
</tr>
<tr>
<td>3. I was in such a state that I messed everything up again and I just thought when my wife dumped me, I am never going to be right. I got on the railway tracks and lay down</td>
<td>Yes most people don’t want to know about it. Yes. It affects my wife and then it affects the medical profession. sometimes I feel I take up time that shouldn’t be given to me</td>
</tr>
<tr>
<td>4. I was going through a bad time, I couldn’t really cope. I just wanted to end it all. Well I got knocked down ‘cos I ran in front of a car just over four weeks ago</td>
<td>I haven’t confided in anyone ‘cos I cant approach someone and talk to them about, ‘cos I am never sure what their reaction will be. there’s a lot of people who would resent you They look upon you as being different it would affect family if they knew about it ‘cos they’d be worrying about you.</td>
</tr>
</tbody>
</table>
TABLE 6.20B
Narratives of subjects who presented with anxiety as spontaneous pattern of distress and had low EMIC Stigma scores

<table>
<thead>
<tr>
<th>PATTERN OF DISTRESS</th>
<th>EXPERIENCE OF STIGMA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stress, a lot of stress</td>
<td>I tried to explain to my parents, but they seem to put their nose somewhere else. Now its okay. People have attitude problems. You can kick your friends away.</td>
</tr>
<tr>
<td>2. Everything just got too much for me. The stress that has been caused and I just felt helpless</td>
<td>I did speak to a social worker. I felt I needed to talk to somebody. I would like to tell people who have some sort of authority, say the press or something like that, that should know what is going on and it should be made public. If someone is going through the same thing they would know that they are not on their own and do something before it gets into a situation like what has happened to me.</td>
</tr>
<tr>
<td>3. Erm, it started off as worries and then it became terrible anxieties. The things I shouldn’t be anxious about.</td>
<td>Well obviously I told my wife, my family, and neighbour next door. They have all been sympathetic and they have all said that other people have had this, erm, they get over it. It takes time, but they get over it.. I am free to tell anybody.</td>
</tr>
<tr>
<td>4. It was partly mental stress and strain because of sexual problems and partly just because sometimes I feel that I am allergic to people. I get so nervous with people you know.</td>
<td>Yes I have told my sister, my brother. I would like to tell a doctor or nurse, somebody who has direct contact with me, you know, or that is involved somehow in my life.</td>
</tr>
</tbody>
</table>
6.6.3 Perceived causes: number of explanations, and relationship with EMIC Stigma scores and HDRS scores

Figure 6.21 below shows a histogram detailing frequency of explanations offered by each subject (mean 12, range 2 to 26).

Table 6.22 overleaf details the relationship between number of explanations offered with age, sex, HDRS, and EMIC Stigma scores. Number of explanations were
positively associated with EMIC Stigma scores but showed an inverse statistically
non-significant association with HDRS scores and Age.

**TABLE 6.22**
**NUMBER OF EXPLANATIONS CORRELATED* WITH HDRS AND EMIC
STIGMA SCORES, AGE AND SEX**
**(R=Spearman’s coefficient, non-parametric)**

<table>
<thead>
<tr>
<th>Number of Explanations</th>
<th>R*</th>
<th>Sig. 2 tailed</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDRS Scores</td>
<td>-0.07</td>
<td>0.60</td>
</tr>
<tr>
<td>Age</td>
<td>-0.23</td>
<td>0.12</td>
</tr>
<tr>
<td>Sex</td>
<td>0.10</td>
<td>0.50</td>
</tr>
<tr>
<td>Emic Stigma scores</td>
<td>0.28</td>
<td>0.05</td>
</tr>
</tbody>
</table>

When EMIC Stigma scores were correlated with each of the 59 perceived causes, the
results (Table 6.23 overleaf) showed a statistically significant positive association
with the following causes: body image, disclosure, loneliness, and boredom problems;
and a negative association with ‘nerves’. Note that only 5 out of the 59 causes have
been tabled to show the significant associations.

To illustrate and amplify the manner in which prose data add meaning and validity to
statistical relationship, Tables 6.24A and 6.24B show how subjects presenting
patterns of distress and their experience of stigma. Subjects who scored low on EMIC
Stigma (scores <9, lower quartile) and provided ‘nerves’ as an explanation for their
illness (Table 6.24A, and pages 142-143) were compared with those who scored high
on EMIC Stigma (scores >12, upper quartile) but also provided ‘nerves’ as an
explanation (Figure 6.24B, and pages 144-145).
TABLE 6.23

CORRELATION ANALYSIS BETWEEN PERCEIVED CAUSES AND EMIC STIGMA SCORES

$R = $ Spearman’s correlation coefficient (non-parametric analysis). N=47

Only those perceived causes that have significant associations with EMIC Stigma have been shown

<table>
<thead>
<tr>
<th>PERCEIVED CAUSE</th>
<th>R, Significance</th>
<th>EXAMPLE OF PROSE ACCOUNTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body image</td>
<td>R 0.33, 0.02</td>
<td>Female, age 47 years</td>
</tr>
<tr>
<td>Disclosure problem</td>
<td>R 0.31, 0.03</td>
<td>• You do not eat and you get sick and you go into hospital and you get on a drip and it is all very depressing. I bottle up my problems in my mind. I just keep thinking and it is there and it is just horrible. You think about it too much and you do not get hungry and then you get a headache. It is partly boredom, but not all of it. If affects my son and my daughter. They keep saying mum is sick. People think you are mental and you are mad and they don’t trust you. You get fed up with telling people. There is no one to talk to (pause). There is no one to talk to.</td>
</tr>
<tr>
<td>Loneliness</td>
<td>R 0.39, 0.01</td>
<td></td>
</tr>
<tr>
<td>Boredom</td>
<td>R 0.38, 0.01</td>
<td></td>
</tr>
<tr>
<td>Nerves</td>
<td>R -0.33, 0.02</td>
<td>Male, age 59 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• I mean I am not a doctor but I had many many attacks of SVT. Maybe that was nerves. Nerves to me means keeping, being able to keep your hands straight, outstretched and calm. It is born in you I think. Nervous things. I think you are that type or not. I am shattered from being a man to just sort of nobody now. Every one got to know I was ill. I have spoke to other people about my problems. Yes I have. It does not make any difference to me. I do not think they thought less of me. In fact the Vicar used to come and see me.</td>
</tr>
</tbody>
</table>
TABLE 6.24 A (pages 142-143)
Experience of stigma and patterns of distress for subjects who scored low on EMIC Stigma and perceived nerves as cause of their problem

<table>
<thead>
<tr>
<th>Experience of stigma</th>
<th>Spontaneously elicited pattern of distress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female, age 26 years</strong></td>
<td>Well it is the problem with my head. I feel am lot of tension, a lot of discomfort in my head the sensations I feel in my head my scalp feels very tight sometimes I feel tingling underneath the head.</td>
</tr>
<tr>
<td>(Do you feel that your problem is a burden to others?) Well no it wouldn’t be dangerous or bad effects, no. (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) No. (Talking about problem upset others?) Um, I don’t think so. I don’t know. It’s a difficult question. I don’t know. (prompt) Well certain people, yeah. (Prevent you telling people?) Well that happened about my sister but I finally told her. (If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?) No, I don’t think so.</td>
<td>(What has been troubling you and led to seek help from a psychiatrist?) Well I suppose it started when I had this rather bad chest. When it goes on my chest and I was I tried to get over it without going to doctors which didn’t work. I went into the chemist and bought different things after a week I went to the doctors and he gave me antibiotics which had a depressing effect on me...every time I get a cold I get this business, you know, and all that. I was struggling on my own and that was about a month before I tried to commit suicide.</td>
</tr>
<tr>
<td><strong>Male, age 65 years</strong></td>
<td></td>
</tr>
<tr>
<td>(Do you feel that your problem is a burden to others?) No, well it could be a burden if I get depressed when I am with my sister because she doesn’t want depression. You know she has had her problems as well. (How?) Well she lost her husband and all that about the same time as I lost my wife. She wouldn’t want me to be too depressed and all that obviously you know. (In what way a problem?) I think she has had a certain amount of depression herself as well after she lost her husband. (Seeing you depressed may make it worse?) Well it may do and I told her when I rang her, does she know what she is letting is letting herself in for because I could still get depression even now. Even with the anti-depressants they have given me. Am I speaking fairly frankly to you? (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) Well as I told you, it will only be my family, but I mean I am not living with anybody at the moment, but when I move down I shall be living with her. She is on her own, you see, a widow. (If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?) That is a difficult question really. Some people would probably, yes. They will think you are possibly a coward or something, you couldn’t face up to life. Well that is it isn’t it.</td>
<td></td>
</tr>
<tr>
<td>Experience of stigma</td>
<td>Spontaneously elicited pattern of distress</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------</td>
</tr>
</tbody>
</table>
| **Female, age 26 years**  
(Do you feel that your problem is a burden to others?) No  
(Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) No. Yes, I used to think that. There was a phase where my life wasn’t very good. Attitude problems. You can kick your friends away. You don’t have no one to talk to. (If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?) I think they would be a bit concerned. I don’t really know. |  
(What has been troubling you and led to seek help from a psychiatrist?) Stress a lot of stress. I have plenty of aches and pains. I get tired very easily and start to fall asleep anywhere |
| **Male, age 59 years**  
(Do you feel that your problem is a burden to others?) Dangerous or bad effects? No. (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) Well there are difficulties about access. Not from the court but from my wife is that she thinks that I might harm the children or something, but I wouldn’t harm the children. She has always insisted on a third party being there. (prompt, talking to other people about your problems?) It could do if you talk to other people really, maybe it could upset. I suppose for other people it might be a bit boring. They generally tend to keep themselves to themselves. (Within this culture, could telling people affect them, how?) Yeah, I think so yes. I think there is something in that. (Who is it that is excluded from this?) Well I don’t know, maybe just relations you see. Maybe certain relations might be excluded. (Why not susceptible to being harmed by listening) Well, no it is difficult to tell really. (If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?) Well they may feel sorry for you, yes. I think they. When I lived in Kennington when I was ill, everybody got to know that I was ill. (Think less of you?) I don’t think they thought less of me, no. In fact the vicar used to come to see me. The priest used to come to see me. Methodist. | My marriage, business break up, loss of children. I sometimes get a pain in the chest. |
| **Male, age 59 years**  
(Do you feel that your problem is a burden on others?) Not now. Well it was from my brothers and that, they kind of get me right and err, I suppose I was a bit of a burden to them. (How?) Well I am not saying a burden, that’s the whole thing you know I suppose it was a worry for them and that, you know, but touch wood I can’t. (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) No as I say um, it was upsetting for my family, to see me like it. (If they knew about your problems, would your neighbours, colleagues or others in your community think less of you?) Yeah I think some of them have that attitude myself and that, if they think you are..of course a lot of them don’t look at it as a like an illness, a bit of an illness, they think you are balmy..(What does balmy mean?) Well insane, they classify all in one..but as I was saying a lot of it, the younger generation now don’t look at it like that I don’t think. But the older ones who have a bit of a Victorian attitude, they do. | Err, when my sister died I was all right after the funeral but it just seemed to come over me and everything seemed to get on top of me. The only thing is that I suffer with my back a bit, you now |
TABLE 6.24B (pages 144-145)
Experience of stigma and patterns of distress for subjects who scored high on EMIC Stigma and perceived nerves as cause of their problem

<table>
<thead>
<tr>
<th>Experience of stigma</th>
<th>Spontaneously elicited pattern of distress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male, age 28 years</strong></td>
<td><strong>Experience of stigma</strong></td>
</tr>
<tr>
<td>(Do you feel that your problem is a burden to others?) Sometimes I feel very unstable. And I feel angry. I feel very angry sometimes and at those times you see I think that it would be very easy if somebody annoyed me, if somebody gave me provocation that something bad could happen. But you see, also at the same time that... In my own mind I keep this thought that I know the difference between right and wrong and you know that I can’t keep making excuses you know if something bad did happen because I would, because I know the difference. (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) My emotions. Er, (prompt) Well no. The person that I really speak to is my sister and she knows and she understands. (Any others?) No, because people are not directly involved somehow. Close family like my sister I mean there is nobody else I would speak to except my sister or maybe a doctor or a nurse. Somebody who has direct contact with me, you know, or that is involved somehow in my life, but if it is just people that I might know on a casual basis then I would never tell them anyway.</td>
<td>It was partly mental stress and strain because of sexual problem and partly just because sometimes I am allergic to people that I have. I have very strong difficulty dealing with people in just ordinary social situations because I get so nervous with people you know.</td>
</tr>
<tr>
<td><strong>Female, age 58 years</strong></td>
<td><strong>Experience of stigma</strong></td>
</tr>
<tr>
<td>(Do you feel that your problem is a burden to others?) Yeah. (Whom does it affect most? how?) Well, I don’t know about now, but it affected my children. (How?) Because I took all my problems out on them. Well it wasn’t a problem to me it was an illness. (Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) I should imagine, if I was to tell them. I don’t know whether it affects the doctors or Pauline. I get worried about Pauline, telling Pauline. (If they knew about your problem, would your neighbours, colleagues or others in your community think less of you?) I wouldn’t dare tell my neighbours. (prompt) If they knew, oh god. I don’t know.</td>
<td>Um. I think I have always suffered with depression. Always as far as I can remember.</td>
</tr>
<tr>
<td><strong>Male, age 50 years</strong></td>
<td><strong>Experience of stigma</strong></td>
</tr>
<tr>
<td>(Do you feel that your problem is a burden to others?) Yes. My wife and my mother. (prompt) theory worry about me (Because of your problem, do you think your emotions or feelings could upset or have a negative influence on others?) Yes, well concern, worry, whatever. (Would your community think less of you?) Um, I think I need to answer an earlier question there and that is that I yeah... I wouldn’t want my neighbours to know. Um, but in terms of... you see the trouble is I have lost so many friends as a result of my depression, you know, and I am really left basically with one and only because he suffers from manic depression and he understands.</td>
<td>Depression.</td>
</tr>
<tr>
<td>Experience of stigma</td>
<td>Spontaneously elicited pattern of distress</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Male, age 24 years</strong></td>
<td>Erm, le le le, erm, depression for a lot of it. And suicidal tendencies. As I said stemming back from my family problems, everyday living, problems with my child, not being able to see my child, relationship with my girlfriend, being made redundant. A host of small bits and pieces add up to like an erupting volcano and then it explodes, and that is the depression coming out.</td>
</tr>
<tr>
<td>(Do you feel you are a burden to others?) Yes. (Who? And how?) The people that have to deal with my problem, whether I am being irritable, and I have been irritable because of my depression. Erm, I, I may be over-rational or I may talk a lot of, excuse my language, bullshit. It, may, you know, basically I have told maybe to do something a certain way and I haven’t done it and then I have learnt something else. (Do you think your emotions or feelings upset others?) Oh yes. erm, because they reflect erm, the eyes of the soul, is it the eyes? You know, the windows to the soul, so, yeah, I do. (If they know, would your community think less of you?) Yes. Unfortunately the thing, the stigma about a psychiatric ward, it is still thought of as very Victorian and goes back to what happened in the Victorian era where people would be just, whether it would be depression or whatever, and depression comes in many forms, a lot of people were just locked up and there wasn’t really the adequate care that there is at the proper...also the same bit of knowledge as well, people were very uneducated in certain areas (How can this be helped?) Well, you have more of a religious and family commitment, maybe sounds very two-faced coming from someone who doesn’t go to church but having said that, if you look at where your culture is, Asia, or a lot of other cultures, they are very based on two main things, the whole of the family is very religious and it is always, all the family rallies around, it is very close. Britain hasn’t got as many morals, I do not know as Westerner. I don’t know Asia. There is a lack of communication and in my family there is and what I can see from other people.</td>
<td></td>
</tr>
<tr>
<td><strong>Female, age 22 years</strong></td>
<td>My memories. My memories of my childhood. They are very disturbing. When they get bad, I feel like taking my life.</td>
</tr>
<tr>
<td>(Do you feel you are a burden to others?) Yes I always think I am wasting their time. I would be telling them and you think, you have got your own problems, what am I doing telling them mine. (Are your emotions upsetting to others?) Yeah. (If they come to know your problems will your community think less of you?) No, probably think I was a ...not really no.</td>
<td></td>
</tr>
<tr>
<td><strong>Female, age 50 years</strong></td>
<td>Dreadful, dreadful. I couldn’t get the money to go into Rudolph Steiner Hospital.</td>
</tr>
<tr>
<td>(Do you feel you are a burden to others?) I think before my husband and I split up, he perceived it that way, but I don’t know how much he chose to perceive it that way because he had been informed by these people that I told about it, I was that kind of person. (Whom does it affect most?) My husband. (Are your emotions upsetting others?) Well I think if they want to be responsible for my emotions, yes, but I am responsible for my emotions. I think people’s behaviour and what they do with their emotions affects others. I think it is a very blandly egocentric culture. If you are happy they wonder what is wrong with you or if you are miserable they wonder what is wrong with you (If they come to know would others in your community think less of you?) Yes.</td>
<td></td>
</tr>
</tbody>
</table>
The prose data in Tables 6.24A and 6.24B indicate:

1. Subjects who scored low on EMIC Stigma and perceived nerves as a cause of their problem did not think their problem was a burden to others, did not mind others knowing their problem, and expressed their presenting problems in somatic terms.

2. Subjects who scored high on EMIC Stigma and perceived nerves as a cause of their problem felt they were a burden to others, preferred others did not know their problems, and expressed their presenting problems in psychological terms, chiefly as sadness.

6.6.4 Correlation of EMIC Stigma scores with HDRS scores (Table 6.25)

This shows no association between the full 24 item HDRS scores and EMIC Stigma scores but a significant inverse relationship between EMIC Stigma and Hamilton Anxiety sub-scale scores.

<table>
<thead>
<tr>
<th>EMIC STIGMA SCORES</th>
<th>HAMILTON 21 ITEM DEPRESSION SCORE</th>
<th>HAMILTON ANXIETY SUB-SCALE SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>Sig. 2 tailed</td>
</tr>
<tr>
<td>0.07</td>
<td>0.61</td>
<td>-0.27</td>
</tr>
</tbody>
</table>
6.7 Help Seeking

6.7.1 Family and Social Supports (Table 6.26)

Table 6.26 details perceived family and social supports for the study sample. Less than 50% of the sample perceived that: a) they were able to get help from their family and other immediate social supports, and b) had received, asked, or wished further help from their family.

<table>
<thead>
<tr>
<th>SOCIAL SUPPORTS AND FAMILY HELP</th>
<th>Frequency percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Able to get help from social supports?</td>
<td>44.7</td>
</tr>
<tr>
<td>Asked family for more help?</td>
<td>40.4</td>
</tr>
<tr>
<td>Has family helped?</td>
<td>48.9</td>
</tr>
<tr>
<td>Like family to be more helpful?</td>
<td>34.7</td>
</tr>
</tbody>
</table>

6.7.2 First and Most Important Help Sought (Table 6.27, Figures 6.28 & 6.29)

Table 6.27 provides median time (days) taken for subjects to consult their general practitioner and psychiatrist from onset of illness episode. Medians are chosen over means as the best representation of lag time because the distribution of data is skewed and inflates the mean lag time. It should be noted that poor subject recall prevented an accurate recording of time taken to present to various help seeking sources. As a result, only 28 out of the 47 (i.e. 59.6% of the sample) subjects in the study were included in the analysis shown in Tables 6.27.

Female subjects took longer than males to consult GPs and over four times longer to consult psychiatrists (120 days and 28 days respectively).
TABLE 6.27
Median lag time from onset of illness to help seeking (Days)

<table>
<thead>
<tr>
<th>Type of Help Sought</th>
<th>Sex</th>
<th>N</th>
<th>Median lag time</th>
<th>Std. Dev</th>
<th>Min.</th>
<th>Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>Male</td>
<td>17</td>
<td>11</td>
<td>31</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>11</td>
<td>18</td>
<td>118</td>
<td>0</td>
<td>360</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>28</td>
<td>15</td>
<td>83</td>
<td>0</td>
<td>360</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Male</td>
<td>17</td>
<td>28</td>
<td>41</td>
<td>1</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>11</td>
<td>120</td>
<td>233</td>
<td>4</td>
<td>720</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>28</td>
<td>30</td>
<td>169</td>
<td>1</td>
<td>720</td>
</tr>
</tbody>
</table>

Pie charts (Figure 6.28 and 6.29) depict the first and most important help sought by the entire sample when specifically screened for each source of help. Although GPs were the commonest source of first help sought, over 14% of the study sample sought first help from psychiatrists (Figure 6.28). Figure 6.29 indicates that psychiatrists (37%) were considered a more important source of help than general practitioners (27%). A further 12% did not consider any source of help sought as important, and social workers considered the least important.
First Help Sought

- Psychiatrist (14.29%)
- GP (61.90%)
- Social Worker (7.14%)
- Psychologist (2.38%)
- Psychotherapist (2.36%)
- Spiritual healer (4.76%)
- Other (7.14%)

Most Important Help

- Psychiatrist (36.59%)
- GP (26.83%)
- Social Worker (2.44%)
- Psychologist (4.88%)
- Psychotherapist (7.32%)
- Spiritual healer (4.88%)
- Other (4.88%)
- None (12.20%)

Figures 6.28 (First Help Sought) & Figure 6.29 (Most Important Help Sought)
6.7.3 How Help Sought was reported (Figure 6.30)

6.7.3.1 Coding strategy

Bar chart in Figure 6.30 reports how help sought was reported in response to probes. This was calculated by producing a summary score for emphasis on particular sources of help seeking apart from self help or help from friends and family, and is based on responses to items 46 and 47 of the UK EMIC. A value of 3 was assigned if a help provider type was mentioned spontaneously in response to an open ended query on help sought. If not mentioned spontaneously, but mentioned in response to the probe on help seeking for the current episode, then this response was assigned a value of 2, and if not used for the current episode, but used for prior episode, the response was assigned a value of 1.

Similarly a summary variable, help seeking prominence, is a score obtained by summing ‘how reported’, ‘most important’, and ‘first help’. This score was used to analyse the relationship between help seeking with patterns of distress, perceived causes, EMIC Stigma and HDRS scores.

6.7.3.2 Results of probing for help sought

Figure 6.30 shows the diversity of help sought by subjects, although GPs and Psychiatrists were the most commonly sought sources of help. More significantly, excepting chemists, herbalists and spiritual healers, all sources of help required probing to elicit help sought for the current episode. And the maximum frequency response for this related to help sought from psychiatrists (over 30% of the sample, brown colour in bar chart).
Help Seeking
How help sought was reported

FIGURE 6.30
6.7.4 Relationship between Help Sought with HDRS and EMIC Stigma scores

(Tables 6.31 and 6.32)

Hamilton Depression Rating Scale scores did not correlate with help sought from either general practitioners or psychiatrists (Table 6.31). However, EMIC Stigma scores were positively associated with help sought from general practitioners (p<0.02) and inversely associated with help from psychiatrists (p<0.08, Table 6.32). Although Tables 6.31 and 6.32 also shows significant correlation with other medical specialists, masseurs, homeopaths and aromatherapists, the numbers were too small to consider this significant for further discussion.

TABLE 6.31
Correlation between Help sought & Hamilton Depression Rating Scale Scores
(R= Spearman’s coefficient, non-parametric)

<table>
<thead>
<tr>
<th>HELP SOUGHT</th>
<th>HAMILTON DEPRESSION RATING SCALE SCORES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
</tr>
<tr>
<td>GENERAL PRACTITIONER</td>
<td>0.038</td>
</tr>
<tr>
<td>PSYCHIATRIST</td>
<td>0.005</td>
</tr>
<tr>
<td>PSYCHOLOGIST</td>
<td>-0.074</td>
</tr>
<tr>
<td>SOCIAL WORKER</td>
<td>-0.009</td>
</tr>
<tr>
<td>PSYCHOTHERAPIST</td>
<td>-0.108</td>
</tr>
<tr>
<td>OTHER MEDICAL SPECIAL</td>
<td>0.303</td>
</tr>
<tr>
<td>CHEMIST</td>
<td>-0.191</td>
</tr>
<tr>
<td>HOMEOPATH</td>
<td>-0.003</td>
</tr>
<tr>
<td>AROMATHERAPIST</td>
<td>-0.093</td>
</tr>
<tr>
<td>MASSEUR</td>
<td>-0.335</td>
</tr>
<tr>
<td>TM-MEDITATION</td>
<td>-0.022</td>
</tr>
<tr>
<td>HERBALIST</td>
<td>-0.005</td>
</tr>
<tr>
<td>SPIRITUAL HEALER</td>
<td>-0.096</td>
</tr>
<tr>
<td>OTHER</td>
<td>0.189</td>
</tr>
<tr>
<td>NONE</td>
<td>-0.054</td>
</tr>
</tbody>
</table>
6.7.5 Help sought from psychiatrists and causal explanations (no tables)

A correlation between psychiatric help seeking (prominence variable) and causal explanations (grouped) showed no positive association. Supernatural explanations were however inversely related with help sought from psychiatrists (p=0.03). More significantly, medical-somatic explanations did not show an association with psychiatric help.
6.8 Semen regulation and psychological problems

Figure 6.33 is a bar chart showing frequency percentage response to the question “Does losing or retaining semen cause any psychological problems?” Subjects were asked this question in the perceived causes section of the UK EMIC. Responses were recorded in prose and coded as shown in the bar chart.

Forty-two percent of subjects felt semen loss or retention or both did not cause psychological problems, and 11% said that this concept was unknown or strange to them. Among those who believed semen retention or loss caused psychological problems, semen retention was the largest group (17%).

Prose response are detailed in a tabular format on pages 49-50, and separated into three categories: those who believed losing semen caused psychological problems, those who believed both losing and retaining semen caused psychological problems, and those who believed retaining semen caused psychological problems.
Could losing or retaining semen cause psychological problems?

**FIGURE 6.33**

**Losing semen can cause psychological problems**

1. *Male, age 43*
   Yes it does to me. I am not firing emotionally correctly. This frustration. I think it can to some people, yes. Their idea of a relationship is sex that needs sex if they can't get it then its going to cause them real problems which will cause depression. Yes, losing semen can cause psychological problems.

**Both losing and retaining semen can cause psychological problems**

1. *Female, age 29*
   Um, I do believe, I mean you lose too much (of semen) you could lose too much energy. I think my boyfriend thinks that as well. Certainly not being able to lose any would not be very helpful either. Maybe that energy can cause depression.

2. *Female, age 36*
   Yeah both (losing and retaining) because my ex-boyfriend was bit like that. Because they have to release themselves after a while. My guess is that they would go loopy, they would end up losing a part of their brain or whatever.
Retaining semen can cause psychological problems

1. Male, age 64
It can, yeah. Because they cannot lose it. Well it (semen) becomes inhibited and insular. I believe in it immensely.. they become withdrawn I believe and can’t smile, things like that.. can’t be happy.

2. Male, age 26
Well my past experience is that it is hard to ejaculate.. because of taking medications.. that can cause problems.

3. Male, age 50
I suppose it would. I mean it is not based on any factual evidence, um, but I suppose there is a build up of tension as a result (of retaining). I am not sure there is chemical evidence to say so, but, yeah.. then the sexual appetite is not satisfied it can cause further problems. It might encourage release in ways that might not be useful

4. Male, age 58
From the man’s point of view, I think the regular build up and release of semen, part from all the physical sort of things release a lot of tension which as you can feel building up in yourself. (If retained) it will damn up the energy I think. (Where is that energy coming from?) Well it’s given off improperly in the way I twitch (shows his muscles) but also one would be encouraged to build up tension again.. rather like doing exercises on a bicycle.. the easiest example I can give is my step brother-in-law.. he has got mental illness.. it has never worried me.. I mean I have thought of having a vasectomy..

5. Male, age 64
Well with younger people it would be.. the urge with younger people is very.. quite something. It doesn’t worry me.. unless they (younger people) get a relief in some way it could affect them mentally. (How?) I don’t know

6. Female, age 29
Well if a man retains sperm then well every man has to procreate and if that is not fulfilled then it will become inwardly frustrating. If it is linked to the prostrate gland then that links a signal to the brain in need of fulfilment, a signal of death looming.. then a man might become depressed.. the body gets confused and the male’s mind automatically becomes dead. (What about losing semen?) No. I think the more semen the man loses then the more it will regenerate itself. The body will say I need it more, more, more (that is just the opposite in India where losing semen causes concern) no, my theory is use it or lose it

7. Female, age 45
I would have to say yeah. I should imagine it is like if you don’t have periods you get bloated, you feel horrible and after the period is over it is like going.. you know the loo, and having a poo every day... I feel clean after that and feel brand new.. so if men carry too much semen wouldn’t men not masturbate?
6.9  Relationship between Patterns of Distress and Perceived causes

Table 6.34 shows correlation between three major patterns of distress (somatic, sadness and anxiety, prominence ratings) and grouped perceived causes (as outlined in the grouping strategy in Table 6.12).

Somatic symptoms were not associated with any major causal group, the symptom sadness was inversely associated with psychological causes but positively associated with supernatural explanations, and the symptom anxiety was inversely associated with explanations on heredity.

<table>
<thead>
<tr>
<th>GROUPED CAUSES</th>
<th>SOMATIC R</th>
<th>SOMATIC Sig.</th>
<th>SADNESS R</th>
<th>SADNESS Sig.</th>
<th>ANXIETY R</th>
<th>ANXIETY Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ingestion</td>
<td>0.008</td>
<td>0.958</td>
<td>0.043</td>
<td>0.773</td>
<td>-0.033</td>
<td>0.825</td>
</tr>
<tr>
<td>Medical Somatic</td>
<td>0.228</td>
<td>0.123</td>
<td>0.221</td>
<td>0.136</td>
<td>0.124</td>
<td>0.406</td>
</tr>
<tr>
<td>Psychological</td>
<td>-0.032</td>
<td>0.833</td>
<td>-0.451</td>
<td>0.001</td>
<td>0.111</td>
<td>0.458</td>
</tr>
<tr>
<td>Social</td>
<td>-0.148</td>
<td>0.320</td>
<td>0.077</td>
<td>0.606</td>
<td>-0.003</td>
<td>0.985</td>
</tr>
<tr>
<td>Victim-Abuse</td>
<td>-0.070</td>
<td>0.640</td>
<td>-0.036</td>
<td>0.811</td>
<td>0.160</td>
<td>0.284</td>
</tr>
<tr>
<td>Heredity</td>
<td>0.114</td>
<td>0.445</td>
<td>-0.027</td>
<td>0.855</td>
<td>-0.328</td>
<td>0.025</td>
</tr>
<tr>
<td>Toxicity-Sanit-Hyg</td>
<td>0.061</td>
<td>0.683</td>
<td>-0.043</td>
<td>0.775</td>
<td>0.072</td>
<td>0.628</td>
</tr>
<tr>
<td>Sexual</td>
<td>0.175</td>
<td>0.241</td>
<td>-0.074</td>
<td>0.620</td>
<td>0.055</td>
<td>0.715</td>
</tr>
<tr>
<td>Supernatural</td>
<td>0.255</td>
<td>0.084</td>
<td>0.320</td>
<td>0.028</td>
<td>-0.168</td>
<td>0.260</td>
</tr>
<tr>
<td>Fate-Chance</td>
<td>-0.001</td>
<td>0.996</td>
<td>0.027</td>
<td>0.857</td>
<td>-0.009</td>
<td>0.952</td>
</tr>
<tr>
<td>Humoral</td>
<td>0.196</td>
<td>0.187</td>
<td>-0.085</td>
<td>0.569</td>
<td>-0.066</td>
<td>0.657</td>
</tr>
<tr>
<td>Other</td>
<td>-0.003</td>
<td>0.983</td>
<td>0.086</td>
<td>0.568</td>
<td>-0.205</td>
<td>0.168</td>
</tr>
<tr>
<td>Cannot Say</td>
<td>0.031</td>
<td>0.838</td>
<td>0.126</td>
<td>0.399</td>
<td>-0.085</td>
<td>0.568</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN
DISCUSSION

7.1 Clinical characteristics

An unexpected finding was the absence of statistically significant clinical difference between in-patient and out-patient groups on Hamilton Depression Rating Scale scores (Table 6.04). If severity of depressive psychopathology (an etic factor) did not influence hospital admission, what emic factors could have influenced admission? It is plausible that the clinicians' decision to admit might have been influenced by patients' explanatory models and social class - they were poorer, rather than more objective indices such as severity of depressive psychopathology. Although the study design did not aim to investigate this question, the data generated allows a limited degree of exploration.

Analysis of several dimensions of patients' explanatory model such as presenting and most troubling symptoms, causal explanations (grouped), perceived seriousness, expectation from treatment, history of deliberate self harm, and impact on current and future income; did not show any significant difference between out-patient and in-patient groups (section 6.4.6, Chapter Six).

Although this is puzzling, it is possible that confounding variables might account for this finding. These include timing of presentation, staffing levels and experience of admitting doctor, availability of beds including gate-keeping procedures in the NHS, nature of doctor-patient communication, non-verbal cues such as patients' appearance and dress, that may have influenced admission. Another crucial variable,
not included in this study, is the nature of explanatory models held by the admitting doctors and other mental health staff, at the time of presentation.

The scores on Hamilton Depression Rating Scale in the present study were significantly higher compared to the literature (reviewed in Endicott et al. 1981). Summarising the controversy over ratings on the HDRS the authors state that:

“Several studies involving HDRS ratings have suggested various cut off points as a standard for determining severity of depression: a total score greater than 24 for severe depression (in-patients), greater than 17 for mild depression (outpatients), and less than 6 for essentially no depression. However, many investigators have been dissatisfied with the item weights or the item content” (ibid.).

Previous studies examining concordance of self report and clinician’s assessment of depression (Carroll et al 1973, Corruble et al 1999, Paykel and Prusoff 1973, and Prusoff et al 1972) suggest other factors apart from severity of depression. These include: general psychopathology, personality traits, somatisation, and anxiety. The consensus view among these researchers is that patients ‘overestimate’ symptoms when ill. These studies also confirm that sex, age, marital status, number of previous episodes, and lengths of episodes are not linked to the discrepancies.

There could be three factors contributing to the unusually high scores on the HDRS in this study. First, the sample selected in this study was perhaps suffering from severe depression and was incorrectly diagnosed as Neurotic Depression. An
independent diagnostic assessment was not done by this researcher. The selection of subjects was carried out by asking medical staff for their clinical diagnosis either over telephone or in person. Only those patients who were given a diagnosis of Neurotic Depression (ICD-9) by treating clinicians were asked for consent to participate in the study. Second, because all subjects were assessed on the HDRS after the EMIC interview, the ensuing rapport and empathy developed with subjects may have led this researcher to rate high on the HDRS. Additionally, detailed probing on the EMIC may have uncovered latent psychopathology: such as the high levels of somatic distress upon probing (Figure 6.05, Chapter Six). It is hypothesised that emic style qualitative interviewing inflates subsequent psychopathological ratings. A separate study, reversing the sequence of interviews (HDRS followed by the UK EMIC) could test such a hypothesis. Third, those objective rating scales such as the HDRS do not capture nor reflect personal distress and suffering. Perhaps they are not designed to do so. This issue shall be discussed later under the section on patterns of distress and their correlation with HDRS.

7.2 Patterns of Distress (Figures 6.05 and Table 6.06)

7.2.1 Reporting style

The striking difference between reporting symptoms offered spontaneously (sadness 87.2%) as opposed to when probed (somatic symptoms 76.6%) suggest three possible explanations:

1. Depression as an illness is primarily conceptualised as a psychological disorder among subjects presenting to NHS psychiatrists.

2. British psychiatrists conceptualise depression as a psychological illness and therefore encourage expression of psychological idioms.
3. Reporting styles may not directly relate with underlying conceptualisation of illness. They may just be a transient situational response, related to other factors including interviewer characteristics, accepted cultural norms including mode of presentation to hospital, and perceived stigma.

Each of these explanations will be now discussed in detail:

**Explanation 1 and 2**

Historical literature, reviewed in Chapters One and Two, suggest melancholia and its successor, depression, as a British psychological cultural construct. Consequently, both patients and psychiatrists operating within this culture are embedded in this frame (i.e. point nos. 1 and 2).

This study does not allow further clarification on the relative contribution from the first two factors. Moreover these two factors are not independent. If this study were to be extended to a primary health care setting or a general medical clinical site in London, it might help clarify whether the latter (explanation no. 2) is indeed a significant influence on symptom presentation. Recent findings from a similar study at Bangalore (Raguram et al 1996, and Weiss et al 1995) among rural and urban south Indian depressed subjects indicate reverse findings. Figure 7.1 compares the reporting style of subjects in a study at Bangalore using the Indian EMIC for depression and the current study in London. The majority of subjects in Bangalore spontaneously report somatic patterns of distress but when specifically probed reported extensive psychological idioms. This is just the reverse for subjects in this study. This finding therefore directly challenges the current clinical notion that ‘depression’ is primarily a psychological illness, somatic features being secondary
manifestation of the illness, or for that matter, the currently accepted association of somatisation with a particular ethnic or cultural group within conventional psychiatric literature (Kaplan and Saddock 1995). Clinicians in general, might assume somatic symptoms are not integral to depression, but the bar chart in Figure 7.1 shows how the quality of probing challenges this assumption. It is more likely that symptoms are expressed in clinic settings in a manner so as to conform to expectations from health professionals who in turn are guided by their academic explanatory schema. Patients at Bangalore are likely to perceive psychiatrists’ practice application of western biomedical technology, and therefore more likely to play up bodily symptoms so as to engage their attention and receive ‘western’ treatments (Jadhav 1997, 1998). And the reverse in London.

Consider for example, the argument that white British subjects in this study were actually suffering from a more somatic version of Depression akin to neurasthenia as described in research on Chinese subjects in mainland China and Taiwan (Kleinman 1988). Indeed the bar chart in Figure 7.1 provides empirical support for this. The British subjects in this study presented with predominantly psychological symptoms thus masking the ‘true’ underlying somatic ‘form’ of illness. This masking having occurred as a result of (British) cultural prescriptions (or sanctions) for certain culture specific idioms of expression. In other words, psychological symptoms are the cultural ‘content’ that needs teasing out to reveal a core somatic ‘form’. It follows that psychological features of depression, in particular, mood symptoms are ‘culturally’ generated whilst somatic symptoms are the ‘core’ universal features of the psychopathology of neurasthenia. Neurotic Depression among white Britons is thus merely a cultural variation of Neurasthenia. This mode of analysis is
deliberately presented as it exposes the inadequacy of the form-content framework of German psychiatric phenomenology. The form-content framework posits that psychiatric symptoms are characterised by a ‘form’ for example, depressed mood, that is a core universal feature of depressive disorders; the popular somatic ‘form’ in traditional societies being a mere cultural variation. This variation then considered to be related to local factors shaping the expression of depressed affect into somatic symptoms (Leff 1973). Medical anthropologists and the ‘new cross-cultural psychiatry framework’ have critiqued this ‘old transcultural’ premise that western psychiatric disorders and criteria (as reflected in the DSM) are universal, any deviation in presentation is only a matter of cultural ‘colouring’ or ‘influence’ that can be clarified by teasing out or peeling away the cultural masking to reveal the ‘true’ underlying ‘form’ or core feature of the disorder (Littlewood, 1990b). The findings from this study confirm that it is indeed problematic to consider Neurotic Depression for the London sample as a more ‘true’ disorder, the Bangalore or Chinese version then a cultural ‘masking’ of the former.

**FIGURE 7.1**
(Source: Swiss Tropical Institute, annual report 1998*)

*London data from this study*
Explanation no 3

Authors of the Bangalore study cited earlier, and of recent research in China (Kleinman et al 1995) suggest somatic presentations in developing countries are directed at escaping stigma. Table 6.19 reveals sadness distress patterns strongly associate with stigma scores \((p=0.02)\), but inversely with anxiety distress patterns \((p=0.005)\), and inversely but less strongly so with somatic distress patterns \((p=0.3)\). In order to allow for transient, more situational factors influencing reporting style, correlation has been done in two ways, using both reporting style and degree of definiteness of presenting symptoms. The findings remain consistent.

These findings make it difficult to draw clear conclusions. A strong association of the EMIC Stigma scores with sadness and anxiety distress patterns but in opposite direction indicate that it is more acceptable for white British subjects to report anxiety rather than sadness distress patterns. It is hypothesised that the experience of stigma would be less for anxiety disorder as compared with depression. A separate study with a sample of patients diagnosed with anxiety disorder and interviewed on the UK EMIC could test this hypothesis.

A weak but inverse relationship with somatic distress patterns suggests that, like in Bangalore, physical symptoms (for white Britons) protect from stigma: the inverse association between somatic distress and stigma measures might have been stronger if the sample size in this study was large enough.

An examination of the prose data (Tables 6.20A & B) between subjects who scored high on stigma (upper quartile) and presented with sadness distress patterns with
those who scored low on stigma (lower quartile) and presented with idioms of anxiety confirm the ease with which anxiety is expressed and disclosed to the community. A similar examination of prose for those who presented with somatic distress patterns is inconclusive, in part, due to small number of subjects in this category.

7.2.2 Additional influences on symptom presentation

Results from this study allow some clarification on how local British cultural factors might shape the presentation of depressive symptoms. Published research suggests four major influences on symptom presentation: 1. Social class 2. Gender 3. Causal explanations, and 4. Nature of help sought (Kleinman 1977, and Kleinman and Good, 1985).

1. Social class: Subjects in this study were from predominantly working class background. More crucial, the historical association of (upper) social class with (male) gender renders it difficult to tease out this relationship. This will be discussed in more detail below.

2. Gender: Male subjects tend to report psychological symptoms, especially sadness, more frequently than female subjects who tend to report with anxious mood (Table 6.08A). There is no difference between the men and women on their frequency of presentation with somatic symptoms. This finding is unexpected. The literature on culture, doctor-patient interactions and emotional vocabulary of depression in British context suggests a gender split, but in the reverse direction (Babb 1951, Doughty 1926, Jadhav 1996, Lloyd et al 1999). Ascribing difficulty for
men to express feelings and emotions, with a historical cultural sanction for women to express their emotions more easily, and for 'depression' to be viewed both as a desired state and status (Delumeau 1990, Jackson 1986). If this was the case, the present study should have shown results in the opposite direction.

The following explanations could be considered:

a. Historical social literature has relied on popular assumptions that were never systematically tested out and these were simply impressionistic.

b. The social class and health care setting of the sample in this study. This was mainly a working class group presenting at NHS clinics as opposed to description in the literature and popular media that may have generalised popular stereotypes (such as the 'stiff upper lip') derived from the upper social classes.

c. The interviewer's gender and south Asian ethnic background may have allowed men to express their feelings more readily but perceived as psychologically threatening by women who may have withheld expressing more intimate and private feelings.

d. An artefact of coding strategy. Numerical coding might well not have captured subtle aspects of psychological talk when subjects were directly asked what troubled them. More recent literature suggests that the distinction between psychological and somatic is oversimplified and that subjects if encouraged may well talk about bodily or somatic symptoms in a psychological manner (Kirmayer and Young 1996). However, the EMIC section on Patterns of Distress allowed for coding after examining prose data and also for multiple coding to reflect degree of prominence for each of the 13 symptom categories.
e. Male subjects interviewed in this study had experienced more severe depression and therefore reported them spontaneously. In other words, male subjects felt somatic symptoms alone were insufficient to express their distress. This is supported by the finding of higher mean scores for men on HDRS, when compared with female subjects (p<0.02, Table 6.08A). It also suggests that in general the male sample in this study experienced more severe symptoms. This in turn could be due to either men reporting later than women to their GPs or referred later (than women) by their GPs to NHS psychiatrists. This is however not the case and will be discussed in more detail in the help seeking section 7.7 of this chapter.

f. Women experience less stigma reporting their problems through somatic and anxiety idioms. This is confirmed by an analysis of EMIC Stigma scores within male and female subject groups. The EMIC stigma scores for women relate inversely with reporting anxiety and somatic symptoms as compared to sadness (Table 6.08B). A similar statistically insignificant inverse relationship is observed for men reporting anxiety symptoms.

3. Causal explanations: Subjects reported as many as 26 explanations (Figure 6.21). It is methodologically difficult to establish which of these should be analysed with subjects' presenting patterns of distress. Similarly, most important explanations cut through all of the 55 discrete causes despite collapsing them into 12 major causal groups (Table 6.15, column 3). When the latter group (of collapsed causes) were correlated with presenting patterns of distress, sadness as a presenting symptom was inversely related with psychological explanations, but positively associated with supernatural explanations (Table 6.34). This confirms that presenting symptoms of
depression do not directly link with underlying explanations. In other words, presenting symptoms and underlying explanations are not isomorphic. If symptoms were expressions of underlying causal explanations, one would have expected sadness to be associated with psychological explanations and somatic symptoms with medical explanations.

4. Help seeking: In order to examine the influence of a particular help seeking site on symptoms reported, it is necessary to have more longitudinal data. Ideally, subjects would have to be prospectively followed throughout their help seeking career so that symptoms reported at different help provider sites could be compared. As the present study did not attempt to do this, it is difficult to establish the relationship between idioms of distress with the site of help sought.

7.2.3 Patterns of distress and severity of psychopathology (Tables 6.09A, B, and C)

The correlation between sadness as a presenting symptom with its objective counterpart on the Hamilton Depression Rating Scale indicates the latter instrument accurately reflects subjective complaints of sadness. This contrasts with the inverse association between subjective reports of both somatic and anxiety symptoms with HDRS scores. Moreover there is no correlation of the anxiety sub-scale of the HDRS with subjective anxiety symptoms.

The Hamilton Depression Rating Scale is sensitive to subjective depressive symptoms relating to ‘sadness’ but insensitive to anxiety and somatic symptoms. It follows that there is an incongruency between the latter group of symptoms (anxiety
and somatic patterns of distress) and professional evaluation of the same. One might argue that the Hamilton Depression Rating Scale instrument is not a diagnostic instrument but one that assesses symptom severity through an objective (clinical) lens. Perhaps future studies incorporating the use of Research Diagnostic instruments such as the SCAN and the SCID instead or in addition to the HDRS might clarify this incongruency. However, if the full configuration of common symptoms of depression (such as anxiety and somatic complaints) is not accurately represented within instruments that assess illness severity, they preclude examining the significance of such symptoms and raise questions over the construct validity of Hamilton Depression Rating Scale. For example, how central are symptoms of anxiety and somatic nature for an illness such as Neurotic Depression? Current diagnostic criteria for Depression preclude anxiety and somatic symptoms as core features of the disorder. It could be argued that Anxiety and Depression are not distinct nosological entities as symptoms of both conditions overlap. Although debated by nosologists (Hamilton 1960, Snaith 1993), both conditions, Anxiety and Depression, continue to merit separate categorical codes in current diagnostic manuals (ICD-10 and DSM-IV). Indeed, the abandonment of the term Melancholia and the adoption of the term Depression were in order, it was hoped, to “designate in an unassuming way exactly what was meant” (Meyer 1905 quoted in Snaith 1993).

Researchers in cross-cultural psychiatry have cautioned against a ‘category fallacy’ in researching across cultures (Kleinman 1977). If professionals constructs, including symptoms, have poor validity within their own (lay) culture, then this too might be viewed as an extension of the category fallacy. This finding of an inverse association between anxiety and somatic symptoms with Hamilton Depression
Rating Scale indicates the need for developing symptom rating instruments (for establishing both diagnosis and illness severity) that are sensitive to, and reflect subjective distress patterns of patients (i.e. their symptoms). Ensuring this validity might lead to a better and more sensitive management of such conditions. The UK EMIC for Depression is one such instrument that attempts to measure subjective distress and severity and facilitates comparison with more formal psychiatric instruments.

In this context, there is a more challenging and pressing question that warrants further research. Is it possible that depressive phenomenology itself has changed over time? If, as discussed in Chapter Two, there have been major shifts in symptoms in non-western cultures, what is to prevent a change from occurring within Britain? Hamilton developed his rating scale on the basis of patients interviewed in the 1960s (Hamilton 1960) and this scale has been used relatively unchanged. However, the experience of suffering could be argued to have considerably changed since that time. The discrepancies in results discussed earlier could be explained to some degree if this question is researched further.

7.3 Perceived Causes

7.3.1 Introduction

Medical anthropological psychiatric literature argues against eliciting causal ideas using a cognitive method, i.e. asking subjects what they thought was the cause of their problem, as opposed to a more interpretive approach, i.e. observing what subjects actually do to infer their causal ideas from their behaviour. This
fundamental objection is in part, due to a concern that doctors eliciting explanations might tend to use it like a checklist questionnaire (Kleinman 1980).

Neither of these methods (cognitive and interpretive) have been empirically deployed to study concepts of depression among white Britons. Nor have there been attempts to examine the relationship between subjective experiences and clinical outcome measures. The objectives in this section of the study include an empirical study of causal ideas, and a systematic examination of the direction of change if any, including an attempt to examine the relationship between causal ideas and clinical parameters.

Critics of the explanatory model approach argue that such explanations are fluid and contextual therefore invalidating assessment of explanatory models (Young 1976, Marsella and White 1982). To provide an analogy that counters this view, it is well established that brain dopamine levels rise following psychotic episodes and drop on commencement of neuroleptic medication. Documenting this change, including the relationship between baseline dopamine level and shifts from this baseline have contributed towards a better understanding of the nature of psychotic illness and treatment response. This has been possible despite tremendous variation in both cerebrospinal fluid and blood dopamine levels. Similarly, documenting baseline causal ideas for a specified condition (such as depression in this study) and examining its relationship with clinical measures is a pre-requisite to examining change, if any, and the direction of this change with respect to clinical measures. This, along with other factors such as patterns of distress and help seeking would
then enable development of research designs to assess cultural factors that influence course and outcome of a defined illness and allow for cross-cultural comparison.

To recapitulate, it is necessary for such an investigation to proceed through two stages:

**Stage 1:** An instrument that has been locally validated and field tested to screen, measure, and detail casual ideas in a specified community. Such an instrument will also need to demonstrate some ability at integrating more quantitative measures (such as types, nomenclature, linkages and influence) with qualitative data that would elaborate causal ideas, and clarify the meaning of numerical coding, and yet be retrievable for specific analysis.

**Stage 2:** Deploying such an instrument using a prospective longitudinal study design for a specified illness condition to measure both baseline and shifts over the course of illness.

The present study addresses objectives of Stage One. The following section will discuss:

1) number of causal explanations held by subjects,
2) range and types of such causal explanations, including whether they were elicited spontaneously or on specific screening,
3) stability of such explanations over time, including first and most important.

### 7.3.2 Number of explanations

The histogram in Figure 6.21 provides the mean number, 12.0, of explanations elicited from the study sample. Although the number of explanations is fluid and
changing, this finding merits a further discussion. Table 6.22 suggests these are unrelated to hospital status (in-patient or out-patient), age, and sex but positively associated with EMIC Stigma scores. The diversity and multiplicity of these contradictory explanations held by individual subjects suggest four possible inferences:

a) This diversity of explanations as described so far among Asian and other 'traditional' non-western cultures (Leslie 1992) appear to be more universal. This finding has major implications for health care. If patients hold multiple, assorted and seemingly contradictory explanations about their illness, attempts to change their understanding through health education campaigns would be challenging in at least two major ways: (a) which of the 12 explanations will need encouragement and which ones will need to be corrected? (b) which of the 12 explanations are to be selected as outcome measures to assess change or to evaluate the impact of health education campaigns? Table 6.16 shows how explanations elicited are extensively linked and overlapping. Thus, subjects refer to other explanations when discussing a specific cause. Moreover, the same subject might not consider these referred explanations when specifically asked if that was also their explanation. It is perhaps best to consider illness explanations as a 'web of causation' that is highly contextual, overlapping, and dynamic.

b) That patient explanations (both numbers and types of causes) about their illness matter less compared to perceived effectiveness of treatment from a specified help seeking source (Weiss et al 1992). Figure 6.29 shows subjects in this study considered the psychiatrist (followed by GPs) to be their most important source of help. But causal explanations elicited reveal only 9% offering medical-biological explanations as most important for their condition (Table 6.16). And this emerged
only on specific screening. None offered biochemical or hormonal explanations. This may relate to the social class of the sample in this study.

c) The seemingly contradictory nature of such explanations challenge existing anthropological literature that posits a western ‘self’ as homogenous and unitary (Gaines 1992). Or that popular white British explanations are closely linked with more biomedical (rationalist) explanations as opposed to “Indians [who] commonly assume that illnesses arise from a concatenation of events, so that it is reasonable to consult different specialists for the same illness if it seems intractable” (Leslie 1992). Results from this study suggests white Britons are as likely as their Indian counterparts, to hold a wide range of diverse explanations, far removed from biomedical theories; and evoke the same “inconsistency to an outside observer” (ibid.) as a western anthropologist would towards an Indian. Future research will need to tease out the nature and function of this plurality. Although the data are derived from a clinic population and have limitations for generalisation to the community, a longitudinal follow up study might clarify how such diverse and plural explanations link with cultural worlds, and more significantly, predict clinical outcome.

d) As a coping strategy to escape stigma. Table 6.22 shows a positive correlation between the number of explanations with scores on the EMIC stigma sub-scale. This table also suggests a weak but inverse correlation with Hamilton Depression Rating Scale scores. This indicates that those who hold multiple explanations experience ‘more’ stigma. It is difficult to interpret this association as the direction of causality could operate both ways: highly stigmatising experiences might lead to a search for more explanations in order to escape stigma or more varied and confusing explanations might lead to experiencing high stigma. Again, a prospective follow up
design alone would clarify this circular mode of reasoning. The weak but inverse relationship between explanations and Hamilton Depression Rating Scale scores suggest that holding more number of explanations may help contain distress. Also, the absence of an association between Hamilton Depression scores and EMIC stigma scores (Table 6.25), and with hospital status (Table 6.04) suggest experience of ‘stigma’ appears unrelated to severity of psychopathology.

7.3.3 Range and type of explanations

Of the 59 causal categories devised during the pilot phase of the UK EMIC, all except three were elicited from the study group (Figures 6.10). These three were: 1) evil eye 2) failure to marry and 3) congenital non-hereditary, as causes for depression. These three casual categories were deliberately retained from the Indian EMIC to test if they were indeed present among white Britons. Failure to elicit these three Indian causal explanations also indicate that the process of biomedical construction does not necessarily operate in all contexts. More significantly, ideas relating to semen regulation were confirmed and depicted in Figure 6.33 and are discussed separately under section 7.3.5.

Figure 6.10 suggests the value of screening for the full range of causal explanations that were obtained during field testing. Only 29 out of the 55 (53%) explanations were offered in response to spontaneous open ended queries. If subjects were not specifically probed for the remaining 26 explanations that were not offered spontaneously, their clinical significance would have been missed. The clinical relevance of such hidden explanations are discussed later under section 7.6.
It is plausible that perceived causes elicited through fixed semi-structured questions, are transient explanations evoked in response to more situational factors such as site of help sought, site of interview, or style of eliciting explanations. Personal characteristics of interviewer, such as gender and ethnicity, may have influenced the nature of data elicited. Chapter Five discussed at length how the nature and number of questions put to informant’s influence their response. Colson’s (1971) study on Malay informants revealed over 500 causes for tuberculosis, but the relationship between such ideas and observed action would be impossible to detail nor would it be plausible to conclude that informants actually ran through all 500 causes in their minds.

7.3.4 Stability of explanations

Results (Figures 6.13, 6.14 and Table 6.16) depicting spontaneous, first, and most important cause are not, strictly speaking, an indication of the temporal stability of causal explanations. Instead, they tap different modes of reasoning: which explanation is offered spontaneously, which explanation they thought of first when their illness began, and which among the full range of explanations did they think was most important to them. It is very likely that such modes of reasoning do not occur simultaneously, and to that extent they are also a function of both time and context.

Table 6.16 suggests that explanations are largely stable (regardless of which mode of reasoning was being tapped), with the exception of supernatural explanations that dropped three fold. Also interesting, and alluded to in the previous section, was the paucity of medical psychiatric explanations on spontaneous open ended response as
compared to four fold increase on specific probing (Figure 6.12). The MORI polls that have recently been used to elicit popular attitudes for two major public mental health campaigns in Britain (Priest et al 1996, Cowan and Hart 1998, Royal College of Psychiatrist 1992 and 1998, Byrne 1999) could therefore have missed out on a range of explanations that might have been relevant to help seeking. A similar flaw in design and method is evident in the general attitudinal studies, which assume that eliciting community attitudes tap knowledge (or the lack of knowledge) about mental illness (Wolff et al 1996). This fundamental error could lead to a serious flaw in evaluating the impact of public health interventions. This aspect has been discussed in detail in Chapter Three.

7.3.5 Semen regulation and the ethnopsychophysiology of depressive affect

When asked if loosing or retaining semen caused any psychological problems, only 42% of the sample responded with a definite ‘no’. A quarter of the sample elaborated in detail ways in which semen loss or retention or both caused psychological problems. Prose data below Figure 6.33 suggest two major metaphors embedded within the prose: 1) hydraulic and 2) chemical.

It is important to note that none of the subjects related semen regulation problems as causal to their own illness (i.e. of depression). This suggest such explanations are either not entertained by subjects when depressed, or that such ideas are not readily disclosed but offered when elicited in a ‘projective’ third person style of questioning. Indeed, a recent study confirms the value of eliciting potentially stigmatising and socially unacceptable attitudes through indirect queries that were adapted from the
EMIC (Vlassoff et al 1999). The responses generated in the present study are unlikely to be an artefact of the interview as all subjects were specifically asked if this particular idea was an interviewer artefact (see Figure 6.33 and UK EMIC for Depression, Appendix C: coding guidelines). If positive responses to this question resulted from professional construction (i.e. the notion that when doctors repeatedly ask questions, that might actually lead to subjects responding in the affirmative), then results should have also led to explanations about ‘evil eye’ and ‘failure to marry’ as causes of depression. They did not.

Research on semen loss related psychological distress has so far been restricted to low-income countries and developing societies, particularly the Indian sub-continent (Raguram et al 1994) and considered as a culture bound syndrome (Dhat syndrome). Indeed, Dhat syndrome found a place in all editions of the ICD, and is a separate diagnostic category within the ICD-10 (WHO, 1992). The description of Dhat syndrome in the literature from the Asian sub-continent is quite different from the results in this study. None of the explanations in this study matched with features of Dhat syndrome. The core feature of Dhat syndrome is a constellation of fatigue, weakness and non-specific somatic symptoms and their attribution to semen loss (Wig 1960) through urine. The distress caused is related to subjects holding a popular ayurvedic folk idea that links vital elements (dh\textit{\textasciitilde}tus) with semen loss, and one that emphasises conservation of vital elements. The latter is an extract from a broader formal ayurvedic textual theory on health and humoral regulation (Shastri and Chaturvedi 1984). The debate on whether dhat syndrome is a psychiatric disorder or just a cultural explanation continues. Empirical positivistic research adopting the form-content framework (Bhatia and Malik 1991, Chadda 1995,

This issue is at the heart of the current research study. If one were to adopt the empirical positivistic perspective, then it could be argued that psychological symptoms are, in part, associated with an unique British cultural concern over regulating semen. Just as concerns with semen loss in India articulate core moral values of celibacy and failure of control over sexual desires (Alter 1997); the concerns among white Britons express local cultural and moral values over blocked sexual gratification (frustration) and repression of sexual desires. Indeed, Freudian analytical concepts linking the mind (ego) with sexual pathology illustrate this point more clearly. This has been discussed in detail in Chapter One (pages 5-7).

If folk explanations of an alien culture could be [mistakenly] abstracted into a clinical syndrome by a western psychiatrist, as in Dhat syndrome (Littlewood 1996), what is to prevent arguing that the 55 discrete and fairly stable explanations for depression elicited in this study, several of which are unique to white Britons, are separate illnesses in themselves? Similar to the earlier discussion on neurasthenia in
section 7.2.1, there is a fallacy in this mode of reasoning, and one that is often overlooked in research on culture-bound syndromes (Guarnaccia and Rogler 1999). Obeyesekere (1985) succinctly states the problem inherent in such an approach: "the conception of the disease is [considered as] the disease".

Certainly, semen regulation ideas are not alien to European cultural history. Galen considered involuntary loss of semen as ‘gonorrhoea’ (Hawkins 1963), and the first European textbook of sexuality in 1642 (Sinibaldi, in Comfort 1967) reiterated the position of previous theories on the undesirability of semen loss, adding gout to a long list of medical conditions caused by semen loss. A couple of centuries later, an influential psychiatrist in Britain, Henry Maudsley, held the view that semen loss through masturbation resulted in serious mental illness (Comfort 1967). Indeed, the medical management of spontaneous emissions during this period included recommending sleeping with hands tied, use of spiked leather sheath over the penis (Hare 1962), and electric bells based on the principles of the modern enuresis alarm (Milton 1887).

A more interpretive approach suggests that it is the very elicitation of responses that generate such explanations: a case in support for bio-medical construction. The discussion in the preceding paragraphs however argues against this. Whether such explanations are unique to depression or indeed any psychiatric illness is difficult to answer from the method utilised in this study. Indeed, many of the subjects in this study seem to argue that semen retention leads to depression (see prose below Figure 6.33). A separate study with a larger sample size that compares depressed patients with related groups such as attendees at a genito-urinary clinic, with other
psychiatric conditions, and a general population sample, might clarify whether this is indeed specific to a particular illness or part of a wider folk psychology.

7.40 Stigma

Whilst notions of stigma (primarily a professional construct) may vary across cultures, the EMIC section on stigma was aimed at clarifying personal and community response to disclosure. This concept of disclosure was borrowed from Goffman’s notion of spoiled identity (Goffman 1968), and operationalised by the senior author of the EMIC. Field testing during this study led to an additional item in this section: whether subjects’ emotions could upset or have a negative influence on others.

The response generated on the EMIC were recorded in prose form and numerically coded after perusing prose data. An analysis for Cronbach’s Alpha established the internal consistency of items on the EMIC Stigma sub-section. Table 6.18 shows those questions that were retained with an alpha value of 0.61. Items dropped out were chiefly those related to the impact of illness on marriage. This indicates that among white Britons, marriage does not discriminate community and personal response towards depression. This is further confirmed by the absence of response to the perceived category ‘failure to marry’ as a cause of depression.

7.41 Developing a stigma scale utilising an emic approach

The development of 5 item stigma scale suggests it is possible to generate emic based instruments for specified aspects of illness experience. In this research, it pertains to the experience of disclosure. This scale is culturally grounded in that it is
based on local ideas of disclosure although the construct of stigma (i.e. disclosure) was borrowed from Goffman’s work on ‘spoiled identity’ which itself was derived from observation and assessment of patient experiences. Further, such an approach not only permits cross-cultural comparison on those items that are retained in the final scale but also allows detail examination of items that differ across cultures.

The development of the EMIC Stigma scale establishes a framework for further studies to examine more specific hypotheses: For example, how do different illness categories (i.e. depression, schizophrenia and personality disorder) compare on perceived discrimination (following disclosure) from relatives, friends, employers, and psychiatric services? How would these results differ across cultures? To what extent do stigmatising experiences influence course and outcome of formal psychiatric disorders?

7.4.2 Stages in the development of an emic scale

Stage 1: Field work to examine popular ideas about discrimination or encouragement on specified dimensions such as disclosure, community participation, social roles, ideas around heredity, consequences for work, marriage etc; and informed by theory in the field such as Goffman’s work in the present study.

Stage 2: Formulate specific questions that would require refinement and allow both numerical precoding and qualitative prose recording.

Stage 3: Utilise such an instrument for a specified sample: psychiatric or medical condition and setting: community or hospital.

Stage 4: Compute scores and establish internal consistency and reliability.
**Stage 5:** Compare results with other emic approaches such as vignette based studies (Littlewood and Jadhav 1998) that capture stigmatising attitudes for a specified illness or problem in order to establish validity.

The present study also examined the relationship between these stigma measures and other experiential aspects of depression such as patterns of distress and perceived causes; and with more clinical variables such as Hamilton Depression Rating Scale scores for depression. These will be discussed below.

### 7.5 Stigma, psychopathology and idioms of distress

Results indicate lack of an association between the EMIC Stigma scores and Hamilton Depression Rating Scale scores (Table 6.25). This is in contrast to results from the Bangalore study cited earlier, which reported a positive association between EMIC stigma and severity of depression. The authors conclude that this association supports the hypothesis that symptom expression is governed by perceived stigma attached to psychological modes of expression. The findings in this study show no association between stigma and severity of psychopathology. How could these findings be understood?

Perceived stigma is perhaps more likely to correlate with more subjective measures such as the most troubling symptom(s) that subjects report, rather than with some objective measure of severity such as the Hamilton Depression Rating Scale. This is indeed confirmed by the demonstration of a positive association between sadness (both as reporting style and degree of definiteness) and EMIC Stigma scores (Table 6.19). Other variables, apart from stigma, that influence symptom expression such as
social class, gender, and causal explanations have been discussed earlier under section 7.2.2.

Somatic symptoms in this study are inversely associated (although weakly) with stigma scores (Table 6.19). This finding was however more robustly established in the Bangalore study. Despite the association of less stigma with somatic mode of presentation, the British sample overwhelmingly reported psychological symptoms, somatic symptoms showed up only on probing. However, stigma measures seem to be more significantly inversely associated with anxiety. This applies to both objective measures such as the Hamilton Anxiety sub-scale (Table 6.25) and reported patterns of distress (Table 6.19).

As discussed earlier under section on patterns of distress (7.2.1: explanation number 3), this might indicate that social pressures and culturally accepted norms could override stigma reducing symptoms. This has implications (if confirmed with a wider sample and in a non patient population) for public mental health education initiatives and stigma reduction campaigns. If so, prescribing a more medical disease image for Neurotic Depression may protect from stigma.

7.6 Stigma and causal explanation

Table 6.23 indicates ‘nerves’ as the only explanation negatively associated with stigma scores and confirms earlier discussion about a physical locus protecting against stigma. The prose data within this table further clarifies the association between disclosure and stigma. Explanations that positively associated with EMIC stigma scores were: body image, disclosure, loneliness, and boredom; all of which
could be considered as 'psychological' constructs. Once again, the prose data reveals the nature of stigma experienced by such subjects. Figure 6.10 clearly shows that none of these causal explanations were elicited on spontaneous open ended queries. The value of probing for individual causes would have gone undetected if this study were to have adopted a checklist of propositions that were not field tested in advance or if the data was collected through a MORI poll. Table 6.34 establishes this point in a different manner. Subjects chose to explain depressive mood symptoms (sadness) through supernatural explanations, and the converse: psychological explanations were least likely to be offered for the symptoms, sadness.

A clinical biomedical approach to 'nerves' would emphasise it as a symptom and translate it into conventional psychiatric nosology, thus missing out on the meaning and experience of the symptom (Davis and Guarnaccia 1989). Table 6.16 suggests such an approach is problematic. Here, 'nerves' as a principal category is causally linked with a range of explanations, chiefly psychological conflicts, personality, and interpersonal concerns. Although the meaning of nerves is diverse for different cultures (nara: Kannada, ataques de nervios: Spanish American), the essentially somatic 'form' suggests this might be a final common pathway or symbol across Kannada, Hispanic and English cultures. Each culture articulating different concerns through a common idiom; with gender, social class, occupation, and the health setting determining the context and style for expressing suffering (Low in Davis and Guarnaccia 1989).

In conclusion to this section, differing approaches to analysis support the notion that symptoms of sadness are associated with high stigma; somatic and anxiety
symptoms with low stigma. Psychological explanations are perceived as more stigmatising in contrast to more bodily (or physical) explanations which are associated with low stigma. A hypothesis worth exploring is whether social class and other personality attributes create the very conditions that might then be perceived as stigmatising. Indeed, some of the items on the EMIC Stigma scale such as thinking less of oneself, and perceived community response to illness might well be antecedents to the actual illness. For example, could the conditions of poverty bring about similar stigmatising experiences? If not, to what extent do stigmatising experiences inter-digitate with psychopathology? Recent literature argue that psychiatric services might themselves contribute to stigma (Lawrie 1999). Whilst a prospective study is impractical, a detailed comparison of stigma across social class and for different psychiatric disorders and unaffected subjects might unravel the complex association of stigma with class and nature of psychiatric disorder.

7.7 Help seeking

7.7.1 Sources of help

Table 6.26 illustrates the poor social supports available for subjects in this study. This result, combined with the finding that two-thirds of the study sample did not have a close confidant and over 80% had poor relationship with neighbours, affirms the role of professional help seeking services for mobilising such supports. Despite the obvious face validity for family intervention, the experience of this researcher during the period of field work and actual data collection showed that GP referral process as well as subsequent psychiatric formulation rarely included discussion on constructive family intervention or therapy. It is possible that a certain proportion of subjects with the diagnosis of Neurotic Depression were referred by GPs direct to
family therapy clinics, or later by psychiatrists for family intervention. This is not restricted to professional interventions alone. Subjects themselves, when asked what they thought would help them best never mentioned family intervention. The overwhelming preference was for individual therapy and medication. This is at odds with the more enthusiastic family intervention shared by all mental health professionals for severe illnesses: as in expressed emotions for schizophrenia. In a culture that emphasises individualism and autonomy, the family is perhaps not viewed as a resource by both patients and professionals. The case of expressed emotions and schizophrenia is not so odd when one probes further. The interventions frequently lead to a therapeutic separation of the ill member from their critical and hostile relatives, either as recommendation to spend time at a day hospital or separate housing for the ill member. Viewed in this context, the underlying theme is that the family is toxic for personal health and autonomy. Family interventions designed to keep the family together are thus not in keeping with core cultural values although this might also be a class related phenomenon.

Pie charts in Figures 6.28 and 6.29 show frequency of help sought from both formal and informal sectors including the NHS. Comparison of first help seeking with most important help seeking reveals a reduction in GPs (from 62% to 27%) and increase in psychiatrist (from 14% to 37%). Although this suggests patients view psychiatric help important, the relative frequency (37%) is just over a third of the total percentage for both formal and informal care in the community.

These and other findings on help seeking discussed below must take into account the nature of organised referral system in the NHS, including non-payment for
consultation. A further complication is over reports on help seeking. At the time of intake into the study, only those subjects who had used the NHS psychiatric services for the first time ever were interviewed. Yet when specifically screened in the help seeking section of the EMIC, for past help sought, subjects disclosed earlier psychiatric consultations. This may once again relate to issues around reluctance of disclosure to health service professionals and indicate possible perceived stigma of their condition.

7.7.2 Lag time for consultation

Table 6.27 shows the mean lag time for subjects consulting GPs and Psychiatrists. Discussion of these results is limited by the scant data in the present study, and reveals the general difficulty in reconstructing past help seeking. Only 28 out of the 47 subjects were able to accurately recall the time taken to present to their GPs and Psychiatrists. The time taken to seek help from both sources differ significantly between men and women.

A recent study (Gormley and O'Leary 1997) with 76 moderate to severely depressed Irish subjects undergoing their first psychiatric admission, revealed a mean duration of 76 days between onset of illness and psychiatric consultation (range 1-747 days) and 40 days (range 0-515 days) between presentation and commencement of adequate antidepressant treatment. The study did not find any association between time to seek medical help with demographic variables such as age, sex, social class, marital status, education or history of depression. Although the study did not explore time taken to consult with GPs, it is possible that ant-depressants were commenced by GPs. This might explain the shorter time taken to commence treatment compared
with time taken to consult psychiatrists. Results from the present study are at odds with this. It is possible that because the authors of the Irish study used mean duration to calculate time taken for help seeking (compared to median in the present study) their time lag is much longer than in the present study.

In this study, women presented later to their GPs (18 days for women, range 0-360; 11 days for men, range 0-90). More significantly, there was considerable delay in seeking help from NHS psychiatrists (120 days for women, range 4-720; 28 days for men, range 1-180). If men reported sadness more often than women, and experienced this symptom as most troubling compared with women, it is possible that health professionals (who endorse a more psychological view of depression), may have detected and referred men earlier to the psychiatric services. The same factor might also have influenced the time lag for women presenting to their GPs later than men. Their late presentation may also reflect gender disparity on the use of health services in general. A recently published research (Shaw et al 1999) utilising the GHQ and SCAN in a general population setting in Manchester, suggests ‘white European’ and ‘African Caribbean’ patients suffering from Depression reported more ‘somatic’ than ‘psychological’ symptoms. Unfortunately their results do not show symptom frequencies for these ‘somatic’ symptoms. The same study also revealed that among those who had consulted a GP in the previous six months, white European women presented with more depressive symptoms as compared to their male counterparts. Additionally, major national and cross-national studies on pathways to psychiatric care (Goldberg and Huxley 1980, Gater et al 1991, Gater and Goldberg 1991) suggest somatic symptoms significantly delay presentation to psychiatric care irrespective of gender. Viewed in this context, the gender difference
on lag time in this study could be better understood if women presented with more somatic symptoms. However, Table 6.08A shows no gender differences on somatic symptoms. There was however differences on psychological symptoms but the results are mixed: men scored more on sadness and women on anxiety symptoms. An ANOVA comparing mean prominence scores (for the total sample) for sadness, somatic and anxiety symptoms with time taken to present at NHS psychiatric clinics showed no significant association. In view of the restricted sample for this analysis (n=28), these ANOVA results are not presented in Chapter Six. Despite this limitation, it is important to note that the studies cited earlier have tended to use a rather simplistic concept of ‘somatic’ and ‘psychological’ presentation. The terms have been used as if they were mutually exclusive. This further limits comparison with findings from the present study. Further interpretation and clarification on this result is only possible if a similarly designed study is carried out in a primary health care setting.

The bar chart in Figure 6.30 shows how help sought was reported in the EMIC interviews. A significant finding is the diversity of help sought for a condition such as Neurotic Depression. Table 6.31 shows sources of help sought were unrelated to severity of psychopathology. Exceptions to these were ‘other medical specialists’ and ‘masseurs’. As the numbers consulting these two sources were too low, the statistical significance does not merit further discussion.

7.7.3 Stigma and help sought

Comparison of EMIC stigma scores with help sought reveals a strong positive association with GPs, Aromatherapists and Homeopaths (Table 6.32). The
interesting finding is the inverse association of EMIC Stigma scores with help seeking from NHS psychiatrists. This also contradicts the association of high stigma scores among subjects who hold more psychologically oriented explanations for their condition (Table 6.23A). Based on discussions in earlier sections of this chapter, it would appear that subjects consider somatic presentations and explanations as less stigmatising in the context of perceiving psychiatrists as specialists dealing with psychological pathology.

7.7.4 Help sought and causal explanations

Public mental health campaigns assume that patient explanations would be congruent with the site and nature of help sought (Jadhav and Littlewood 1994). A previous prospectively designed study using the Indian EMIC with leprosy patients at a Hansen’s clinic in Bombay showed ‘ayurvedic’ but not ‘biomedical’ explanations that predicted better attendance at a leprosy clinic in Bombay. In this study, no particular explanation was positively associated with preference for psychiatric help. Earlier sections in this chapter have discussed how other variables (such as presenting symptoms and perceived stigma), might influence choice for help from any particular source. Public mental health interventions designed to re-educate patients so as to shape their explanations into a more ‘biomedical content’ would be ineffective if patient explanations alone were chosen as a focus for educational intervention.

7.8 Methodological issues

This study was aimed at eliciting subjective experience and views on depression, and comparing them with more objective assessments. In order to accomplish this, the
development of a culturally validated instrument was considered necessary. Several problems that might have affected data collected and conclusions drawn will be discussed below.

7.81 Interview characteristics

Earlier experience with the writer's EMIC interviews at Bangalore (during the period 1983-1986), informed and guided the EMIC interviews in London. The mean time taken to complete the EMIC interview was approximately two hours followed by approximately 30 minutes for administering the Hamilton Depression Rating Scale. As a result, subject and interviewer fatigue could have influenced quality of data generated although the volume of prose gathered was enormous. In addition, the site of interviews may also have affected the quality of data gathered. In general, home interviews were easier on pace, duration and nature of subject response.

Future EMIC studies are now in a position to utilise screening or short versions focussing on specific sections depending on the nature of research objectives. As the present study was primarily exploratory, shortening the EMIC would have missed out on opportunities to examine items that were redundant and those that were revealing. Consider for example, the final UK EMIC section on Mind-Body-Soul concepts. This has the potential to integrate with the earlier sections that detail subjective experience of depression to yield additional insights on cultural ideas about anatomy and physiology relating to depression. For example, in some of the EMIC interviews in the present study, subjects located their depression around the epigastrium, and described how they could feel 'it' rising and affecting their 'head'.
These ideas could have been better captured if they were probed in the final section through additional questions focusing on cultural anatomy and physiology:

Describe on this human outline, the site your illness affects most and how?

Draw a sketch on this human outline to show how anti-depressants work?

If you believe in the existence of the soul, what is its relationship with your current problem that brought you to see a psychiatrist?

Recent literature suggests attempts to produce a shortened EMIC, the SEMI (Lloyd et al 1998). However, in the absence of background information on the manner in which this instrument was derived (i.e. cultural grounding), it is difficult to conclude whether this is truly an emic instrument. Other approaches such as Rosenstock and Becker’s Health Belief model (1988), Eisenbruch’s EMQ (1990), Furnham’s Lay Belief Model (1991), and Minas’s EMI (1991) suffer from similar problems. See Chapter Three for a more detailed discussion on these models and instruments.

There could be several problems that might arise in shortening a detailed clinical ethnographic procedure. For example, in the section on screening for perceived causes, subjects frequently reported confusion over separating cause from consequence of their illness. This was overcome at the outset during field testing of the EMIC. Interviews were structured in a manner that ensured empowering introductions to each section with culturally appropriate examples, followed by more open ended queries before moving on to screening specific causes. The coding strategy for discrete perceived causes allowed for noting linkages in the narrative provided by subjects. This strategy enabled this researcher to capture the full range of ‘cause and consequence’ (see Table 6.16). Additionally, interviewer artefacts (i.e.
a new idea introduced by the interviewer) and causal concepts that might be unknown or strange to the subject were separately coded. In a similar fashion, the section on ‘Patterns of distress’ coded for the full range of symptoms expressed on open ended queries followed by probes. Ensuring these aspects were critical for generating detailed accounts on illness meaning and experience. These matters allowed for the rich data that would have otherwise eluded the researcher if the EMIC was shortened into a checklist. It is difficult to envisage how shortening the EMIC could ensure valid data if such fundamental methodological issues were to be addressed.

7.82 Consent

Previous experience on consenting subjects to participate in EMIC interviews at Bangalore was overwhelmingly positive. All subjects readily agreed to speak with the interviewer, to the point of feeling embarrassed at being asked to discuss their own ideas and regarded the written consent form amusing.

This was not so with the present study. Consent was not always given. Some cited time, and others mentioned confidentiality as reason for not participating in the interview. This is in keeping with a culture of individual autonomy and the nature of the doctor - patient relationship in Britain. At Bangalore, subjects were keen to establish fictive kinship ties: the doctors’ wish to elicit subjective experiences and views were perceived as a cue by subjects who felt it suggested the doctor was keen to establish a more personal relationship with them. In fact, several subjects would return to the out-patient clinic and seek out the interviewer indicating the strength of the relationship established following EMIC interviews. Although this was not the
case in London, several subjects did find the interview helpful and thought
provoking. They requested findings of the study to be made available to them.

7.83 Rating the EMIC interview and the Hamilton Depression Rating Scale
Unlike EMIC research centres elsewhere, a single researcher carried out this study.
Interviewing subjects on the EMIC required progressively moving into the realm of
their subjectivity whilst interviews on the Hamilton Depression Rating Scale
required a more objective professional distancing. This distancing or switching into
another mode was at times difficult and may have obscured the distinction between
‘explanations’ (on the EMIC) and ‘facts’ (symptom rating on the Hamilton
Depression Rating Scale). Future studies may need to take this into account and
preferably be done by two interviewers alternating for EMIC and etic evaluations.

Subject recall on the help seeking section raise questions of reliability about time
intervals between consultations. But as the study sought to detail subjective
perceptions not objective assessments, this is not a central problem of the study.
Responses generated on community perception and reaction to the illness
experienced by the study subjects are not the full range of stigmatising experiences.
They focus on issues of disclosure and to that extent it is not justified to view this a
comprehensive stigma scale.

7.84 Data
The interviews generated a large volume of data. As detailed in earlier chapter
(Methods), the subjects were chosen semi-randomly from in-patient and out-patient
general adult psychiatry services of University College London group of hospitals.
Selecting patients who were given ICD-9 diagnosis of Neurotic Depression by their treating psychiatrists introduced an element of homogeneity in terms of depressive psychopathology. However, the range of ethnic background, and other demographic features such as age, education, occupation, employment, and previous psychiatric experiences far out-weighed the homogenous ‘psychopathology’. The data is therefore unrepresentative of white Britons in general but does allow for a limited generalisation among white Britons in inner London attending psychiatric services for a mild depressive disorder. It was also for this reason that non-parametric statistical tests were conducted for further analysis of Hamilton scores for depression. As this was an explorative study, the results suggest further scope for testing more refined hypotheses.

Much of this is yet to be analysed and is beyond the scope of current thesis objectives. This large body of data is now available for cross-cultural comparison with data from other research studies using locally adapted versions of the EMIC.
CHAPTER EIGHT

CONCLUSIONS

8.1 A historical analysis of British cultural vocabulary of Depression suggests that current terminology and concepts have their own unique history and meanings, deeply embedded in local cultural institutions. Predicated on a western epistemology, these constructs developed in response to prevailing concerns at different periods in western society, but now assumed to be universal natural entities that await further scientific research and investigation. This brief historiography concludes that the cross cultural validity of Depression requires an extensive re-examination.

8.2 A literature review outlined conceptual flaws in cross-cultural research on Depression. It highlighted: (a) the need for revealing the cultural basis of western psychiatric theory and models, (b) that folk models for any psychiatric disorder among contemporary white Britons are unknown, and (c) the absence of a method to facilitate systematic analysis of folk models of illness and establish a relationship with clinical features of the illness have hampered further research in the field. A recently established approach and method, the EMIC, that links anthropology with psychiatry is considered important for addressing this caveat.

8.3 The EMIC, an instrument originally developed in India, was culturally adapted to capture the lived experience of Neurotic Depression among white Britons in London. The resulting instrument, the UK EMIC for Depression,
was then deployed to systematically detail subjective experience of distress, perceived causation, and help seeking in both qualitative and quantitative form.

8.4 Age, gender, severity of psychopathology, and history of deliberate self-harm were unrelated to hospital status. Subjective illness experiences such as presenting and most troubling symptom, causal explanation, perceived seriousness, expectation from treatment, impact on income, and perceived stigma were also unrelated to hospital status. An intensive prospective microanalysis of admission procedures including patient consent, explanatory models of admitting staff, and administrative aspects of admission process might clarify factors that differentiate hospital status.

8.5 Patterns of distress

8.5.1 Although subjects reported symptoms through predominant psychological metaphors, when specifically probed, reported extensive somatic symptoms. Whilst this was finding was unexpected, it suggests that somatisation and psychologisation are cultural products of the encounter between patients and mental health professionals. Gender, causal explanations and stigma influence reporting distress patterns.

This finding challenges the cross-cultural and universal notion that psychological symptoms are primary features of Neurotic Depression, whilst somatic symptoms are secondary elaboration. Viewed in a cultural context,
the phenomenological distinction between form and content is fluid and interchangeable. Findings from this study suggest that British Depression could be viewed as a cultural variation of Neurasthenia: a somatic form with psychological content. In other words, local culture determines the form-content distinction.

8.5.2 There were significant gender differences in reporting and expressing distress. Men experienced more severe degree of psychopathology and reported sadness as a symptom more frequently. Women tended to report anxiety and somatic symptoms and experienced these idioms less stigmatising as compared to reporting sadness. Prose data confirm the ease with which subjects could disclose their problem if couched in somatic or anxiety symptoms, and the difficulty disclosing symptoms of sadness.

8.5.3 Subjective report of somatic and anxiety symptoms were not mirrored by more objective evaluation through the Hamilton Depression Rating Scale. If perception of illness severity by subjects does not match with clinical assessment, it suggests that the HADRS is not a phenomenologically valid instrument. It failed to reflect lived experience of suffering.

8.6 Perceived Causes

8.6.1 55 explanations for depression were elicited with a mean of 12. These causal explanations were multiple, contradictory, overlapping but fairly stable. They were unrelated to age, sex, or hospital status. This finding challenges existing literature that posits western self as homogenous and unitary.
8.6.2 It is likely that holding multiple explanations might be a strategy of coping with stigma. The inverse association between number of explanations and severity of psychopathology might also suggest that the former help contain illness distress.

8.6.3 Attempts at deliberately eliciting causal explanations that may not be culturally valid for white Britons, such as evil eye, and failure to marry, did not result in such explanations being elicited. However, subjects did confirm that semen dysregulation could lead to depression and other psychological problems. This item (on semen loss and retention) was included during field work in culturally adapting the EMIC for white Britons and attests significance to the crucial need for local cultural validation of psychiatric instruments. The EMIC interview method also helped clarify and tease out interview artefacts, including concepts that are strange or alien. It is possible though not confirmed through this study that semen loss, as a causal explanation might be part of a wider folk category in Britain. This may have so far gone unrecognised because mental health professionals do not ask questions around semen regulation and its relationship to psychological states.

8.6.4 A physical locus (real or symbolic) of causal explanation protects against stigma of disclosure. More psychological and individual explanations (such as body image disturbance, disclosure, loneliness, boredom, and life meaningless) were associated with high stigma. Explanations related to nerves on the other hand were associated with a low stigma. If subjects were
not screened specifically for any of the above causal explanations, their significance would have gone unnoticed.

8.6.5 Medical explanations were infrequently offered spontaneously but elicited in greater detail on specific screening. Recent national public mental health education campaigns deploying MORI polls to elicit attitudes would have missed out on a range of explanations that might have been relevant to help seeking. This would also have lead to flaws in evaluating the impact of educational intervention related to such campaigns.

8.7 Stigma

8.7.1 Construction of a Stigma scale

The study also showed that it is possible to construct an emic base scale for assessing stigma, and one which can be now used for cross cultural comparison. This stigma scale was based on ideas and concerns about disclosure of illness to society. The final validated scale showed that prospects of future or existing marriage did not hold together as an emic construct with other items about community rejection.

8.7.2 Psychological modes of reporting symptoms, in particular sadness, and providing psychological causal explanations for depression were associated with high stigma. In contrast, somatic or physical styles, were associated with low stigma. This finding holds true at various levels of analysis (patterns of distress, perceived causes, and source of problem) discussed in earlier sections. Prescribing a more medical explanation might protect from stigma.
8.8 Help seeking

8.8.1 Most subjects did not consider their friends and family as helpful but instead preferred professional help. Additionally, neither professionals nor patients considered the family as a therapeutic resource.

8.8.2 Subjects consulted with a wide range of help seeking sources. About a third of the sample considered help from psychiatrists as most important.

8.8.3 Women took significantly more time to consult both general practitioners and psychiatrists compared to men. This is in keeping with previous literature and reflects gender disparity on the use of health services in general.

8.8.4 Psychiatrists were viewed as significantly less stigmatising when compared to General Practitioner. This is despite the possibility that they tend to see more severe degree of psychopathology compared to GPs.

8.8.5 No specific explanations associated positively with help seeking preference for psychiatrists. Supernatural and victim-abuse explanations were inversely associated with psychiatric help.

8.9 Implications of this study

8.9.1 Theoretical

Until recently theory and published literature within the discipline of cross-cultural psychiatry lamented the lack of a method that could overcome some of the central problems articulated through the framework of the “new cross-cultural psychiatry”. These included the category fallacy, the paucity of local indigenous explanations for any particular psychiatric disorder, and the relationship between both experiential and professionally derived categories.
Most crucially, there was no method available that could integrate both subjective experience and clinical professional evaluation, and allow for replication of such a study. The latter has been one of the major problems for researchers working at the interface of anthropology and medicine, the subject matter of medical anthropology. Whilst the ethnographic method seeks to capture the lived experience of suffering, engaging at a personal level; the psychiatric attempts at empirical, objective and experience-distant evaluation of distress.

Integration of quantitative with qualitative data has been one of the salient aspects of the method deployed in this thesis. The most important advantage of this approach has been to allow for empirical statistical tests with prose data providing substantive meaning and validity to the statistical findings. Until recently, research in this field was hampered by a method that allowed for generalisability of findings and yet retain unique insights obtained through ethnographic in-depth studies. The experience of this researcher together with the findings from this study suggest it is feasible to design and carry out research that marries experience near (emic) vocabulary with more experience distant professional evaluation (etic). In other words, meanings and numbers are not incompatible. Although the ethnographies and flavour of individual personal meanings of illness do not come through in this thesis, this is purely a practical limitation of reporting the findings within the framework of this thesis. Coding of the results did pose some difficulties that are implicit to conflicts between the naturalistic and personalistic approaches.
For example, several subjects when probed for their causal explanations for depression, did ask whether they should tell the researcher the cause or the consequence of their problem. Others queried whether they should talk about explanations for earlier episodes or for the current episode. This confusion between depression as a fact for which they had to provide an explanation often contradicted the reverse logic: that depression was an explanation for subjects’ own causal facts (such as food, water, stress, loneliness). This circularity could potentially create confusion in coding if the EMIC was turned into a checklist of explanations that have to be scored – which it is not. All coding was done after reading the prose account provided. More over, as stated in chapter 4, the UK EMIC coding structure allowed for scoring linkages with other causal explanation, interview artefacts, and degree of definiteness. It therefore did not create an all or none choice dilemma for the researcher that often are a limitation of standard epidemiological instruments.

This study is also the first such successfully applied method in a western setting for an identified mental health problem. However, as this was an exploratory data generating study, several theoretical and clinical hypotheses remain unaddressed and will be discussed in the penultimate section.

8.9.2 Clinical

Kleinman’s articulation of the explanatory model approach was critiqued for its inability to lend itself to any empirical analyses. More crucially, explanatory models were considered fluid dynamic constructs. This led to an assumption that such an approach would be futile for research aimed at
eliciting explanatory models, generalising such elicited ‘models’ to characterise a community, and to establish their clinical relevance.

This study shows that it is possible to empirically assess explanatory models in detail, and yet capture the personal experience of an illness. Similarly, various dimensions of an explanatory model (patterns of distress, perceived causality, and help seeking) could be usefully compared with objective measures of psychopathology such as through rating scales. Future research could explore this with a prospective follow up design, and allow comparison across cultures. Although this study did not follow up changes over time, it has successfully established a method (the UK EMIC) that could now be deployed to test more refined hypotheses.

In the context of recent concerns, locally in Britain (e.g. The Stigma and Defeat Depression Campaigns of the Royal College of Psychiatrists), and in more international settings (World Psychiatric Association and World Health Organisation), to address stigma; the development of an emic stigma scale is not only timely but represents a conceptual advance.

8.9.3 Future of EMIC instruments

Eliciting subjective experiences or for that matter focussing on the more topical audit oriented consumer views and satisfaction indices in the national health services run the risk of substituting explanatory power with mere reportage of ‘local narratives’. This could lead to a ‘naïve inductivism’ as it tells us nothing about underlying social or cultural structures. EMIC oriented
instruments are at a similar risk. Merely eliciting attributions to fit with time and numerical statistical constraints would lead to problems of attitudinal studies: they fail to capture the full experience of the illness. Although the UK EMIC in its present form might be considered too long and unwieldy to use for research with larger number of subjects, or for deployment in cross cultural studies, shortening it would run the risk of reducing it to a paper and pencil check list inventory. As the senior author of the original EMIC has suggested, the UK EMIC is one amongst a catalogue of EMICs that are specifically designed for particular research objectives. Future use of the UK EMIC will therefore need to be tailored to the nature of specific research hypotheses.
Notes to Chapter 1

1. The term 'Depression’ unless specified, deliberately subsumes both mood (normal and pathological) and disorder, as the author considers it to be a culturally constituted complex.

2. A comprehensive review of the literature (Kleinman and Good 1985), suggests significant differences in guilt, self esteem and somatic symptom; between western developed and non-western developing societies.

3. Various hospital psychiatric clinics of rural and urban Bombay (1978-83) and Bangalore (1983-88). A significant number of self-referred patients are guided by their own idea of what constitutes ‘psychiatric disorder’, or by hospital porters and receptionists whose ‘gate-keeping’ decisions are based on local concepts.


5. The more expensive texts are available in reference sections of the institutions’ library, often mass photocopied at some expense for personal use. Journals highly sought after include Archives of General Psychiatry, American Journal of Psychiatry and the British Journal of Psychiatry.

6. Such as the Research Diagnostic Criteria, latest editions of DSM, Life Events and Locus of Control Questionnaires and Somatisation Schedules.

7. It is common knowledge that prescribed ‘newer’ anti-depressants are often bought in the black market or sent by relatives and friends from abroad, particularly from the Gulf nations, at considerable expense to the family. Many psychotrope medications do not undergo local efficacy studies in view of their approved status in Britain and North America. Most recently, the anti-psychotic drug Clozapine, was introduced without the mandatory blood
count monitoring (Personal communication: Professor R Raguram, Bangalore).

8. The author would like to clarify that this description of everyday clinical routine does not imply that such culture-free care and practice is deliberate nor does he question professional competence. On the contrary, great care is taken to provide consultations in a humane and competent manner that match with practices at internationally renowned clinics. But the issue here is about the criteria used.

9. During the course of this previous research, the author observed several clinicians perplexed and frustrated when patients presented with idioms of distress that did not match with phenomenology in psychiatric (western) textbooks or journals; leading to remarks such as “wish they (patients) read before coming to the clinic” or “if only they were educated” (Jadhav 1986).

10. Thus the academic and folk metaphor for mood disturbances as feeling down or high, and the linear link with past memories illustrated by the association of childhood loss and current depression (Littlewood 1994).

11. For a more detailed discussion, see Elias (1939) and Macfarlane (1978) on how capitalist economic structures shaped the development of private vocabulary. See also Johnson (1993) on how British housing architecture and domestic spaces articulated the distinction between private and public. A good example of commoditised emotion is the popular western psychiatric term “free floating anxiety”.

12. The Church went through centuries of competition between Gregory the Great’s and John Cassian’s list of major temptations. Whilst Cassian suggested eight sins, Gregory reduced the number to seven. Acedia was initially dropped from this but was finally rehabilitated as another related Sin in Gregory’s list, Tristitia, was thought to be synonymous with Acedia (Jackson 1986).
13. Paracelsus (1493-1541). His given name was Theophrastus Bombastus von Hohenheim. His work titled The Diseases That Deprive Man of His Reason challenged earlier Galenic theories on Melancholia. He suggested that melancholic complexions drive the *spiritus vitae* up towards the brain leading to an excess and thus cause melancholia. Thus melancholics are disturbed by their own nature. (Jackson 1986).

14. Thomas Elyot (1490-1546), physician turned clergyman, wrote a popular domestic guide, The Castle of Health. In it, he devoted an entire chapter to the "affectes of the mynde" and another to "hevynesse of minde". In this he used the terms passions and affectations as synonyms for sorrow, which was a result of black bile affecting the mind. He prescription included dietary restrictions, a company of women, avoidance of darkness and keeping a busy mind.

15. Timothy Bright (1550-1615), another physician turned clergyman, postulated that black bile vapours rose from the spleen to obscure the clear mind and cause melancholia; his other significant contribution relates to a distinction between ‘melancholia’ and ‘guilty conscience’ (affliction of the soul through conscience of sinne). This bears some resemblance to the current dichotomy of neurotic and endogenous depression. Delumeau (1990) provides an example of “a German (who) stayed at home during Holy Week to perform devotion, because he feared the excessive quantity of melancholic vapour exhaled by other worshippers”.

16. These were a combination of a range of astrological theories (relating to the influence of Saturn), demonic attributions and moral transgression against the Church. MacDonald suggests that traditional medieval and renaissance models of the universe postulated both supernatural and natural forces at work in a hierarchical order of powers and beings (MacDonald 1981).

17. Thomas Willis (1621-1675) was one of the first to introduce chemical theories. He suggested that the spleen failed to ferment blood juices and
favoured the role of "Chymical Liquors" and their pathological alteration in Melancholia (Hunter and Macalpine 1963).

18. There were several 18th century theories that revolved around the brain and nerves. Influential concepts of well-known European physicians are summarised below:

Friedrich Hoffman (1660-1742) postulated particles in body fluids that blocked the brain pores. Herman Boerhave (1668-1738) introduced a mechanical hydraulic circulatory physiology in which factors that slowed the blood circulation led to stasis around the hypochondriacal region causing melancholia. Richard Mead (1673-1754) who was influenced by Newton’s notion of ether, suggested that animal spirits or nerve juice in the nerve fibres were instrumental for muscular activity. In melancholia, primary mental images caused by prolonged thinking or brooding on a fixed idea led to secondary alteration in the blood. William Cullen (1710-1790) postulated that the Brain was controlled by a system of Newtonian forces, which caused excitement and collapse in various disease conditions. The brains of melancholic patients were firmer and drier in texture, which was therefore vulnerable to higher degrees of excitement. The reader will find a detailed account in Jackson (1986).

19. There were instances of pejorative terms used to describe variants of melancholia, such as Mopishness (Richard Napier), to reflect the sullen inactivity of husbandmen and artisans, whilst the term melancholy being reserved for the dumpish mood of idle gentlefolk. The foolish, weak and stupid people, heavy or dull souls were considered rarely troubled with low spirits (Porter 1990)

20. The term melancholy was recorded disproportionately amongst those of higher social rank with many merely adding the label to enhance themselves and give a dignified status to their conduct. Babb (1951) suggests that the Elizabethan Englishmen believed that exerting one’s brain led to depletion of heat and moisture from the body, and consequently at least a little melancholy
was expected as a result. Consider the French parallel with the terms spasmophilie, one that is biomedically legitimized as a disease and fatigue or la fatigue, which is a culturally sanctioned folk illness. (Gaines, 1992). Compare also with the popular northern Indian Hindi term “Udaas Kabir”, commonly reserved for the dishevelled appearance of young men, after being jilted by their lovers (but one that is neither pathologised by the local culture nor related to social rank); although the commonly accepted term for depression amongst clinic populations is ‘Udasi’.


22. Théodule Ribot, a 19th century French psychologist and editor of the influential Revue Philosophique that attempted to establish material foundations for mental mechanisms. (Rabinbach 1990). Incidentally, he also introduced the term ‘anhedonia’ (in 1897) as a psychopathology to counter-designate the term ‘analgesia’, although now considered a cardinal feature of depressive disorder. This concept highlights a key western cultural preoccupation with the attainment of pleasurable states and unlimited happiness. Obeyesekere points out how this may well differ in non-western, particularly Buddhist societies, where states of general hopelessness are an expression of an ideology that “life is suffering and sorrow, and that the cause of sorrow is attachment or desire and craving.” (Obeyesekere 1985; In Kleinman and Good 1985). Such affects and their accompanying epiphenomena, he argues, are rooted in Buddhist existential discourse, and do not constitute an illness; although features of depressive disorder may well be elicited.

23. Wilhelm Weichardt, a German physiologist whose attempts to synthesise ‘kenotoxins’ and ‘anti-kenotoxins’ for a fatigue vaccine were found ineffective in trials conducted by the Austro-Hungarian army during World War II (Rabinbach, 1990).
Notes to Chapter Four

1 Subjects for EMIC interviews were contacted through several methods:
   
a. Notices posted at out-patient clinics, and community mental health centres.

b. All in-patient wards of the Camden and Islington Community Health Services Trust (excepting for Whittington Hospital) were rung at random by the investigator to enquire from the junior doctor if patients fulfilling ICD-9 criteria for Neurotic Depression were recently admitted. If they were, the subjects were asked for informed consent and an appointment for research interview was made and interviews carried out in the ward where subjects were admitted.

   c. Those patients who contacted the investigator via out-patient clinics were initially screened out by examining their case notes and talking to the junior doctor who had clerked them. They were then given an appointment for this research interview. In such cases, interviews for the majority of subjects took place in the academic department of psychiatry or at the day hospital and in a few cases at subject’s home.
Notes to Chapter Five

1. These were derived in the following manner:

(a) Starting with the Bangalore EMIC for Depression, pilot interviews were helpful in discarding causes that were irrelevant or ones that did not come up with responses in the local population. There was two exceptions to this: causes relating to supernatural explanations and humoral ideas were retained in part to test Obeyesekere’s hypothesis (“reverse category error”). Several new causal categories were included following field work. This included popular folk ideas on Depression among white Britons cited in both historical and contemporary literature: abuse, racism, victimisation, living with emotionally disturbed, disclosure problem, boredom, loneliness, life meaningless, and global concerns. The item on semen loss as a causal category was included with the addition of semen retention as field work suggested the latter idea was indeed prevalent among white Britons.

(b) Through field work as detailed in Stage One of this chapter
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APPENDIX A

Depression: brief history of the idiom
APPENDIX A TO CHAPTER 1 (SOURCE: OED, 1990)

DEPRESSION: BRIEF HISTORY OF THE IDIOM

The term depression originates from: De primere (Latin) to press down. The action of depressing, or condition of being depressed; that which is depressed: in various senses. (Opp. to elevation). The digits in parenthesis (underlined), denote the year when the term was first used.

a) The angulatory distance of a star below the horizon, the apparent sinking of the celestial pole towards the horizon as the observer travels towards the equator (1391: Chaucer Astrol., II. 25, And than is the depression of the pole antartik, that is to seyn, than is the pol antartik by-nethe the Orisonte the same quantity of space).

b) Fig. The act of putting down or bringing low, or the fact or condition of being brought low (in stature, fortunes, etc) (1533: Frith Wks, 5, Aduersitie, tribuation, worldly depression).

c) Disparagement, Depreciation (1628: Feltham Resolves 11. lxxiii. Thus depressing others, it (pride) seeketh to raise it selfe, and by this depression angers them).

d) Suppression (1656: Hobbes. Six Lessons Wks. 1845, VII., 278, You...profess mathematics, and theology, and practise the depression of truth in both).

e) The action of pressing or weighing down, of sinking (1656: Blount Glossogr., Depression, a pressing or weighing down, 1697: Potter, Antiq. Greece III. ix. Flags, the Elevation whereof was a signal to joyn Battle, the Depression to desist).

f) The condition of being depressed in spirits; dejection (1660: Baker's chronicle).
g) A depressed or sunken formation on a surface; a hollow, a low place or part (1665: Phil. Trans., I. 42 Of the Nature of the Ground...and of the several risings and depressions thereof).

h) Reduction to a lower degree of power (1727: Chamber's cyclopaedia, depression of equations)

i) A lowering in quality, vigour or amount, esp of trade (1793: Vansittart Refl. Peace 57, The depression of public funds...began before the war).

j) Lowering of vital functions or powers; a state of reduced activity (1803: Medical Journal X. 116. Great depression...has without doubt lately shewn itself in a very remarkable manner in the influenza).

k) Lowering in pitch, flattening of voice or a musical note (1845: Stoddart in Encyl. Metrop. I. 176/1, A slight degree of elevation or depression, of length or shortness, of weakness or force..).

l) A term for one of the operations for cataract (1851-60, Mayne Expos. Lex., Depression..a term for one of the operations for cataract).

m) The lowering of a muzzle of a gun below the horizontal line (1853, Stocqueler Milit. Encycl., Depression, the pointing of any piece of ordinance, so that its shot may be projected under the point-blank line).

n) A lowering of the column of mercury in the barometer (1881: R. H. Scott in Gd. Words July 454 Barometrical depressions or cyclones).
APENDIX B

THE HAMILTON DEPRESSION RATING SCALE
This is an interview guide for the Hamilton Depression Scale (HDS) and Hamilton Anxiety Scale (HAS). Items from the HAS are surrounded by hatch marks (#); items from the HDS are not. In some studies it may be desirable for the interviewer, in addition to rating the severity of certain symptoms in the HDS, to indicate whether there is a possible or definite organic cause for each symptom (rated as "1 - POSS/DEF ORG") or whether the symptoms are not organic ("3 - NOT ORG").

INTERVIEWER: The first question for each item should be asked exactly as written. Often this question will elicit enough information about the severity and frequency of a symptom for you to rate the item with confidence. Follow-up questions are provided, however, for use when further exploration or additional clarification of symptoms is necessary. The specified questions should be asked until you have enough information to rate the item confidently. In some cases, you may also have to add your own follow-up questions to obtain necessary information.

For some of the HAS items, you will find you have already asked about some of the symptoms. You do not need to repeat questions about these symptoms unless you need additional information to rate their severity.

NOTES: Time period. Although the interview questions indicate that the ratings should be based on the patient's condition in the past week, some investigators using this instrument as a change measure may wish to base their ratings on the previous two to three days. If so, the questions may be preceded by "In the last couple of days..."

Loss of weight item. It is recommended that this item be rated positively whenever the patient has lost weight relative to their baseline weight (i.e., before their current episode of depression), provided that they have not begun to gain back lost weight. Once the patient has begun to gain weight, however, even if they are still below their baseline, they should no longer be rated positively on this item.

Referent of "usual" or "normal" condition. Several of the interview questions refer to the patient's usual or normal functioning. In some cases, such as when the patient has Dysthymia or Seasonal Affective Disorder, the referent should be to the last time they felt OK (i.e., not depressed or high) for at least a few weeks.

This instrument provides an interview guide for both the Hamilton Depression Scale (Hamilton, Max: A rating scale for depression. J Neurol Neurosurg Psychiat 23:56-61, 1960) and the Hamilton Anxiety Scale (Hamilton, Max: The assessment of anxiety states by rating. Brit J Med Psychol 32:50-55, 1959). The anchor point descriptions for both scales, with very minor modifications, have been taken from the ECDEU Assessment Manual (Guy, William, ECDEU Assessment Manual for Psychopharmacology, Revised 1976, DHEW Publication No. (ADM) 76-338). A reliability study of the SIGH-D is currently in press in the Archives of General Psychiatry; a reliability study of the SIGH-AD is currently underway.

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For further information contact Dr. Williams at 722 West 168 St., Box 74, N.Y., N.Y. 10032 (Telephone: 212-960-5524).
OVERVIEW: I’d like to ask you some questions about the past week. How have you been feeling since last (DAY OF WEEK)? IF OUTPATIENT: Have you been working? IF NOT: Why not?

What’s your mood been like this past week?

Have you been feeling down or depressed? IF YES: Have you been feeling worse in the morning? Sad? Hopeless?

In the last week, how often have you felt (OWN EQUIVALENT)? Every day? All day?

Have you been crying at all?

DEPRESSED MOOD (sadness, hopeless, helpless, worthless):

0 - absent

1 - indicated only on questioning

2 - spontaneously reported verbally

3 - communicated non-verbally, i.e. facial expression, posture, voice, tendency to weep

4 - VIRTUALLY ONLY these feeling states reported in spontaneous verbal and non-verbal communication

Specify org: (16)

POSS/DEF NOT ORG ORG (17)

IF SCORED 1-4 ABOVE, ASK: How long have you been feeling this way?

NOTES:

*Janet B.W. Williams, D.S.W., Biometrics Research Department, New York State Psychiatric Institute, 722 West 168th Street, New York, New York 10032
How have you been spending your time this past week (when not at work)?

Have you felt interested in doing (THOSE THINGS), or do you feel you have to push yourself to do them?

Have you stopped doing anything you used to do? IF YES: Why?

Is there anything you look forward to?

(AT FOLLOW-UP: Has your interest been back to normal?)

WORK AND ACTIVITIES:

0 - no difficulty

1 - thoughts and feelings of incapac- city, fatigue or weakness related to activities, work or hobbies

2 - loss of interest in activity, hobbies or work - by direct report of the patient or indirect in listlessness, indecision and vacillation (feels he has to push self to work or activities)

3 - decrease in actual time spent in activities or decrease in productivity. In hosp, pt. spends less than 3 hrs/day in activities (hospital job or hobbies) exclusive of ward chores

4 - stopped working bec. of present illness. In hospital, no activities except ward chores, or fails to perform ward chores unassisted


In the last week, have you had trouble concentrating, or trouble remembering things? (How much?)

How has your interest in sex been this week? (I'm not asking about performance, but about your interest in sex - how much you think about it.)

Has there been any change in your interest in sex (from when you were not depressed)?

Is it something you've thought much about? IF NOT: Is that unusual for you?
FOR MEN: Have you had trouble with premature ejaculation (coming too soon) lately? How about trouble keeping an erection? (When did that trouble start?)

FOR WOMEN: Have you had trouble having an orgasm lately? (When did that trouble start?) Have you had a period in the last month or so? IF NOT: Do you know why not? IF YES: Was it heavier than usual?

FOR ALL: In the past week have you had to urinate more frequently than usual, or have you had urgency to urinate more frequently than usual?

How has your appetite been this past week? (What about compared to your usual appetite?)

Have you had to force yourself to eat? Have other people had to urge you to eat?

Have you lost any weight since this (DEPRESSION) began? IF YES: How much? IF NOT SURE: Do you think your clothes are any looser on you? AT FOLLOW-UP: Have you gained any of the weight back?

**SIG AD**

# GENITOURINARY SYMPTOMS (frequency of # micturition, urgency of micturition, # amenorrhea, menorrhagia, development # of frigidity, premature ejaculation, # loss of libido, impotence): #

# 0 - not present #
# 1 - mild #
# 2 - moderate #
# 3 - severe #
# 4 - very severe #

SOMATIC SYMPTOMS GASTROINTESTINAL:

0 - none

1 - loss of appetite but eating without encouragement

2 - difficulty eating without urging

Specify org:

LOSS OF WEIGHT (Rate either A or B):

A. When rating by history:

0 - no weight loss
1 - probable weight loss associated with present illness
2 - definite (according to patient) weight loss
3 - not assessed

B. On weekly ratings by ward staff, when actual weight changes are measured:

0 - less than 1 lb. loss in week
1 - more than 1 lb. loss in week
2 - more than 2 lb. loss in week
3 - not assessed
How have you been sleeping over the last week?

Have you had any trouble falling asleep at the beginning of the night? (Right after you go to bed, how long has it been taking you to fall asleep?)

How many nights this week have you had trouble falling asleep?

INSOMNIA EARLY:

0 - no difficulty falling asleep

1 - complains of occasional difficulty falling asleep - i.e., more than 1/2 hour

2 - complains of nightly difficulty falling asleep

Specify org:

INSOMNIA MIDDLE:

0 - no difficulty

1 - complains of being restless and disturbed during the night

2 - waking during the night - any getting out of bed (except to void)

Specify org:

INSOMNIA LATE:

0 - no difficulty

1 - waking in early hours of morning but goes back to sleep

2 - unable to fall asleep again if gets out of bed

Specify org:
In the last week, have you had broken sleep, unsatisfying sleep, dreams, or nightmares?

Have you felt tired when you wake up? (How bad has that been?)

How has your energy been this past week?

Have you been tired all the time?

This week, have you had any backaches, headaches, or muscle aches?

This week, have you felt any heaviness in your limbs, back or head?

In the past week, have you lost interest in things, or no longer enjoyed your hobbies? Have you felt worse in the mornings?

# DEPRESSED MOOD (loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing):

0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe

# INSOMNIA (difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors):

0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe

# SOMATIC SYMPTOMS GENERAL:

0 - none
1 - heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy and fatiguability.
2 - any clear-cut symptoms

Specify org:

1 - POSS/DEF
3 - NOT
ORG
ORG

(34)

(35)

(36)

(37)
Have you been especially critical of yourself this past week, feeling you've done things wrong, or let others down? IF YES: What have your thoughts been?

Have you been feeling guilty about anything that you've done or not done?

Have you thought that you've brought (THIS DEPRESSION) on yourself in some way?

Do you feel you're being punished by being sick?

This past week, have you had any thoughts that life is not worth living, or that you'd be better off dead? What about having thoughts of hurting or even killing yourself?

IF YES: What have you thought about? Have you actually done anything to hurt yourself?

In the last week, how much have you been worrying (not just about everyday concerns)?

How much have you been worrying about the worst that can happen, or been afraid of what's going to happen?

Have you been feeling especially irritable this past week?

Have you been feeling especially tense this past week?

Have you been worrying a lot about little unimportant things, things you wouldn't ordinarily worry about? IF YES: Like what, for example?

FEELINGS OF GUILT:

0 - absent
1 - self-reproach, feels he has let people down
2 - ideas of guilt or rumination over past errors or sinful deeds
3 - present illness is a punishment. Delusions of guilt
4 - hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations

SUICIDE:

0 - absent
1 - feels life is not worth living
2 - wishes he were dead or any thoughts of possible death to self
3 - suicidal ideas or gesture
4 - attempts at suicide

ANXIOUS MOOD (worries, anticipation of the worst, fearful anticipation, irritability):

0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe

ANXIETY PSYCHIC:

0 - no difficulty
1 - subjective tension and irritability
2 - worrying about minor matters
3 - apprehensive attitude apparent in face or speech
4 - fears expressed without questioning
In the past week, how much have you had any of these things: being startled easily, crying easily, trembling, feeling restless because of nervousness, not being able to relax?

FOR EACH SX ASK: How bad has that been this past week?

This past week, have you been afraid of the dark, of strangers, of being left alone, of animals, of traffic, or of crowds? IF YES: How afraid?

In the last week, have you been bothered by aches and pains, twitching, stiffness, sudden muscle jerks, grinding your teeth, or having an unsteady voice?

In the past week, have you had ringing in your ears, blurred vision, hot and cold flushes, feelings of weakness, or pricking sensations? IF YES: How bad has that been? (How much has it bothered you?)

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<th>TENSION (feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax):</th>
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<th>FEARS (of dark, of strangers, of being left alone, of animals, of traffic, of crowds):</th>
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<th>SOMATIC (SENSORY) (tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensations):</th>
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<th>SOMATIC (MUSCULAR) (pains and aches, twitchings, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone):</th>
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<th>SOMATIC (SENSOR)</th>
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<td>4 - very severe</td>
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</table>
In this past week, have you had any of these physical symptoms (READ LIST, PAUSING AFTER EACH SX FOR REPLY)?

How much have these things been bothering you this past week? (How bad have they gotten? How much of the time, or how often, have you had them?)

NOTE: DON'T RATE IF CLEARLY DUE TO MEDICATION (E.G., DRY MOUTH AND IMIPRAMINE)

ANXIETY SOMATIC (physiologic concomitants of anxiety, such as)
GI - dry mouth, gas, indigestion, diarrhea, cramps, belching
C-V - heart palpitations, headaches Resp - hyperventilating, sighing
Having to urinate frequently
Sweating):
0 - absent
1 - mild
2 - moderate
3 - severe
4 - incapacitating

In the last week, have you had trouble swallowing? Have you had stomach pain or fullness, nausea, vomiting, burning or rumbling in your stomach, loose bowels, constipation, sinking feelings in your stomach, or heartburn? IF YES: How bad has that been?

In the past week, have you had any flushing in your face, or have you been pale? Have you felt lightheaded, or had a tension headache, or felt the hair rise on your arms, the back of your neck, or your head? IF YES: How bad has that been?

In the past week, has your heart raced, skipped, or pounded? Have you had pain in your chest, throbbing blood vessels, fainting feelings, or shortness of breath? IF YES: How bad has that been?

GASTROINTESTINAL SYMPTOMS (difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation):
0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe

AUTONOMIC SYMPTOMS (dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair):
0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe

CARDIOVASCULAR SYMPTOMS (tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, sighing, dyspnea):
0 - not present
1 - mild
2 - moderate
3 - severe
4 - very severe
In the last week, have you had pressure or tightness in your chest, or choking feelings? IF YES: How bad has that been?

RESPIRATORY SYMPTOMS (pressure or constriction in chest, choking feelings, sighing, dyspnea):

- 0 - not present
- 1 - mild
- 2 - moderate
- 3 - severe
- 4 - very severe

In the last week, how much have your thoughts been focused on your physical health or how your body is working (compared to your normal thinking)?

HYPOCHONDRIASIS:

- 0 - not present
- 1 - self-absorption (bodily)
- 2 - preoccupation with health
- 3 - frequent complaints, requests for help, etc.
- 4 - hypochondriacal delusions

Do you complain much about how you feel physically?

Have you found yourself asking for help with things you could really do yourself? IF YES: Like what, for example? How often has that happened?

RATING BASED ON OBSERVATION

INSIGHT:

- 0 - acknowledges being depressed and ill OR not currently depressed
- 1 - acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
- 2 - denies being ill at all

RATING BASED ON OBSERVATION DURING INTERVIEW

AGITATION:

- 0 - none
- 1 - fidgetiness
- 2 - playing with hands, hair, etc.
- 3 - moving about, can't sit still
- 4 - hand-wringing, nail biting, hair-pulling, biting of lips
Evidence of anxiety during the interview, such as fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

Rating based on observation during interview

Retardation (slowness of thought and speech; impaired ability to concentrate; decreased motor activity):

0 - normal speech and thought
1 - slight retardation at interview
2 - obvious retardation at interview
3 - interview difficult
4 - complete stupor

Specify org:

TOTAL 17-ITEM HAMILTON DEPRESSION SCORE (IGNORING ORGANIC RATINGS):  

TOTAL 14-ITEM HAMILTON ANXIETY SCORE (ITEMS BOXED WITH #s):
APPENDIX C

THE UK EMIC FOR DEPRESSION, Version 2.3
EXPLANATORY MODEL INTERVIEW CATALOGUE

THE EMIC

U.K Version 2.3
Adapted with permission from author

Program for Cross-Cultural Medical Research and Training
Harvard University, Boston.

CULTURAL STUDY OF DEPRESSION

Department of Academic Psychiatry
University College and Middlesex School of Medicine

24 June 1992

Not for quotation or Use Without Permission
INFORMED CONSENT FORM

Subject's Name: ___________________________ P.t.Study No. ________

Project Title: CULTURAL STUDY OF DEPRESSION

I am asking you to participate in a study of the meaning of illness. If you agree to an interview with me, I will ask about your ideas about illness, how you get help and other questions about your life.

Participation in this study is not required for you to continue getting treatment from any of the medical staff who have been helping you. You may leave the study at any time without any effect on your treatment.

Potential Risks: During the interview it is possible, though not likely, that you may find it upsetting to talk about some of the issues I ask about. You may stop the interview at any time or refuse to answer any question.

Expected Benefits: Understanding how illness affects people like you, and how you understand your problems may help clinicians to help people who come to them for help more effectively. You may also feel better after the interview from discussing concerns that are not usually spoken about in the clinic.

Statement of Confidentiality: What we talk about will remain confidential, and I will not identify you as a participant in this study.

Investigator's Statement: I have fully explained to the subject the nature and purpose of the procedures described above and such risks as are involved in its performance. I have asked the subject if he or she has any further questions, and I have answered these questions to the best of my ability.

________________________
Investigator's Signature

Subject's Statement: I understand what has been requested in connection with my participation in this study, and I agree to participate. I also understand that I may withdraw this consent at any time without any effect on the quality of my treatment.

Date: ____________________

________________________
Subject's Signature
EXPLANATORY MODEL INTERVIEW CATALOGUE

FILE NUMBER: ___________ DATE INTERVIEWED: @ / /
TIME INTERVIEW BEGINS: @

1. PATIENT STUDY NUMBER:

2. REFERRAL SOURCE
   C.P.N. . . . [3] In-patient . . . . . [7]
   Casualty . . [4] Other . . . . . [8] *

3. NAME: ____________________________________________________________________________

   3.1. CULTURAL SIGNIFICANCE OF NAME:

      (A) "What does your GIVEN NAME mean to you? Do you like your name?"

            No Meaning/Likes Name . . [1] Yes Meaning/Likes Name . [3]

      (B) "What are the origins of your FAMILY NAME? Do you like your FAMILY NAME?"

            No Meaning/Likes Name . . [1] Yes Meaning/Likes Name . [3]

3.2. AGE: (Yrs) #

3.3. DATE OF BIRTH: @ / /


3.5. RELIGION: "What is your religion?"


   ____________________________________________________________________________
3.6. **ETHNICITY:** "What is your ethnic background or culture?"

Subjects': _________________________________ * 

Fathers': _________________________________ * 

Mothers': _________________________________ * 

Welsh . . . [3] 

3.7. "Are you an especially religious person?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * 

3.8. "Do you feel that your religious background has an important influence on your life and behaviour?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * 

4. **LOCAL ADDRESS:**

Telephone: (H): ______________________________ 

(O): ______________________________ 

4.1. **Permanent or Temporary:** (1=Permanent 2=Temporary) * 

(A) If Temporary, specify Permanent Address:

Telephone: (H): ______________________________
4.2. NEXT OF KIN: "Who would you say is your next of kin?"

Name: ________________________________

Relationship to subject: ____________________ (Referral Code) *_____

(A) Address: ________________________________

____________________________________________________________________

____________________________________________________________________

Telephone: (H): ________________________________

5. MIGRATION:

5.1. "How long have you been living in London (on this occasion)?" (Months) #____

5.2. If subject has ever lived outside of London:

"Where did you live before that? Can you recall all the place where you have lived since you were born and how long you stayed at each place?"

Specify:

Village . . . . [1] City . . . . . . [3]

<table>
<thead>
<tr>
<th>PLACE</th>
<th>STATUS</th>
<th>FROM</th>
<th>TO</th>
<th>DURATION (MTHS)</th>
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<td>(1)</td>
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<td>(10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(A) If subject has migrated to London from elsewhere:

"What were your reasons for coming to London?"

Based on narrative response, code the following:

(1=Yes 2=No 3=Possibly 4=Uncertain)

Job Opportunities: *
Housing Problems: *
Caring for Relatives: *
Pace of City: *
Rural Lifestyle: *
Other: *

(B) If subject has left London to live elsewhere:

"What were your reasons for leaving London?"

Based on narrative response, code the following:

(1=Yes 2=No 3=Possibly 4=Uncertain)

Job Opportunities: *
Housing Problems: *
Caring for Relatives: *
Pace of City: *
Rural Lifestyle: *
Other: *
6. **LIVING CONDITIONS:**

6.1. "How would you describe the place where you live?"

- Homeless .... [1]
- Hostel ....... [5]
- Flat ........ [2]
- Bed and B'fast .. [6]
- Bedsit ....... [3]
- Other ........ [7]
- Specify: ______________ * ___

6.2. "On which floor of the building do you live?"

If more than one, code lowest: (Floor Number) # ___

6.3. "Do you have a lift or an elevator at this place?"

(1=Yes 2=No) * ___

6.4. "Do you have any concerns that the conditions where you live might affect your health?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * ___

6.5. "Do you feel that the place you live in, provides the privacy and space you need?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * ___
6.6. Further characterize residence by specifying:

(A) No of bedrooms: ________________________________

(B) Toilet: (1-Dwelling 2=Shared 3=Public)____

(C) Carpets: (1=Yes 2=No) _______________________

(D) Heating: (1-Central 2-Gas 3=None)__________

(E) Garden: (1=Yes 2=No)________________________

(F) Television: (1=Yes 2=No)____________________

(G) Telephone: (1=Yes 2=No)____________________

(H) Video: (1=Yes 2=No)________________________

(I) Car: (1=Yes 2=No)___________________________

(J) Radio: (1=Yes 2=No)________________________

(K) Refrigerator: (1=Yes 2=No)__________________

(L) Microwave: (1=Yes 2=No)____________________

6.7. "Who pays for your housing?"

Social Serv . . . . [1] Self (Rented) . . . [5]
Self (Owned) . . . . [4] Others . . . . . [8]

6.8. Specify amount (monthly): ____________________ £___

7. NEIGHBOURS AND NEIGHBOURHOOD

7.1. "How would you describe your neighbours?"

________________________________________________
________________________________________________
________________________________________________

(A) "Are they quiet or noisy?"

(1=Quiet 2=Noisy 3=Nondescript) *___
(B) "Are they supportive or uncaring?"

(1-Supportive 2-Uncaring 3-Nondescript) *___

(C) "How do you get along with them?"

(1-Excellent 2-Fair 3-Neutral 4-Poor 5-Uncertain) *___

(D) "How often do you see them?"

(Contacts in a Month) #___

(E) "Do you ever talk to them about your personal problems?"

(1-No 2-Yes 3-Possibly 4-Uncertain) *___

(F) If Yes:

"What kind of problems do you talk to them about the most?"

(0-Not Mentioned 1-Mentioned 2-Emphasis [One Only])

(1) Health/Medical *___
(2) Psychological *___
(3) Financial *___
(4) Work *___
(5) Family *___
(6) Neighborhood *___

(G) If not: "What reasons might they be?"
8. NEIGHBOURHOOD PUB

8.1. "Is there a pub where you go regularly?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

NAME: ___________________________________________________________

8.2. "How many times in a month do you go?" (Visits in a Month) #____

8.3. "Most of the time, do you go there alone, or do you go with friends or to meet friends?"

(1=Pub solitary 2=Pub social 3=Mixed 4=Can't Say) *____

9. MARITAL STATUS: "What is your marital status?"


9.1. If married: "Is this your first marriage? . . . . . . How many times have you been married?"

(Code "nth" marriage) #____

9.2. If unmarried: "Were you ever married?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____
9.3. **If divorced or separated:** "Could you tell me the main reason why you separated (divorced)?"

(0=Not mentioned 1=Mentioned 2=Emphasis [one only])

(A) Infidelity *___
(B) Physical Abuse *___
(C) Verbal/Emotional Abuse *___
(D) Incompatibility *___
(E) Other *___

9.4. **If currently (or ever) in a relationship:** "How long have you been (were you) in this relationship?"

(Years) #___

9.5. **If most recent marriage/relationship has ended:** "How long since separation or death of spouse/companion?"

(Years) #___
10. FAMILY AND HOUSEHOLD*

<table>
<thead>
<tr>
<th>Relative</th>
<th>No</th>
<th>Age range</th>
<th>LWS</th>
<th>LA</th>
<th>INTERACTION</th>
<th>Expired</th>
<th>Yrs Ago</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td>Young</td>
<td>Elder</td>
<td></td>
<td>Freq</td>
<td>Tel/Ltr</td>
<td></td>
</tr>
</tbody>
</table>

10.1. Spouse

10.2. Mother

10.3. Father

10.4. Son

10.5. Daughter

10.6. Brother

10.7. Sister

10.8. Stparents

10.9. Stpchldrn

10.10. Stepsibs

10.11. Others

10.12. TOTAL PERSONS IN SUBJECTS' HOUSEHOLD: 

*LWS: Living with Subject (#) LA: Living Apart (#) Freq & Tel/Ltr: #/Mth
Expired: Yrs Since Most Recent Loss (#) (Code 0 if all are alive) Narrative for "nature" of interactions: "What brings you together? What leads you to meet?"
11. "Are there any tensions in your family that might affect your health?"


12. PETS: "Do you keep any pets at home?"

12.1. ANY PETS: (1=Yes 2=No 3=Possibly 4=Uncertain) *___

12.2. If Yes, specify how many:
   (A) Cat(s): #___
   (B) Dog(s): #___
   (C) Bird(s): #___
   (D) Other(s): #___

12.3. "What would you say is the main thing that makes this (these) pet(s) so important to you?"

   (0=Not mentioned 1=Mentioned 2=Emphasis [one only])

   (A) Company/Loneliness: *___
   (B) Reason to Go Out: *___
   (C) Emotional Bond: *___
   (D) Protection: *___
   (E) Others: *___

12.4. Do they affect your health in any way?


(1=Yes 2=No 3=Possibly 4=Uncertain) *___
13. TELEVISION:

13.1. "What kind of television programs do you LIKE BEST?"
Which is your FAVOURITE?"

(0=Not mentioned 1=Mentioned 2=Favourite [one only])

(A) Soap Operas: *
(B) Educational: *
(C) Movies: *
(D) News: *
(E) Sports: *
(F) Others: *

13.2. FAVOURITE PROGRAMME: ____________________________ (Code A-F): *

13.3. "What kind of television programs do you WATCH MOST frequently? Is there ANY ONE in particular?"

(A) Soap Operas: *
(B) Educational: *
(C) Movies: *
(D) News: *
(E) Sports: *
(F) Others: *

13.4. VIEWED MOST OFTEN: ____________________________ (Code A-F): *
14. NEWSPAPERS

14.1. "Which newspapers do you read most often? ...Which is your favorite?"

__________________________________________________________

__________________________________________________________

__________________________________________________________

(0=Not mentioned 1=Mentioned 2=Read Most [one only])

(A) Standard: *____

(B) Tabloid: *____

(C) Magazine: *____

14.2. FAVOURED NEWSPAPER/MAGAZINE: ________________________ (Code A-C): *____

__________________________________________________________

15. HEALTH LITERATURE AND MASS MEDIA

15.1. "What about health columns in magazines or newspapers? Do you read them?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

__________________________________________________________

15.2. "Do you keep health (or medical) books or related literature at home?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

LIST: (1)_____________________________________________________

(2)_________________________________________________________

(3)_________________________________________________________

15.3. "Describe the kind of troubles or problems that would lead you to consult this health literature at your home".

__________________________________________________________

__________________________________________________________

__________________________________________________________
15.4. "What about the radio? Do you dial in to talk about your problems or to listen to other people talk about their problems?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

16. COMMUNITY SUPPORTS

16.1. "Do you have a personal "agony aunt" or another confidant like that?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

16.2. "Are you a member of a voluntary organisation or support group in your community?"

If so, specify which, otherwise code 1 for "None:" (0=Not Member 1=Member)

None *____ Mind *____ AA *____

Phobic Soc *____ Schiz Soc *____ Other *____

17. MEDICINES AT HOME

17.1. "Do you keep medicines or other remedies for health problems at home?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

18. EDUCATION: "What is the highest level of education you have completed?"

Completed Pri'ry [3] Prof'l Degree . . [8]
"O" Levels . . [5]
18.1. HIGHEST LEVEL COMPLETED: ___________________________ * __

    If dropped out: "...Why?" ___________________________

    (Code most important: 1= Financial 2= Disinterest 3= Other) * __

19. OCCUPATION:

    Skilled Labour ... [5] Unemployed .... [14]
    Vendor/Sales ..... [7] Never employed .... [16]
    Service (Driver, etc) [8] Deceased ....... [17]

19.1. PERSONAL OCCUPATION: ___________________________

    If unemployed, retired or disabled: Prior Occup

19.2. FATHER'S OCCUPATION: ___________________________

    If unemployed, retired or disabled: Prior Occup

19.3. MOTHER'S OCCUPATION: ___________________________

    If unemployed, retired or disabled: Prior Occup

19.4. SPOUSE'S OCCUPATION: ___________________________

    If unemployed, retired or disabled: Prior Occup

20. INCOME:

20.1. "What is your total monthly income?"

    (Monthly Income) £ __

    If subject does not specify exact amount, choose income band:

20.2. **FINANCIAL STRESSORS:**

(A) "Are you currently experiencing any kind of financial stress such as loans, debts, mortgage or poll tax arrears?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * __

(B) "How severe a strain would you rate your financial problems?"

(1=No Strain 2=Mild Strain 3=Moderate Strain 4=Severe Strain 5=Uncertain) * __

---

20.3. **SOCIAL SUPPORTS:** "Are you currently on income benefits such as..." (1=Yes 2=No)

1) Invalidity: # ___ 12) Resettlement: # ___
2) Maternity: # ___ 13) Free/Reduced Price Milk: # ___
3) Retirement: # ___ 14) Redundancy: # ___
4) Sickness: # ___ 15) Child: # ___
5) Unemployment: # ___ 16) One Parent: # ___
6) Widow's: # ___ 17) Guardians': # ___
7) Income supports: # ___ 18) Disability: # ___
8) Housing: # ___ 19) Attendance: # ___
9) Poll tax: # ___ 20) Mobility: # ___
10) Cold weather: # ___ 21) Travelling: # ___
11) Crises: # ___

(Total Number of Codes) = __

---

20.4. **SPOUSE'S OR COMPANION'S INCOME:** £ ___

(A) Specify whether shared or not: (1=Shared 2=Not Shared) * __

(B) "What percentage of spouse's income is shared?" % ___

20.5. **ADDITIONAL INCOME FROM OUTSIDE:** £ ___

Total Income:  - ___
21. **DEPENDANTS ON TOTAL INCOME:**

   (Number of Dependents) # __

21.1. "Does your income support others living outside your household?"

   (1=Yes 2=No 3=Possibly 4=Uncertain) * ____

21.2. If Yes: "How much money do you (or others in your household) send outside?"

   (Monthly) £ ____

21.3. Specify to whom: "Whom do you assist?"

   (Referral Code) * ____

21.4. "Are there other family events or obligations that you may have to support financially in future?"

   (1=Yes 2=No 3=Possibly 4=Uncertain) * ____

21.5. Specify events or obligations:

   ____________________________________________________________

   ____________________________________________________________

22. **LANGUAGES:** What is your mother tongue? ...Are you fluent in other languages as well?

   (1=No Fluency 2=Fluent 3=Mother Tongue)

   (A) English * ____
   (B) German * ____
   (C) French * ____
   (D) Spanish * ____
   (E) Portuguese * ____
   (F) Greek * ____
   (G) Other(s): ____________________________________________ * ____
PERSONAL EXPERIENCE OF ILLNESS

Introduction:

"I will be asking you questions about your health problem. Later, I will ask about what has been helpful in the past and what you think might now be helpful. While doctors have special ways of understanding illness, people like yourself also have their own ideas, which may be different from what the doctors think. It will help us to help people who have had problems like yours by understanding how you think about your problems, the ways you might get help for it, and what you do about it."

PATTERNS OF DISTRESS

23. "What is it that has been troubling you and led you to seek help from a psychiatrist?"

Record prose account of the problem as close to the patient's words as possible.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Code symptoms reported after initial open-ended query:

(0-Not mentioned 1-Mentioned 2-Emphasis [all that apply])

Sleep: *____
Appetite: *____
Libido: *____
Somatic Complaints: *____
Sadness: *____
Anxiety: *____
Fears and Phobias: *____
Loneliness: *____
Social Relations / Stigma: *____
Cognitive Impairment: *____
Functional Impairment: *____
Not Troubled: *____
Other: *____
Can’t Say: *____

23.1. If subject reports no mood or anxiety symptoms, then continue the inquiry with the following probe:

*Along with these problems, how have you been feeling?*
23.2. If subject reports no somatic complaints, then continue the inquiry with the following probe:

"Along with these problems, do you have any aches, pains or other physical troubles?"

Code ONLY symptoms that are more prominent after probes:

(0=Not mentioned 1=Mentioned 2=Emphasis [all that apply])

Sleep: *____
Appetite: *____
Libido: *____
Somatic Complaints: *____
Sadness: *____
Anxiety: *____
Fears and Phobias: *____
Loneliness: *____
Social Relations / Stigma: *____
Cognitive Impairment: *____
Functional Impairment: *____
Not Troubled: *____
Other: *____
Can't Say: *____

24. ONSET OF PROBLEM

24.1. "When did you first notice the problem?" (Months Ago) *____
24.2. "When did this particular episode begin?" (Months Ago) *____

Subsequent questions about perceived causes and help seeking refer to this episode.

25. "What would you call your problem? What is the name of this problem?"

Quote or paraphrase the subject’s own words.

Uncertain . . . . . [0] Nerves . . . . . . [6]
Madness . . . . . . [1] Stress . . . . . . [7]
Tension . . . . . . . [4] Other . . . . . . [10] *____

26. BODY, MIND, SOCIETY AND THE VALUE OF MEDICAL HELP

26.1. "Do you feel the trouble that brings you here mainly affects your body, your mind or you relations with people?"

(0=Not mentioned 1=Mentioned 2=Emphasis [one only])

(A) Problem Affects Body *____
(B) Problem Affects Mind *____
(C) Problems Affects Social Relations *____

26.2. "Is yours the kind of problem psychiatrists can help with?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____
(A) If subject specifies NON-PSYCHIATRIC Problem: "How is your problem different from the problems psychiatrists help with?"


27. "How serious is your problem?"

Record patient's response even though other evidence may be contradictory.

- Not Serious . . . [1]
- Mildly Serious . . [2]
- Moderately Serious . . [3]
- Very Serious . . [4]
- Uncertain . . . . [5]


28. "What is most troubling about your problem?"

Code category of most troubling symptom:

- Sleep . . . . [1]  Loneliness . . . . . . . [7]
- Anxiety . . . . [6]  Can't Say . . . . . . . [12]

*___
29. **ANTICIPATED OUTCOME:**

- Cure . . . . . . [1]
- Severe Disability . . . [5]
- Cure . . . . . . [1]
- Fatal . . . . . . . [6]
- Improve/Not Totally . . [2]
- Suicide . . . . . . . [7]
- Remain Stable . . . . [3]
- Other (Specify) . . . . [8]
- Worsen . . . . . . [4]

"What do you expect to happen as a result of this problem?..."

29.1. "...With Treatment?"  
(code the best outcome) (*) ______

29.2. "...Without Treatment?"  
(code the worst outcome) (*) ______

(Details) ____________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

30. "Have you ever thought of hurting yourself or taking your life?"

(1=No 2=Possibly 3=Yes without DSH 4=Hx of DSH 5=Uncertain) *___

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

31. **RATE EFFECTS ON HOUSEHOLD INCOME:**

31.1. "Has your problem reduced the income of your household, either because you or someone else cannot work and earn as much?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

31.2. "Do you expect it to have any (further) effect?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
SELF ESTEEM AND STIGMA

32. DISCLOSURE

Record and code response under headings below. Consider all aspects of the illness, not just isolated symptoms.

32.1. "Is there anyone whom you told about this problem, because you wanted them to know, perhaps because you thought they should know, or they might help, or for some other reason?"

TOLD SOMEONE WHOM YOU WANT TO KNOW

________________________

________________________

________________________

________________________

32.2. "Does anyone else know about this problem, anyone whom you might not want to know about it?"

SOMEONE KNOWS WHOM YOU PREFER DID NOT:

________________________

________________________

________________________

________________________

32.3. "Does anyone else know about this problem, someone whose knowing or not knowing makes no difference to you?"

SOMEONE KNOWS, BUT NO MATTER:

________________________

________________________

________________________

________________________

CODE: 1=Yes 2=No 3=Possibly 4=Uncertain
32.4. "Is there someone you would like to tell about your problem whom you have not yet told?"

NOT YET TOLD SOMEONE YOU WANT TO KNOW: * ___

33. SELF REGARD AND COMMUNITY RESPONSE TO ILLNESS

33.1. Do you think less of yourself because of your problem?"

THINK LESS OF YOURSELF: * ___

33.2. "Do you feel that your problem is a burden to others?"

BURDEN TO OTHERS: * ___

(A) If yes or possibly: "Whom does it affect most? ...How?"

(Influence Code Options) * ___

33.3. "Because of the nature of your problem, do you think your emotions or feelings could upset or have a negative influence on others?"

EMOTIONS UPSETTING TO OTHERS: * ___

33.4. "If they knew about it, would your neighbours, colleagues or others in your community think less of you because of your problem?"

OTHERS WOULD THINK LESS OF YOU: * ___

CODE: 1=Yes 2=No 3=Possibly 4=Uncertain
34. **EFFECTS ON MARRIAGE**

34.1. **ABILITY TO MARRY**

**IF UNMARRIED:**

"If people knew about it, might this problem make it more difficult for you to get married?"

**IF MARRIED:**

"Suppose you were not married. If people knew about it, would this problem make it more difficult for you to get married?"

* ___

34.2. **EFFECTS ON ONGOING MARRIAGE**

**IF UNMARRIED:**

"After you get married, do you think this problem might cause you trouble in your marital life?"

**IF MARRIED:**

"Might this problem cause trouble of any kind in your marital life?"

* ___

34.3. **EFFECTS ON A RELATIVE’S MARRIAGE**

"Could this problem make it more difficult for someone in your family to get married?"

* ___

**CODE:** 1=Yes 2=No 3=Possibly 4=Uncertain
PERCEIVED CAUSES

INTRODUCTION:

"Each of us may explain something that happens in various ways. For example: if a car broke down, some people might think it happened because they were out of gas, were low on batteries, were not maintaining it properly, or because of bad roads, or just bad luck, or perhaps a combination of several reasons. Similarly, people have different ideas about what hurts them or makes them sick. I would like to understand your own ideas about your problem, even if they are different from ideas of your friends, family or your doctors."

Provide further examples if necessary.

35. "What do you think is the cause of this problem?"

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

Code Response: (1)*____ (4)*____ (7)*____
(2)*____ (5)*____ (8)*____
(3)*____ (6)*____ (9)*____
SCREENING PERCEIVED CAUSES

36. "Do you feel that it is mainly your body, your mind or relations with people that are mainly responsible for your problem?"

(0=Not mentioned 1=Mentioned 2=Emphasis [one only])

A. Problems Comes from Body * ___
B. Problem Comes from Mind * ___
C. Problem Comes from Social Relations * ___

37. "People with troubles like yours have many different ways of explaining their problem. I am going to ask you about a number of these explanations. Do you think any one or several of these, which I will list, might have caused the problem for which you have come here for help?"

37.1. "Do you believe your problem results from food--perhaps eating the wrong kind, eating too much or not eating enough? Do you think it may be due to water, alcohol, smoking, drugs or prescribed medicines?

S - A - I - L - CR*

_________________________ 1) Food-Water __""--""--""--"
_________________________ 2) Alcohol __""--""--""--"
_________________________ 3) Smoking __""--""--""--"
_________________________ 4) Abused Drug __""--""--""--"
_________________________ 5) Prescribed Med __""--""--""--"

_________________________
_________________________
_________________________
_________________________

*PC CODES: S-Status: B=Definite C=Poss D=Not Cause E=Unclear F=Concpt Unknw
A-Artifact: A=Yes B=No C=? I-Influence: (See Codes) L-Linkage: D=Dependent
R=Related I=Independent CR-Code Reference: If L=D or L=R, PC Code Ref Number
37.2. "Do you believe your problem is caused by some injury, prior illness, pregnancy or childbirth (women only)? Could it be due to constipation, weakness or some other physical problem?"

S - A - I - L - CR*

6) Injury, Accident

7) Prior-Existing Illness

8) Pregnancy-Childbirth

9) Congen-not Heredity

10) Anatomical-Phys Prob

11) Weakness

37.3. "Do you believe your problem is caused by your physical appearance such as being overweight, too tall or short, poor complexion or perhaps just unappealing looks?"

S - A - I - L - CR*

12) Body Image

*PC CODES: S-Status: B=Definite C=Poss D=Not Cause E=Unclear F=Concp Unkwn
A-Artifact: A=Yes B=No C= I-Influence: (See Codes) L-Linkage: D=Dependent
R=Related I=Independent CR-Code Reference: If L=D or L=R, PC Code Ref Number
37.4. "Do you believe your problem is caused by tensions and aggravations within your family, with your children or other close relationships? Could it be from listening to problems of others?"

S - A - I - L - CR*

13) Family problems __-__-__-__
14) Marital problems __-__-__-__
15) Failure to marry __-__-__-__
16) Other Interpersonal __-__-__-__

37.5. "Do you believe your problem results from more global concerns about the world, such as the depletion of rain forests, the ozone hole, or uncertainties in the future of humanity and the world?"

S - A - I - L - CR*

17) Global Concerns __-__-__-__

*PC CODES: S-Status: B=Definite C=Poss D=Not Cause E=Unclear F=Concept Unknown
A=Artifact: A=Yes B=No C=? I-Influence: (See Codes) L-Linkage: D=Dependent
R=Related I=Independent CR-Code Reference: If L=D or L=R, PC Code Ref Number
37.6. "Do you believe your problem comes from a feeling of life being too much, or the result of some shock, stressful events, the death of someone close to you, loss of a pet or some other terrible tragedy?"

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<tr>
<td>18) Bereavement</td>
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<td>19) Stress-Loss-Shock</td>
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37.7. Do you believe that your problem may be a result of having been a victim of physical or sexual abuse, injustice, burglary or racism?

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<tbody>
<tr>
<td>20) Physical Abuse (Adult)</td>
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<tr>
<td>21) Sexual Abuse (Adult)</td>
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<tr>
<td>22) Racism</td>
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<td>23) Child Abuse</td>
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<td>24) Other Injustice</td>
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<tr>
<td>25) Other Victimization</td>
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37.8. "Do you believe your problem is caused by your mind, thoughts, feelings or emotions; perhaps because you are the kind of person who worries too much or suffers from nerves? Could it be due to some other aspect of your personality or nature?"

_______________ 26) Mind-Thoughts-Worries ___-__-__-__

_______________ 27) Nerves ___-__-__-__

_______________ 28) Personality ___-__-__-__

37.9. Do you believe that your problem results from difficulties at work? Could it be from conflicts with your employers, work colleagues or other kinds of stress at work?"

_______________ 29) Work Problem ___-__-__-__

37.10. Do you believe your problem is caused by financial stress, such as not being able to earn enough, high mortgage, poll tax, other debts, or because you are poor?

S - A - I - L - CR*

30) Financial Stress

37.11. Do you believe your problem is caused by black magic (sorcery) or evil eye?*

S - A - I - L - CR*

31) Evil Eye

32) Other Sorcery

37.12. "Do you believe your problem is caused by something passed on in your family, a hereditary factor?"

S - A - I - L - CR*

33) Heredity

37.13. "Do you believe your problem is caused by germs, viruses, dirt, or contact with an infected person? Is it a result of not taking care of yourself or keeping yourself clean enough, poor housing or environmental pollution?"

   ___________ 34) Sanitation/Living Conditions
   ___________ 35) Personal Hygiene
   ___________ 36) Germs-Inf-Contam-Contact
   ___________ 37) Environment-Pollution

37.14. "Do you believe your problem is caused by living in proximity or contact with an emotionally disturbed person?"

   ___________ 38) Living w/Emotionally Disturbed

*PC CODES:  S-Status:  B=Definite  C=Poss  D=Not Cause  E=Unclear  F=Concept Unknown
A-Artifact:  A=Yes  B=No  C=?  I-Influence:  (See Codes)  L-Linkage:  D=Dependent
R=Related  I=Independent  CR-Code Reference:  If L=D or L=R, PC Code Ref Number
37.15. "Do you believe that your problem is caused by not being able to say what you feel, keeping your problems to yourself (bottling them up) or because you lack close friends and confidants?"

__________________________ 39) Disclosure Problem
__________________________ 40) Loneliness

37.16. "Do you believe your problem is caused by boredom or an inability to find meaning, purpose or direction in your life? Could it be from something lacking in your spiritual life?"

__________________________ 41) Boredom
__________________________ 42) Life Meaningless
__________________________ 43) Spiritual Deficit

*PC CODES: S-Status: B-Definite C-Poss D-Not Cause E-Unclear F=Concpt Unkwn
A-Artifact: A=Yes B-No C=I-L-Linkage: D-Dependent
R-Related I-Independent CR-Code Reference: If L=D or L=R, PC Code Ref Number
37.17. Men: "Do you believe your problem is caused by loss or retention of semen?"

Women: "Do you believe your problem is caused by loss of vaginal fluid (not menstrual fluid)?"

_________ 44) Semen-Vaginal Fluid

Include comments on semen and vaginal fluid even if not a perceived cause of the current problem:

Yes, Losing . . . . [1] No . . . . . . . . . . [4]

(A) "Do you think that loosing or retaining semen causes problems?"

(B) "Do you think that loosing or retaining vaginal fluid (not menstrual fluid) causes problems?"

*PC CODES: S - Status: B=Definite C=Poss D=Not Cause E=Unclear F=Concept Unkwn
A-Artifact: A=Yes B=No C=? I-Influence: (See Codes) L-Linkage: D=Dependent
R=Related I=Independent CR-Code Reference: If L=D or L=R, PC Code Ref Number
37.18. "Do you believe your problem is caused by masturbation, sexual relations of any kind, your sexual preferences or identity or how you think about yourself sexually?"

- A - I - L - CR*

45) Masturbation

46) Sexual Experience

47) Sexual Identity

37.19. "Do you believe that your problem is caused by too much or too little heat or cold in your body, or outside due to weather?"

- A - I - L - CR*

48) Heat-Cold in Body

49) Climate: Heat-Cold

37.20. "Do you believe your problem is caused by too much "wind," "bile," or "phlegm?"

<table>
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<tr>
<th>S-A-I-L-GR*</th>
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<tbody>
<tr>
<td>50) Wind-Bile-Phlegm</td>
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</tbody>
</table>

37.21. "Do you believe that your problem results from fate, chance or bad luck? Is it due to something wrong that you may have done in the past? Is it due to bad stars or the will of God?" Could it be the result of something you did in your past life?"

<table>
<thead>
<tr>
<th>S-A-I-L-GR*</th>
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</thead>
<tbody>
<tr>
<td>51) Astrology</td>
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<tr>
<td>52) Fate-Chance</td>
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<td>53) Will of God</td>
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<td>54) Bad Deeds</td>
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<td>55) Karma</td>
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</tbody>
</table>

*PC CODES: S-Status: B=Definite C=Poss D=Not Cause E=Unclear F=Concept Unknown
37.22. "Do you believe your problem is caused by supernatural or religious forces?"

\[ S - A - L - I - C R^* \]

\( \underline{56) \text{ Religious} \} \)

\( \underline{57) \text{ Other Supernatural} \} \)

\( \underline{\text{Spirits-Forces-Energy}} \)

37.23. "Is there anything else that you believe may have caused your problem?"

Include here detail about any other perceived cause the subject mentions if not yet recorded.

\[ S - A - L - I - C R^* \]

\( \underline{58) \text{ Other} \} \)
38. FIRST PERCEIVED CAUSE AND CHANGES OVER TIME

"Which of these causes that you have mentioned, or perhaps something else, was the one that you thought of first when this problem began?"

(PC Code) * ______

________________________________________

________________________________________

________________________________________

39. PREVIOUS IDEAS ABOUT CAUSE:

"Since your problem began, not just this episode, have you changed your mind about what you think may have caused it?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * ___

If no, skip to MOST IMPORTANT PERCEIVED CAUSE.

If yes:

39.1. "What did you think caused it previously, but not now?

PREVIOUS BELIEFS LESS NOW:

(##=PC Code) (*)_____ (*)_____ (*)_____

_______________________________

_______________________________

39.2. "Alternatively, what do you now think causes it that you did consider previously?"

CURRENT BELIEFS LESS BEFORE:

(##=PC Code) (*)_____ (*)_____ (*)_____
40. MOST IMPORTANT PERCEIVED CAUSE:

"Which of these causes that you have mentioned (or perhaps something else) do you now consider the most important cause of your problem?" *

If not yet clear:

"Tell me in more detail how this main cause is related to your problem."
"How does it work?".

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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41. SOCIAL SUPPORTS AND FAMILY HELP:

"In general, do you feel you are able to get help if you need it from your (spouse,) employers, family friends or others you know?"

(1=Yes  2=No  3=Possibly  4=Uncertain)  *
41.1. "Have you asked your family for help?"
   (1=Yes 2=No 3=Possibly 4=Uncertain) *___

   If yes:
   (A) "What kind of help did you ask them for?"

   If no:
   (B) "What were your reasons for not asking them for help?"

41.2. "Has your family helped you in any way with your problem?"
   (1=Yes 2=No 3=Possibly 4=Uncertain) *___

41.3. "Would you like your family to be more helpful?"
   (1=Yes 2=No 3=Possibly 4=Uncertain) *___
HELP SEEKING FOR THIS PROBLEM:

42.1. "People do many things to help themselves. Aside from any professional help, what was the main thing you did for yourself to cope with this problem?"

(A) Reading, Radio, Television

(B) Home Remedy

(C) Talking to Friends

(D) Taking a Holiday

(E) Sports or Exercise

(F) Self Help Group

(G) Other (Specify ______________________) 

(0=Not mentioned 1=Mentioned 2=Emphasis [one only])

PREVIOUS HELP SEEKING BY CATEGORY:

"We realize that you have come here for help, but many people who come here have also tried to get help from many other sources. This is certainly understandable and not something you should be embarrassed about discussing with me. Please tell me what kinds of help you sought for this problem. Where did you go first when this episode began? Please list the sequence of all the other kinds of help you sought after that, not including family and friends.

(HS Codes) (1) *_________ (2) *_________ (3) *_________ (4) *_________

(5) *_________ (6) *_________ (7) *_________ (8) *_________

(9) *_________ (10)*_________ (11)*_________ (12)*_________
44. HELP SEEKING BY CATEGORY:

"Now I would like to ask you about a number of sources from whom people often seek help. Please tell me whether you have consulted any of them."

**Column 1:** "Have you consulted .... (HS source) for your problem since this episode began?"

**Column 2:** "How long was it after this episode began?"

**Column 3:** If "yes" for column 1, otherwise skip to column 4:

"Was it useful?"

**Column 4:** If "no" for column 1, otherwise skip to next query:

"Have you ever made use of ... (HS source) for this problem before this episode?"

<table>
<thead>
<tr>
<th>HS SOURCE</th>
<th>TRIED FOR THIS EPISODE (1=Yes 2=No)</th>
<th>TIME AFTER ONSET (# Days)</th>
<th>CONSIDERED USEFUL (1=Yes 2=No 3=Poss 4=Unc 5=Unkn Concept)</th>
<th>TRIED FOR PRIOR EPISODE (1=Yes 2=No)</th>
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<tr>
<td>1) G.P.</td>
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<tr>
<td>2) Psychiatrist</td>
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<td>3) Psychologist</td>
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<td>4) Social Worker</td>
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<td>5) Psychotherapist</td>
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<td>Type Unknown</td>
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<td>6) Other Medical Specialist</td>
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<td>7) Chemist</td>
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(*) indicates whether the source was considered useful or not.
### HS SOURCE

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<td>TIME AFTER ONSET (# Days)</td>
<td>CONSIDERED USEFUL (1=Yes 2=No 3=Poss 4=Unc 5=Unkn Concp)</td>
<td>TRIED FOR PRIOR EPISODE (1=Yes 2=No)</td>
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<td>8) Homeopath</td>
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<td>9) Aromatherapist</td>
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<td>10) Masseur</td>
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<td>11) TM / Meditation</td>
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<td>12) Herbalist</td>
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<td>13) Spiritual Healer</td>
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<td>14) Other (Specify)</td>
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### 45. CHURCH ATTENDANCE:

45.1. Do you attend church regularly?*

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

45.2. "Since this episode began, when you now go to church or pray at home, do you have it in mind that it will bring relief for your problem?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___
45.3. "Since this episode began, did you make a special visit, or do you go to church more often than before?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *____

45.4. "Before your problem began, how many times in a month did you go to church?"

(# Times/Month) #___

45.5. "How many times in a month do you go now?"

(# Times/Month) #___

45.6. "When did you last go to any church?"

(# Days Ago) #___

46. FIRST HELP-SEEKING

"You mentioned earlier that after this episode began, the first help you sought was from (...FHS...). Is that correct, or was there anything else before that?"

(HS Code) *____

Inquire about further details of first help seeking outside the home only if different from this clinic. Otherwise continue with REFERRAL CLINIC.
46.1. "What was the main reason that led you to decide to get help from that source?"

(0=Not mentioned  1=Mentioned  2=Emphasis [one only])

(A) Cost *___
(B) Convenience *___
(C) Past Experience *___
(D) Reputation (Popular) *___
(E) Spiritual Power *___
(F) NHS GP *___
(G) Other Referral (Professional) *___
(H) Other__________________________ *___
(I) Uncertain *___

46.2. "Who suggested that you get help there?"

(Referral Code) *___

46.3. "Who accompanied you?"

(Referral Code) *___

46.4. "When did you first get help there, how many times did you go and for how long?"

(A) First Use: (Months Ago) #___
(B) Follow Up: (Number of Visits) #___
(C) Over How Many Months: (Number of Months) #___

46.5. "How long did it take to reach there the first time you went?"

(Hours) #___
46.6. TREATMENT:

"What sort of help did you get? What did they do for you? Did they give you anything or do anything else to help you?"

Probe without mentioning specific treatments.

0) None *___
1) Antidepressants *___
2) Anxiolytics *___
3) Antipsychotics *___
4) Other Medications *___
5) Injections *___
6) E.C.T *___
7) Indiv. Psychoth. *___
8) Counselling *___
9) Group Psychotherapy *___
10) Cognitive Therapy *___
11) Behaviour Therapy *___
12) Occupational Therapy *___
13) Physiotherapy *___
14) Physical Examination *___
15) Laboratory Tests *___
16) Acupuncture *___
17) Herbal Medicine *___
18) Hospital Admission *___
19) Assessment/Evaluation *___
20) Referral *___
21) Not Yet Treated *___
22) Cannot Say *___
23) Other __________________ *___

If subject mentions more than one of the above, inquire:

(A) "Which of these do you feel was most important?"

(Tx Code) *___
46.7. "What did this person whom you first went to for help tell you about your problem? By what name did he (or she) call it?"

Anxiety . . . . [3] No Name Given . . [6]

(A) If name was given:

"What does this name mean to you?"

(B) If no name or explanation was given:

"How did you feel about getting no name or explanation for the problem?"

46.8. "Were you satisfied with the help you received there?"

(1=Yes 2=No 3=Possibly/Mixed 4=Uncertain) *

47. MOST IMPORTANT HELP SEEKING

"Among all the sources of help you consulted before you came here, which one of them do you consider the most important? Perhaps you consider this particular person or place most important because you think about it the most, because you spent the most money or time there, because of the spiritual power, because of your faith in that place or person, or for some other reason?

Record "Most Important Help Seeking" (MIHS) other than THIS CLINIC by code number. If it is the same as FIRST HELP SEEKING, code "FHS." Also, if subject cannot identify MIHS, indicate CANNOT SPECIFY by "CS" and skip to THIS CLINIC.

(HS Code) *
47.1. Reasons for Identifying Site as Most Important Help Seeking:

"What was the main thing about this help that that made it most important?"

(0=Not mentioned  1=Mentioned  2=Emphasis [one only])

(A) Most Disappointing  * ___
(B) Spent Most Money    * ___
(C) Most Helpful        * ___
(D) Spiritual Power     * ___
(E) Reputation          * ___
(F) Other ________________    * ___
(G) Uncertain           * ___

47.2. "What was the main reason that led you to decide to get help from that source?"

(0=Not mentioned  1=Mentioned  2=Emphasis [one only])

(A) Cost                      * ___
(B) Convenience               * ___
(C) Past Experience           * ___
(D) Reputation (Popular)      * ___
(E) Spiritual Power           * ___
(F) NHS GP                    * ___
(G) Other Referral (Professional) * ___
(H) Other ____________________ * ___
(I) Uncertain                 * ___

47.3. "Who suggested that you get help there?"

(Referral Code) * ___
47.4. "Who accompanied you?"

(Referral Code) *___

47.5. "When did you first get help there, how many times did you go and for how long?"

(A) First Use: (Months Ago) #___

(B) Follow Up: (Number of Visits) #___

(C) Over How Many Months: (Number of Months) #___

47.6. "How long did it take to reach there the first time you went?"

(Hours) #___
47.7. **TREATMENT:**

"What sort of help did you get? What did they do for you? Did they give you anything or do anything else to help you?"

Probe without mentioning specific treatments.

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<tr>
<th>Code</th>
<th>Treatment</th>
<th>Mentioned</th>
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<tr>
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<td>Antidepressants</td>
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<td>Other Medications</td>
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<td>16)</td>
<td>Acupuncture</td>
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<td>22)</td>
<td>Cannot Say</td>
<td>*</td>
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<tr>
<td>23)</td>
<td>Other</td>
<td></td>
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</table>

(0-Not mentioned 1-Mentioned)

47.8. *If subject mentions more than one of the above, inquire:*

(A) "Which of these do you feel was most important?"

(Tx Code) *___
47.9. "What did this person whom you first went to for help tell you about your problem? By what name did he (or she) call it?"

Anxiety . . . [3]  No Name Given . . [6]

(A)  If name was given:

"What does this name mean to you?"

(B)  If no name or explanation was given:

"How did you feel about getting no name or explanation for the problem?"

47.10. "Were you satisfied with the help you received there?"

(1=Yes  2=No  3=Possibly/Mixed  4=Uncertain)  *____

48. THIS CLINIC (REFERRAL CLINIC):

48.1. "Have you been to this/that clinic before today for this problem?"

(1=Yes  2=No)  *____

If yes, inquire further:

(A)  "When did you come to the clinic for the first time for this problem?"

(Months Ago)  #____

(B)  "About how many times have you been here before for this problem?"

(Number of Visits)  #____

(C)  "When was the last time you were here for this problem?"

(Months Ago)  #____
49. PRIOR VISITS TO THIS CLINIC FOR ANOTHER PROBLEM:

"Have you ever come here before for some other problem?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

If yes, what was that problem:

________________________________________________________________________

________________________________________________________________________

50. THIS CLINIC FOR THIS PROBLEM:

50.1. "What was the main reason for your referral here for this problem?"

________________________________________________________________________

________________________________________________________________________

(0=Not mentioned 1=Mentioned 2=Emphasis [one only])

(A) Advice from Family/Friends *___

(B) Referral *___

(C) Symptom Severity *___

(D) Other________________________________________ *___

50.2. "Who referred you here?" (HS Code) *___

________________________________________________________________________

________________________________________________________________________

50.3. "How were you able to get this referral? Was it difficult to arrange?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

________________________________________________________________________

________________________________________________________________________

50.4. "After your referral was made, how long did you (will you) have to wait for your first appointment with the psychiatrist?"

(Months) #___

________________________________________________________________________
51. TREATMENT IN THIS CLINIC:

51.1. "Before your initial visit, what help did you expect? What did you think they would give you? Did you expect they would do anything else for you?"

Probe without mentioning specific treatments.

0) None * 12) Occupational Therapy *
1) Antidepressants * 13) Physiotherapy *
2) Anxiolytics * 14) Physical Examination *
3) Antipsychotics * 15) Laboratory Tests *
4) Other Medications * 16) Acupuncture *
5) Injections * 17) Herbal Medicine *
6) E.C.T * 18) Hospital Admission *
7) Indiv. Psychoth. * 19) Assessment/Evaluation *
8) Counselling * 20) Referral *
9) Group Psychotherapy * 21) Not Yet Treated *
10) Cognitive Therapy * 22) Cannot Say *
11) Behaviour Therapy * 23) Other ____________ *

0-Not mentioned 1-Mentioned

If subject mentions more than one of the above, inquire:

(A) "Which of these do you feel was most important?"

(Tx Code) *

If not yet clear:

51.2. "Have you gone yet for your initial appointment at the psychiatry outpatient clinic?"

1=Yes 2=No *

If not yet seen in the clinic, skip to GENERAL ILLNESS BELIEFS (GIB).
If subject has been seen in the clinic, inquire further:
51.3. "Since you have come, what have they actually done for you here? Did they give you anything or do anything else for you here?"

Probe without mentioning specific treatments.

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<td>0) None</td>
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</tbody>
</table>

(O=Not mentioned  1=Mentioned)

If subject mentions more than one of the above, inquire:

(A) "Which of these do you feel was most important?"  
(Tx Code) * ___

51.4. "What did the doctors here tell you about your problem? By what name did they call it?"

Uncertain . . . [0]  Personality . . [3]
Depression . . . [1]  Other . . . . . [4]
Anxiety . . . . [2]  No Name Given . [5]

* ___
51.5. If name was given:

"What does this name mean to you?"

(A) If no name or explanation was given:

"How did you feel about getting no name or explanation for the problem?"

51.6. "Are you satisfied with the help you are receiving here?"

(1=Yes  2=No  3=Possibly/Mixed  4=Uncertain) * ___

(A) "Would you have liked any other kind of treatment than what they gave you?"

(1=Yes  2=No  3=Possibly  4=Uncertain) * ___
If yes:

(B) "What kind of help would you have liked that you didn't receive from the clinic?"

Probe without mentioning specific treatments.

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<td>Cannot Say *___</td>
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<tr>
<td>23</td>
<td>Other _____________ *___</td>
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</table>

(0=Not mentioned 1=Mentioned)

If subject mentions more than one of the above, inquire:

(C) "Which of these do you feel was most important?"

(Tx Code) *___

(D) "Did they do anything here you didn't like?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___
If yes:

(E) "What was that?"

Probe without mentioning specific treatments.

If subject mentions more than one of the above, inquire:

(1) "Which of these do you feel was most troubling?"

(Tx Code) *___
51.7. "What effects has the treatment you received here had for you? Has it been helpful?"

Probe further to clarify for coding:

- Helped more than Expected [1]
- Helped as Expected [2]
- Helped but Disappointing [3]
- No Effect [4]
- Made Things Worse [5]
- Mixed Effects [6]
- Uncertain [7]

52. IDEAS ABOUT TREATMENT

52.1. "What properties would you ascribe to the pills they gave you? Are the pills they gave you hot or cold?"

(1=Hot  2=Cold  3=Neither) *___

52.2. "Are the pills they gave you light or heavy?"

(1=Light  2=Heavy  3=Neither) *___

52.3. "Are the pills they gave you strong or weak?"

(1=Strong  2=Weak  3=Neither) *___

52.4. "How else would you describe them?"

52.5. "Would you explain to me how they work?"
52.6. "Did these pills give you any trouble?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

53. MENTAL HEALTH SYSTEM

53.1. "Before you saw the psychiatrist, did you have any expectations about what this person would be like?"

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

53.2. "Would you describe in your own words the psychiatrist who saw you?"

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

53.3. "Did this psychiatrist fulfill your expectations?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

53.4. "Do you feel the psychiatrist listened to you? Was he or she willing to hear all you needed to say?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

________________________________________________________________________
53.5. "Did the psychiatrist ask how you understand your problem?"

(1=Yes 2=No 3=Possibly 4=Uncertain) * ___

   (A) "Do you feel this is important?"

   (1=Yes 2=No 3=Possibly 4=Uncertain) * ___

   "Would you explain why?"

53.6. "People in this country are often reluctant to see a Psychiatrist. I would like to hear your views about that. Would you explain this to me?"

53.7. "Do you feel there are any particular problems that may result from consulting a psychiatrist, problems affecting one's ability to work or function in the world?"

   (0=Not mentioned 1=Mentioned)

   (A) Loss of Job * ___
   (B) Problems with Insurance * ___
   (C) Problems with Driver's License * ___
   (D) Problems with Bank Loan or mortgage * ___
   (E) Other ______________________________ * ___
53.8. **Common terms for psychiatrists:**

*What are some of the common names that people here use for a psychiatrist?*

<table>
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<tr>
<th>POPULAR TERM</th>
<th>MEANING</th>
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<tbody>
<tr>
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<td>(B)</td>
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<td>(C)</td>
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<td>(D)</td>
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(0=Not mentioned 1=Mentioned)

(1) Shrink *___
(2) Psych *___
(3) Mental Doctor *___
(4) Trick Cyclist *___

53.9. *Would you have preferred seeing someone other than a psychiatrist?*

(1=Yes 2=No 3=Possibly 4=Uncertain) *___

If yes:

*Whom would you have preferred most to see?*

<table>
<thead>
<tr>
<th>G.P.</th>
<th>Social Worker</th>
<th>Psychologist</th>
<th>Other Med Spclst</th>
<th>Other (Specify)</th>
<th>Uncertain</th>
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</thead>
</table>

*___

53.10. *Psychiatrists in this country tend to have a negative image. Do you have any ideas about why this is so?*
53.11. "What do you feel needs to happen for psychiatrists to improve their image?"

53.12. "Some feel that people who seek psychiatric help may be stigmatized. What in your opinion needs to happen to reduce that stigma?"

GENERAL ILLNESS BELIEFS

54. "We have been asking you many questions about the problems that brought you here today. We would also like to know what you think about some other problems, whether or not they have troubled you or your family directly."

54.1. (A) "What do you think is the cause of EPILEPSY?"

(B) (1) "If others were to know about someone having EPILEPSY, is it likely to cause problems for this person?"

   (1=Yes 2=No 3=Possibly 4=Uncertain) *___

   If yes:

   (2) "What is it about EPILEPSY that might cause such problems?"
(3) "Would someone with EPILEPSY feel ashamed of this condition?"
(1=Yes  2=No  3=Possibly  4=Uncertain)  *____

(4) "Would most people refuse to take food or water from this person? What about you?"
(1=Yes  2=No  3=Possibly  4=Uncertain)

Others  Subject
*____  *____

(5) "Would most people be concerned if someone who has EPILEPSY were to marry into their family? What about you?"
(1=Yes  2=No  3=Possibly  4=Uncertain)

Others  Subject
*____  *____

(6) "Would most people refuse to visit the home of this person? What about you?"
(1=Yes  2=No  3=Possibly  4=Uncertain)

Others  Subject
*____  *____
(7) "Would most people with a relative who has EPILEPSY prefer to keep others from knowing about it if they could? What about you?"

(1=Yes 2=No 3=Possibly 4=Uncertain) Others Subject

*  

(C) (1) "If someone has EPILEPSY and others come to know about it, is it likely to cause problems for the family? Will it reflect poorly on the family?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *  

(2) "Would EPILEPSY make it difficult for relatives of this person to marry?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *  

(D) "If this were a problem for you or your family, what kind of help of any kind do you think would be useful? Have you or your family ever made use of it?"

If only a medical provider mentioned, then inquire further:

"Would you consider someone other than a doctor?"

PRIOR USE:

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<th>PERS</th>
<th>FAMILY</th>
<th>PRIOR USE:</th>
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<td>N-No</td>
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</table>
54.2. (A) "What do you think is the cause of SCHIZOPHRENIA?"

PC Code

__________________________________________________________ *

__________________________________________________________ *

__________________________________________________________ *

(B) (1) "If others were to know about someone having SCHIZOPHRENIA, is it likely to cause problems for this person?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *

__________________________________________________________

If yes:

(2) "What is it about SCHIZOPHRENIA that might cause such problems?"

__________________________________________________________

(3) "Would someone with SCHIZOPHRENIA feel ashamed of this condition?"

(1=Yes 2=No 3=Possibly 4=Uncertain) *

__________________________________________________________

(4) "Would most people refuse to take food or water from this person? What about you?"

(1=Yes 2=No 3=Possibly 4=Uncertain)

Others Subject *

__________________________________________________________

(5) "Would most people be concerned if someone who has SCHIZOPHRENIA were to marry into their family? What about you?"

(1=Yes 2=No 3=Possibly 4=Uncertain)
(6) "Would most people refuse to visit the home of this person? What about you?"
(1=Yes 2=No 3=Possibly 4=Uncertain)

(7) "Would most people with a relative who has SCHIZOPHRENIA prefer to keep others from knowing about it if they could? What about you?"
(1=Yes 2=No 3=Possibly 4=Uncertain)

(C) (1) "If someone has SCHIZOPHRENIA and others come to know about it, is it likely to cause problems for the family? Will it reflect poorly on the family?"
(1=Yes 2=No 3=Possibly 4=Uncertain) *

(2) "Would SCHIZOPHRENIA make it difficult for relatives of this person to marry?"
(1=Yes 2=No 3=Possibly 4=Uncertain) *
(D) *If this were a problem for you or your family, what kind of help of any kind do you think would be useful? Have you or your family ever made use of it?*

If only a medical provider mentioned, then inquire further:

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<tbody>
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<td>(Y=Yes N=No)</td>
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55. **MIND - BODY RELATIONSHIP**

55.1. *Are mind and body the same or different?*

...What is the nature of their relationship?

...How are they different or similar?

- Same . . . . . . . . . . . . . . . . . . . . . [1]
- Different & Unrelated . . . . . . . . . . . [2]
- Different & Related . . . . . . . . . . . . [3]
- Different & Unsure if Related . . . . . [4]
- Incomprehensible Question . . . . . . . [5]
- Uncertain . . . . . . . . . . . . . . . . . . [6]

55.2. *Does the mind have a place? Where would you put it?*

(1=Head 2=Chest 3=Both 4=Other 5=Cannot Say) *__
55.3. "Does mind control the body or does the body control the mind?"

(1=Mind Over Body  2=Body Over Mind  3=Equal  4=Uncertain) *____

55.4. "What about 'soul'? Do you think it exists?"

(1=Yes  2=No  3=Possibly  4=Uncertain) *____

55.5. "Does the soul have a place? Where would you put it?"

(1=Head  2=Chest  3=Both  4=Other  5=Cannot Specify) *____
56. **CLINICAL DIAGNOSIS (Based on Clinic Charts)**

56.1. Psychiatrist's Diagnosis: ____________________________

56.2. G.P. Diagnosis: ____________________________

57. **TREATMENT:**

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Specify Details: ____________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
58. Based on the entire interview compare symptoms reported initially in the section on patterns of distress (coded above), symptoms reported after specified probes for emotional and somatoform symptoms (also coded above), and subsequently in the interview, including SCID and HDARS (code here).

(0=Not mentioned 1=Mentioned 2=Emphasis [all that apply])

<table>
<thead>
<tr>
<th>SYMPTOMS</th>
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<th>PROBE</th>
<th>SUBSEQUENTLY</th>
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<td>Libido:</td>
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<td>*_____</td>
<td>*_________</td>
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<td>Anxiety:</td>
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<td>*_________</td>
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<td>Fears and Phobias:</td>
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<td>*_____</td>
<td>*_________</td>
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<td>Loneliness:</td>
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<td>*_____</td>
<td>*_________</td>
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<tr>
<td>Social Relations/Stigma</td>
<td>*______</td>
<td>*_____</td>
<td>*_________</td>
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<td>Functional Impairment:</td>
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<tr>
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<td>Can't Say:</td>
<td>*______</td>
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59. INTERVIEWER: *SSJ*

60. INTERVIEW DATE(S): (1) @______________
                (2) @______________

61. DATE COMPLETED: @__________________

62. ADDITIONAL COMMENTS

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
DIRECTIONS FOR SCREENING AND CODING PERCEIVED CAUSES

(1) **Status.** Rate the status of each perceived cause (PC) with respect to the significance the subject attaches to it:

- Clearly a cause ............................................. [B]
- Possible or less significant cause . . . . . . . . . [C]
- Not a cause ...................................................... [D]
- Role not clear ................................................. [E]
- Subject states unknown concept . . . . . . . . . . . . . [F]

(4) **Artifact.** Specify whether this idea is an artifact by asking whether the subject considered it prior to the interview or only afterwards.

- Artifact ............................................. [A]
- Previously Held Belief [B]
- Uncertain .................................................... [C]

(3) **Influence.** Specify the most important influence on this belief for each of the PCs rated with status B or C. If you cannot identify a single influence, specify "Multiple [MU]" among the following:

<table>
<thead>
<tr>
<th>Cannot Specify</th>
<th>Other Family Influence</th>
<th>Other (Specify)</th>
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</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Friends or Colleagues</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Community Pref(Elders)</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>Asian healer</td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td>Homeopath</td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td>Faith Healer</td>
<td></td>
</tr>
<tr>
<td>Aunt</td>
<td>Doctor</td>
<td></td>
</tr>
<tr>
<td>Uncle</td>
<td>Health Worker</td>
<td></td>
</tr>
<tr>
<td>Son</td>
<td>Reading</td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td>Self (Own Idea)</td>
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</tr>
<tr>
<td>Grandmother</td>
<td>Interviewer (i.e.artifact)</td>
<td></td>
</tr>
<tr>
<td>Grandfather</td>
<td>Multiple</td>
<td></td>
</tr>
<tr>
<td>Watching T.V.</td>
<td>No One</td>
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</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

(5) **Linkage codes** indicate how this idea may be linked to other PCs. Record "I" if it is an independent PC. Also, if several ideas are linked together in a complex model, code the most prominent as "I" and others linked to it as "R" for related or "D" for dependent. Specify related or dependent based on the nature of the link between the two PCs. If one is related to another, but makes sense in the narrative on its own, code it "R". If the meaning of the PC for this patient, however, makes no sense without considering the link to another PC, code it "D".

6) **Code Reference.** If this PC is related to or dependent upon another, specify the category to which it is linked. If it is linked to several, specify the one that it is linked to most prominently and indicate any others in the prose elaboration.

7) **Narrative.** Elaborate narrative details in the space provided, as the patient presents them.
### HELP SEEKING OPTION CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Option</th>
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<tbody>
<tr>
<td>GP</td>
<td>Self Care/Help at Home</td>
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<tr>
<td>Psychiatrist</td>
<td>Friends/Relatives</td>
</tr>
<tr>
<td>Psychologist</td>
<td>Church/Religious healer</td>
</tr>
<tr>
<td>Social Worker</td>
<td>Astrologist</td>
</tr>
<tr>
<td>Psychoth'pist Nonspec</td>
<td>Acupuncture</td>
</tr>
<tr>
<td>Other Med Specialist (NHS)</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>Chemist</td>
<td>Hospital (NHS)</td>
</tr>
<tr>
<td>Homeopath</td>
<td>Hospital (Private)</td>
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<tr>
<td>Aromatherapist</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Masseur</td>
<td>Specialist (Private)</td>
</tr>
<tr>
<td>TM/Meditation</td>
<td>Comm Psychi Nurse (CPN)</td>
</tr>
<tr>
<td>Herbalist</td>
<td>Vol. Health Worker</td>
</tr>
<tr>
<td>Spiritual Healer</td>
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<tr>
<td>Other</td>
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### REFERRAL CODE OPTIONS

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<tr>
<td>MO</td>
<td>Mother</td>
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<tr>
<td>FA</td>
<td>Father</td>
</tr>
<tr>
<td>OF</td>
<td>Other Family</td>
</tr>
<tr>
<td>SE</td>
<td>Self (own idea)</td>
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<td>GP</td>
<td>GP</td>
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<td>PS</td>
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<td>PT</td>
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<td>Social Worker</td>
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<td>VW</td>
<td>Vol. Health Worker</td>
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<td>HO</td>
<td>Homeopath</td>
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<td>HE</td>
<td>Herbalist</td>
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<tr>
<td>RH</td>
<td>Church/Relig. Heal</td>
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<td>HT</td>
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### TREATMENT OPTION CODES

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<td>2</td>
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<td>3</td>
<td>Anxiolytics</td>
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<td>5</td>
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<td>Injections</td>
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<td>8</td>
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<td>9</td>
<td>Counselling</td>
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<td>11</td>
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<td>Behaviour Therapy</td>
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<td>Physiotherapy</td>
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<td>19</td>
<td>Assessment/Evaluation</td>
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### PERCEIVED CAUSE OPTION CODES

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<tr>
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<td>Injury, Accident</td>
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<td>Prior-Existing Illness</td>
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<td>Pregnancy-Childbirth</td>
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<td>Congen-not Heredity</td>
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<td>Anatomical-Phys Prob</td>
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<td>Weakness</td>
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<td>Failure to marry</td>
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