“To acknowledge that cultural unities are ideological is not therefore to dismiss them as unreal. To demonstrate that elements making up a given cultural unit have diverse origins...is no proof that a unity does not exist. To argue that a ‘culture’ must be seen as a process does not exclude the possibility that it is a unified process. A unified culture is not necessarily one without contradictions; rather relations of contradiction between (cultural) elements themselves presuppose an embracing unity, however temporary. In short, a particular culture may indeed not be a unified whole, but that is something to be demonstrated, not made into an essential truth about culture per se” (Asad, 1990, p.473).
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ABSTRACT

This thesis examines differences and similarities in the causal attributions of mental distress and attitudes towards seeking help for mental distress of Western and non-Western cultural groups. In doing so, it stresses the importance of culture in the conceptualisations of mental distress. At the same time, it emphasises the necessity for a balanced consideration of cultural factors in the diversity of cultural groupings in the present day.

The first chapter argues for a shift in research from the emphasis on notions of cultural homogeneity suggested by the anthropological viewpoint of the ‘new’ cross-cultural psychology. The second chapter focuses on the impact of culture by considering differences in Western and non-Western cultural concepts and explanatory models of mental distress. The third chapter provides the methodological framework of this research.

Three studies examine the relationship between culture, causal attributions of mental distress and attitudes associated with seeking help for mental distress. The first study investigates causal attributions and associated attitudes underlying seeking help for mental distress of lay populations, in three cultural samples, British Pakistanis, Britons and Pakistanis. The second study examines the relationship between causal attributions, levels of mental distress and attitudes towards help-seeking pathways, in three samples, British Pakistanis, Britons and Pakistanis. The third study examines the relationship between causal attributions, psychological and somatic distress and the choice of one
help-seeking pathway, i.e. GP consultation, between two groups, British Asians and Britons.

Findings indicate differences and similarities between all three groups in the causal attributions as well as in associated attitudes towards seeking help for mental distress. While these differences cannot be dichotomised as Western and non-Western, some cultural themes emerge as being significant in the concepts of mental distress. Results demonstrate a relationship between causal attributions of mental distress and attitudes towards seeking help for mental distress. However, the generalisation of these findings is limited due to the unrepresentative and heterogenous nature of the samples investigated in the three studies. Further limitations of this research are discussed and suggestions for future studies are considered.
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CHAPTER 1

Issues in the Development of Cross-Cultural Research
Part I

Methodological Perspectives
Chapter 1

Issues in the Development of Cross-Cultural Research

Part I

Methodological Perspectives

1.1 Overview

The common objective of research in both transcultural psychiatry and the ‘new’
cross-cultural psychiatry has been the explanation of beliefs and behaviours of
different cultural groups relating to psychological distress. Thus, their central aim is to
examine cultural factors in the aetiology, manifestation and subsequent behaviours
relating to mental distress. These sub-disciplines, however, have diametrically
opposite approaches to gaining understanding of the relationship between culture and
mental distress. Methodological issues, epitomised in the emic/etic dichotomy, have
become central to cross-cultural research in both psychiatry and psychology.

According to Lonner and Berry (1986), cross-cultural psychology¹, unlike other areas
of psychology, seems to be defined primarily by its method rather than its content.
This thesis, therefore, begins by giving a review of the developments of the
methodology of psychological research across cultures. This is necessary because it
demonstrates the shifts in psychology of the emphasis of cross-cultural research,
leading to the integration of anthropological and psychological approaches, with the
emergence of the ‘new’ cross-cultural psychiatry.

It is reasoned that this integration has made an important contribution to a greater
understanding of the issues in cross-cultural research. However, it is suggested that
the anthropological concept of cultural groups as being homogenous and self-
contained is no longer viable in the fast globalising world of today. Therefore, it is
argued that the emic/etic distinction can no longer be seen as dichotomous in an
increasingly heterogeneous, multi-cultural world.

Part I of Chapter 1 has three specific aims. Firstly to illustrate the major shifts that
have taken place in cross-cultural research in psychiatry over the years; secondly, to
analyse the methodological concerns of cross-cultural research; thirdly, to suggest a
way forward from the dilemma that confronts research in cross-cultural psychology

¹ Because this research lies at the interface of psychology and psychiatry, these terms are used
interchangeably.
and psychiatry today.
Accordingly, the first section of Part I of this chapter presents a historical review of psychology, up to the emergence of the 'new' cross-cultural psychiatry. The second section analyses the methodological concerns of the 'new' cross-cultural psychiatry, in assessing the contributions, as well as the limitations, of this approach with reference to the aims of cross-cultural research in psychology. The last section considers ways of making cross-cultural research in psychology ethnographically valid, while at the same time, fulfilling the scientific aims of cross-cultural psychology.

1.2 The development of cross-cultural research in psychology

The link between 'culture' and psychology and can be traced back to the late nineteenth and early twentieth centuries. In 1860, the first issue of 'Zeitschrift für Volkerpsychologie', edited by Lazarus and Steinthal, was published, emphasising the relationship between psychology and culture. Allport (1968) describes Wundt as making the distinction in the field of psychology, in emphasising that all higher mental processes should be studied outside the laboratory. Wilhelm Wundt's publication, between 1900 and 1914, of 'Volkerpsychologie', stressed that 'folk psychology' was strongly mediated by the language, customs and myths of the people in question. Wundt (1908) commented that "only the individual psychology and Volkerpsychologie together constitute the whole of psychology" (Cited in Allport, 1968, p.36).

The aims of research in what later became known as cultural psychology were no different from those of psychology as a whole. Its assumptions were universalistic and, with the dominance of behaviourism in psychology, it adopted a positivist, empirical approach to research. The next sections chart the course of research that specifically studied the link between culture and psychological phenomena by
1.2.1 From ‘cultural psychology’ to ‘cross-cultural’ psychology.

In Klineberg’s (1980) historical account, the comparative approach in psychological research was initially the anthropologist’s and the sociologist’s domain. It was largely ignored by psychology, possibly in the search for universal laws of behaviour. It was anthropology, in questioning the universality of behaviour, which provoked a greater interest in ‘cultural psychology’. However, while anthropologists always focused upon cultural differences i.e. different life styles as opposed to genetic or phenotypic differences, the recognition of the distinction between ‘race’ and ‘culture’ being always present, this distinction was never clear in psychology. In fact, with its roots in the biomedical tradition, it was inevitable that the two primary aspects of a person’s ethnicity - ‘race’ and ‘culture’ - should be somewhat indistinguishable in psychology (Price-Williams, 1979).

The earliest notions in psychology of non-European cultures were understood, according to Price-Williams, from an evolutionary point of view, in that they were seen at an earlier stage of development. He describes how these beliefs about social evolution were replaced by a more ‘racial’ bias - that this inferiority was genetic. Therefore, almost from the beginning, the idea of a hierarchy of mental thought and processes existed when comparing the psychology of different cultures. As Klineberg succinctly notes: "...the others with whom one's own group was compared were those to whom the term 'primitive' was applied" (1980, p.35). Klineberg’s explanation of these attitudes point to the various beliefs, at the time, to do with religious ideas, selection theory, and historical tradition.

The jump, from a hierarchical mentality of races, epitomised by de Gobineau's book *The Inequality of Human Races* (first published in 1853), to the idea that Europeans differed radically from 'non-Europeans' in terms of mental health - that only the former suffered psychological disorders because of higher mental process - was inevitable. This trend in thinking continued, to a large extent, in 20th century
psychological literature by, amongst others, Bevis (1921), who wrote "...most of the race live in the here and now with a limited capacity to recall or profit by experiences of the past. Sadness and depression have little part in his psychological make-up" (Cited in Littlewood & Lipsedge, 1997, p61.).

There were, however, some enlightened voices that called for a more understanding appreciation of the values and the way of lives of others. Boas (1938), in his classic book, The Mind of Primitive Man, talked of 'different traditions'. R. S. Woodsworth said, in 1910, that: "If the savage differs in these respects from the civilised man, the difference is one of degree, and consistent with considerable overlapping of savage and civilised individuals" (Cited in Price-Williams, 1979, p8.).

Thus it was that, in the ensuing years, the emphasis shifted from the notion of hierarchy to differences between cultures, as evidenced by the evolving terminology: 'traditional people' rather than 'primitives' and 'groups with different backgrounds' rather than 'savages' (Price-Williams 1979). The assumption that non-Europeans employed a different type of reasoning had been replaced by the recognition that all human communities use deductive and inductive logic as well as concrete and abstract reasoning, within the limits set by their societies' norms. (Shweder & Bourne, 1991).

Klineberg was thus able to conclude that "... the history of cross-cultural research can be characterised in general as a movement away from hierarchy to an appreciation of differences which are considered as variations in life styles rather than as steps on a scale of excellence or progress" (1980, p.32).

Cultural psychology had been primarily concerned with the link between psychology of the individual and his society or culture, in other words, as a form of social psychology. Cross-cultural psychology or transcultural psychology, as it came to be known, emerged as a more directly comparative paradigm, to extend psychological knowledge by using different populations and people\(^2\). Price-Williams (1979) elaborates on the differences between these two approaches. He points out that

\[^2\] The earliest use of cross-cultural comparison is attributed to Rivers (1901, 1905) who conducted field work in India and New Guinea.
although transcultural psychology may be considered the 'logical consequent' of cultural psychology, they can also be seen as two quite different approaches with different methodologies. He states that while the one concerns itself with man and his context and is more general, the course of the other has been influenced primarily by three modes of thought: 'racial-cultural', 'individual-collective' and 'us-them'. The racial-cultural axis distinguishes between genotype and life style, and the individual-collective focuses on the individual on the one hand and the group or society on the other (which can be seen as epitomising psychological and anthropological differences). The 'us-them' distinction rests on value judgements that are essentially ethnocentric. Price-Williams notes that this distinction “often served to legitimise a racist, as opposed to a ‘racial’, view of other cultures” (p.7).

These issues have been important in defining psychiatric theory and practice in the past. As King (1978) reminds us, the study of mental illness across different cultures has inevitably been the product of historical, social and political factors. These factors have also contributed to the resurgence of interest in cross-cultural research, in the form of the ‘new’ cross-cultural psychiatry (Littlewood & Lipsedge, 1978). This point shall be made clearer in the more direct comparison between transcultural psychiatry and the ‘new’ cross-cultural psychiatry that follows.

1.2.2 Transcultural psychiatry and the ‘new’ cross-cultural psychiatry

The emphasis in transcultural psychiatry, in both practice and research, was always largely on the biological aspects of the disease. Therefore, differences were considered rather superficial while similarities were deep. To use Geertz’s (1983) analogy, the cultural aspect was the ‘icing’ to the biological core, the ‘cake’. The assumptions, held by researchers with a transcultural orientation, were those of universality of psychological phenomena, across different cultures and societies and their emphasis was on the descriptive accounts of symptomatology (Lonner 1979). Much of the first-generation research was based on two-culture comparisons, from the perspective of Western classifications of symptoms of mental distress. The
consequence of this led to a searching of 'goodness of fit' between Western categories of mental disorders and those encountered in other societies (Littlewood & Lipsedge, 1985). In addition, as Littlewood notes, patterns of behaviour which did not fit into these categorisation systems were termed 'culture bound syndromes', leading to the pathologisation of behaviours in communities outside Western societies, which, although outside the normal, were recognised and understood in their social context.

It was the inadequacy of this approach that led Kleinman (1980), to challenge transcultural psychiatric assumptions and give name to the discipline of the 'new' cross-cultural psychiatry. While the transition from cultural psychology to transcultural psychiatry may have been a natural one, what Kleinman was now proposing was a radical departure from the tradition of 'erklären', looking for causal explanations to 'verstehen', interpretative understanding (Bracken 1993). Although Kleinman (1978) had earlier pointed to the marginalisation of psychiatry within medicine precisely because it differed from biomedicine in its concerns, with meaning, interpretation and social relations (e.g. psychotherapy), he called for a split from its "classical logical positivism" (Kleinman, 1988). He not only questioned the universalistic assumptions of the old paradigm of transcultural psychiatry but also the arbitrary imposition of the concepts of Western psychiatry. In attempting to understand and treat disorders in other societies, both these aspects had often been found lacking (Kleinman, 1977; Marsella & White, 1982; Fabrega, 1992; Littlewood & Lipsedge, 1997).

There was also a more compelling interest in taking the role of culture more seriously. With increasing migration from non-western societies into Europe and America, the needs of large minority ethnic groups needed to be addressed. Although the links of cross-cultural psychiatry with anthropology and sociology can be traced back over the last 50 years, the resurgence of psychiatric interest in anthropology can essentially be attributed to one particular movement, i.e. the migration of non-western cultures to the West. Thus, the increase in the research of cultures can be attributed to the re-awakening of interest in the 'cultural' dimensions of mental illness of immigrant communities in the Western world (Littlewood & Lipsedge, 1997). In addition, in
seeing transcultural psychiatry as essentially the study of ‘Black’ people (Littlewood, 1990), anthropologists would argue that, in challenging the assumed superiority of Western science, some of the impetus for ‘new’ cross-cultural psychiatry has come from a desire to minimise the 'us-them' distinction.

Therefore, while transcultural psychiatry and psychology had their roots in biomedicine and the modern scientific tradition, the 'new' cross-cultural psychiatry, had its roots firmly in the discipline of anthropology. Although these approaches have been, from their origin, diametrically different, the ultimate aims of both were, and indeed, are similar - of examining the relationship of culture on mental illness and subsequent behaviour. Their common aims, however, have not led to resolving the dilemmas faced by those carrying out cross-cultural research.

As Skultan (1993) remarked, although the term ‘cross-cultural psychiatry’ can be taken to imply that a resolution has been reached between psychiatry and anthropology, there is, in fact, conflict. He pointed out that ‘cross-cultural psychiatry’ can be taken to represent two points of view - as psychiatry crossing cultures to examine mental disorders or as the researcher crossing cultures to examine psychiatry. Implicit in this dual interpretation is the theoretical problems within cross-cultural research in psychiatry. Considering the contrasting divergence of their views (discussed briefly below), on all aspects of both theory and method, it is obvious that finding common grounds for resolution would not be an easy task.

1.3 The divergent epistemologies of the two perspectives

From the transcultural perspective, researchers have assumed that all aspects of psychological phenomena illness can be conceptualised, measured and studied across societies (Sartorius, 1986; German, 1987). Researchers from the new cross-cultural psychiatry’s perspective have assumed that there is cultural uniqueness in the way illness is perceived and presented, and therefore, cannot be studied across cultures (Kleinman, 1980; Littlewood, 1990). These two approaches represent the most extreme ends of a continuum between universalistic and relativist debates and are
epitomised in the etic/emic dichotomy, described as the perspective of an outsider as opposed to that of an insider. The particular stance of researchers along this continuum determines their concepts, methodologies, research instruments and the number of cultures they aim to investigate. Therefore, one of the central preoccupations of cross-cultural psychological research, indeed if not the central, is the debate on methodological issues and one in which the tension between the universalists and relativists is at its most strained.

Bracken (1993) likens the debates between the ‘old’ cross-cultural psychiatry, transcultural psychiatry, and the ‘new’ cross-cultural psychiatry to the positivist versus anti-positivist arguments that have already generated much debate in this discipline. These contrasting positions are exemplified by the findings, as well as the critique (both of which are presented below), of the World Health Organisation International Pilot Study of Schizophrenia, carried out over several years and in different cultures (WHO, 1973; 1979).

This research aimed to seek a broad base of scientific knowledge to understand, categorise, control, cure and eliminate illness. Psychological phenomena were conceived as universal in all cultures, and therefore, distribution of symptoms and syndromes were studied in different cultural settings by the use of standardised techniques and research instruments. By utilising empirical methods to research mental illness across cultures, it was hoped that comparisons of findings would extend psychological understanding of both psychological phenomena as well as the independent variable of culture (Triandis, 1980). And so indeed, as transculturalists would argue, findings showed that there are significant universal symptoms of schizophrenia (Jablensky, Sartorius, Ernberg & Anker, 1992). Therefore, from the transcultural psychiatrists’ point of view, the WHO study was a good example of the etic approach (Sartorius, Kaelber, Cooper, Roper, Rae, Gulbinat, Ustun, & Regier, 1993).

However, ‘new’ cross-cultural psychiatrists challenged both the medical as well as the positivist model by giving the WHO study as an example of the enterprise of biomedical psychiatry as being “rooted in distinctive cultural traditions” (Kleinman,
Eisenberg & Good, 1978; Marsella & White, 1982; Fabrega, 1992). Kleinman (1987) accused this research for its bias towards focusing on, and finding, similarities between cultures by the use of a standardized diagnostic technique such as those used in the IPSS. His criticism related to restricting the core sample to those with symptomatology delineated on Western experience and behaviour. This, he argued, may pick up similar patterns of symptamotology but commits a 'category fallacy', in reifying a noslogical category, developed for a particular cultural group and then applied to another. Kleinman, amongst others, (Fabrega, 1989; Littlewood & Jadhav, 1994) thereby questioned the entire basis on which present day psychiatry is practiced and researched.

It could be argued that this criticism, although valid from the point of view of the 'new' cross-cultural psychiatry, obscures the value of this type of research. The use of the Western version of a monothetic classification system, as used in the WHO study, has shown that there are common symptoms across separate cultures of mental distress. Although, culture specific meanings of mental distress are not elicited and cultural differences may be minimised, it provides an important basis for the understanding and treatment of disorders (Lock, 1988).

In contrast to this approach, the main aim of Kleinman, as the original proponent of the 'new' cross cultural psychiatry, was to put anthropological questions at the heart of epidemiological, psychopathological and therapy concerns in psychiatry. (Kleinman, 1977; 1980; 1988). An emic methodology, both in concepts and meaning, being the over-riding concern of the 'new' cross-cultural psychiatrist, it emphasised the relativity of all psychological phenomena. The aim was to seek, first and foremost, detailed and culturally valid illness models to gain understanding of psychological phenomena as well as related therapies and panaceas, in one particular culture. Therefore, psychological phenomena of only one culture was studied by the use of more interpretative, hermeneutic methods. Examples of such emic and anti-positivist research are the studies carried out by Beiser, Benfari, Collomb, and Ravel, (1979) in the Serer people of Senegal or by Good & Good’s (1982) on 'heart distress' in Iran. One of the studies that perfectly exemplifies this approach has been carried out in
Chapter 1  
*Issues in the Development of Cross-Cultural Research*

*Part I  Methodological Perspectives*

China, by Ware & Weiss (1994) on neurasthenia, in which detailed and insightful interpretations situate the mental distress in its cultural context.

As is made plain by these discussions, the debates between the 'old' cross-cultural, or transcultural, psychiatry and the 'new' cross-cultural psychiatry, go beyond universalist / relativist arguments. The underlying philosophical assumptions, the aims and the methodology of the two perspectives seem to have no common ground (Rogler, 1992). Furthermore, transcultural psychiatry has been accused of implicit racism, with its reliance on the underlying assumptions of the scientific western approach to illness and its assumptions of superiority (Fernando, 1988). Some anthropologists (and 'new' cross-culturalists) use this argument to accuse psychiatry of more explicit racism, in terms of diagnosis and therapies (Littlewood & Cross, 1980; Lewis, Croft-Jeffreys & David, 1990), particularly in the case of migrant communities. It becomes clear, therefore, that the two perspectives of universalism and relativism encompass polarised viewpoints that seem to have no meeting ground.

1.3.1 The two paradigms of psychiatry: universalism and relativism

While at the heart of the 'new' cross-cultural psychology lie the concepts of cultural relativism and subjective meaning (Fabrega, 1992a), cross-cultural research, in the comparative mode, seeks evidence of the effects of different cultures on various aspects of people's belief and behaviour (Lonner & Adamopoulos, 1997). It is clear, that the principles of cultural relativism run counter to the rigours of scientific enquiry. It is not surprising, then, that the methodological traditions of scientific objectivism of psychology find, in the words of Fabrega, "...the view of culture as shared, experiential and negotiated interactions...hopelessly descriptive, literary, historical, dialectical, anecdotal and relativistic" (1992, p. 564). From the 'new' cross-cultural psychiatrists perspective, and as evidence advanced by Kleinman (1980; 1987) and other 'new' cross-cultural psychiatrists has shown (Ware & Weiss, 1994), it is these very features that give valid meaning to the study of mental distress.

Most cross-cultural researchers, even transculturalists such as Leff (1990), agree that
the resultant debates have brought about a significant shift in emphasis in cross-cultural psychological research. Issues of meaning and interpretation are becoming central to the natural sciences (Hesse, 1980). As a consequence, there has been a paradigmatic shift from cross-cultural comparisons to examining psychological symptomatology in its local context. A range of studies, such as D’Andrade’s (1976) inferential models, Bourdieu’s (1977) procedural models and Weiss’ (1977) explanatory models, in the form of the ‘EMIC’, have used meaning centred approaches.

On the other hand, even some of the more prominent exponents of cultural relativism admit that assumptions of universalism can be as important to the understanding of psychological distress. Fabrega (1992a) accepts that to exclude Western knowledge of biomedicine would lead to a ‘radical’ form of cultural determinism. This, in his opinion, would be non-productive to an understanding of illness, since there are universal indicators of disease and there in an inter-play between these biological and social/cultural factors. Littlewood, (1990) too, has conceded that sociological and cultural factors alone are not sufficient for understanding the entire picture of the complexities of mental distress and illness. As a result, psychiatry, as Littlewood points out, seems balanced between these two dominant paradigms of physical medicine and social science, universalism and relativism. The problem for psychiatry, according to Littlewood, “...is that both paradigms appear necessary and that, in themselves, both are limited” (p. 311).

Although their differential frames of reference have frequently produced polarised results and conclusions, both paradigms have contributed enormously to cross-cultural research. Littlewood declares that, rather than being forced into a choice between objective empiricism and cultural relativism, it is crucial that conflicts within cross-cultural research are considered at greater length. However, whereas this ‘refusal of closure’ leaves Littlewood optimistic that serious considerations will be given to issues within cross-cultural psychiatric research, Skultans (1993), in pointing out that this debate ‘has been going on since the twelfth century’, views the positions of universalism and relativism as being irreconcilable. She sees no common ground
between the former, which emphasises truth, (i.e. a belief in the common core of rationality), with meaning playing a secondary role, and the latter, which holds that both truth and meaning depend on the social/cultural context. This theoretical disharmony, framed within the polarisation of the emic and etic perspectives, remains at the heart of cross-cultural research.

In the last twenty decades, the often heated and extensive debates on the right methodological approach to cross-cultural research have not led to resolving these issues. Etic studies have focused primarily on empirical methodology re-establishing psychiatric principles. Emic studies have focused primarily on an interpretative methodology, re-establishing the importance of culture. The choice of methodology, therefore, seems to be a forced one between empiricism and relativism, between etic and emic. In the light of the above, it seems important that this distinction be considered in greater detail with reference to the aims of cross-cultural psychological research.

### 1.4 The emic / etic distinction in cross-cultural research

The main reason for the existence of cross-cultural research, according to Berry (1990), is to describe behaviour that is meaningful to members of one culture (the emic approach) while at the same time to compare it validly with behaviour in another culture (the etic approach). Berry states that the very name ‘cross-cultural’ implies at least two points of view: ‘cross’ being similar to the etic perspective and ‘cultural’ akin to the emic perspective. In a similar analogy, Lonner (1979) describes psychology as an etic enterprise, anthropology as an emic enterprise.

However, Pike, (1966) who first applied these linguistic terms to research, (phonemic, to mean an aspect of language particular to only one culture; phonetic, to mean universal aspects of languages), states that “two do not constitute a rigid dichotomy...but often present the data from two points of view”. Lonner (1980) maintains that both emic and etic enquiries are essential levels of analysis. Berry (1990) concurs, stating that, in cross-cultural research, it is important that both emic and etic meanings maintain a
Most cross-cultural psychological research, as described by Lonner (1992), is an etic exercise i.e. it is comparative, it looks at more than one culture and employs a theory or critique that is not culture specific. However, the term 'etic' is most often used, in cross-cultural research, to describe studies of non-western cultures by Western concepts, measurement tools, etc. Berry (1969) had criticised this approach, some years before the advent of the ‘new’ cross-cultural psychiatry, as the ‘imposed etic’ approach, where a naive application was made of Western theories and measurement instruments. In the last twenty years, ‘new’ cross-cultural psychiatrists have presented numerous criticisms of etic studies. Kleinman (1987) has argued that imposing Western, that is to say, ‘outsiders’ categories on populations for whom those concepts would have no coherence and meaning, leads to a distorted view of how a culture perceives, presents or experiences a psychological phenomena. He has argued emphatically that such studies are not valid, since validity can only be established through understanding the meanings of that particular culture. The basis of his critique is summarised as follows:

"...interpretations are always judgements whose reliability may be determined by consistency of measurements but whose validity needs to be established through understanding the particular cultural context. Validation is not simply verification of concepts used to explain observations. Rather it is as well verifications of the meaning of the observations in a particular social system". (1987, p. 451)

Skultans (1993) makes a strong expose of the entrenched positions of the two directly opposing approaches. She accuses universalists of directing all attention to truth, with little regard to meaning and relativists of “divorcing truth from meaning, emphasising the importance of the latter and focusing analytic attention upon it” (p. 127). Furthermore, while accepting the value of the latter approach in investigating conceptual indigenous frameworks, she argues that the contextualisation of findings from this perspective is limited for cross-cultural research, in that there is instability of findings and a lack of a ‘comparability component’. Shweder & Bourne (1991), too, add that the ‘self-contained ideational universe’ that is described by relativists provides no grounds for common standards or criticisms, and point out that this approach cannot explain
Lonner (1979) had earlier indicated the problems in adopting an emically oriented anthropological method. He had argued that if there were only *emics* in this world, comparativism would be impossible - there would be nothing in common in any two cultures. Although this latter point might be considered as one of the main assumptions of the 'new' cross-cultural psychiatry, evidence given by the WHO study on schizophrenia (German 1987; Jablensky et al., 1992) has shown that it is not so. In other words, there are common dimensions across cultures in mental disorder.

Skultans, (1993), focusing on the main point of contention between universalists and relativists - that of meaning - turns the criticisms of the relativists on their own arguments. Accepting the difficulty of finding the equivalence between 'categories whose roots lie in quite different social contexts', she argues that the problem of translation applies as much to the indigenous categories explored by the 'new' cross-cultural psychiatry as to any Western category. Therefore, she accuses the relativists of ignoring the very real problem of translating in *any* cross-cultural research, and argues that 'mutual knowledge' is only possible between people sharing the same context. Indeed, this seems a valid point because, as Kleinman (1987) himself admits, it is not just in knowing the language that a valid translation may be obtained.

Earlier Murphy (1969) too, had attempted to address the paradox between *emic* and *etic* methodology. He suggested that the choice depended on whether the variable 'culture' entered as a distortion or as an object of enquiry. An *emic* level was indicated if cultural comparisons were to be made of psychological syndromes; the *etic* level was indicated if culture itself was studied, for example, as in the process of acculturisation. While his suggestion seems to have value, the problem, however, lies in the aims of cross-cultural psychological research, which tends, for the most part, to attempt to encompass both aspects.

Other theorists have attempted to go beyond the *emic/etic* dichotomy, by integrating, in some way, the two methods. Berry, in 1969, had elaborated on the 'derived *etic*' approach, investigating local meanings in order to derive concepts that could then be explored etically. Leff (1990) suggested ascribing equal value to folk beliefs about
mental illness as to the Western biomedical system of psychiatry and then constructing a native lexicon of disease terms. As a more practical approach, Fabrega (1992a) proposed a social theory for studying psychiatric phenomena. He suggested defining psychiatric concepts abstractly in order to embrace phenomena that are comparable across societies, but which may be conceptualised differently. In this way, he argued, a way may be found of measuring, in social terms, how instances of psychiatric are labelled and handled in different societies. Patel (1994), in a similar tone, suggested eliciting the lexicon of idioms of distress and concepts from patients, carers, and healers from a culture. Based on this information, unstructured and semi-structured interviews could be conducted to enable an elicitation of emic phenomenology using an etic standardised approach.

These suggestions, although indisputably acceptable for cross-cultural research, do not elaborate how the problem of language, translation and equivalence, in linking emic and etic concepts, would be surmounted. Nevertheless, these attempts to find a resolution to this dilemma in cross-cultural research give an indication of the importance, perhaps even the urgency, of achieving some progress towards arriving at an understanding between the two paradigms. Indeed, Leff (1990), while endorsing the suggestions of integrating emic and etic investigations, has pointed to the impracticality of waiting for such developments. He has argued for a compromise to be reached which takes into account the practical problems of conducting cross-cultural research.

Others have attempted to resolve this dilemma by approaching it from a more theoretical viewpoint. In a recent paper, Berry, Poortinga, Segall & Dasen (1992) posed three theoretical positions in cross-cultural psychology. They distinguished between ‘absolutism’, ‘universalism’ and ‘relativism’. The ‘absolutist’ approach gives little importance to culture and is equivalent to the ‘imposed etic’ approach, the ‘relativist’ approach gives importance only to culture and is equivalent to the approach suggested by the ‘new’ cross-cultural psychology. The ‘universalist’

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3 A more detailed description of translation issues in cross-cultural psychology are given in Chapter 3.
approach is one in which universality is not assumed in advance and the influence of culture on concepts and behaviour accepted. Segall, Lonner and Berry (1998) equate this middle-of-the-way approach to Berry’s (1969) ‘derived etic’ approach.

From a theoretically related viewpoint, Skultans (1993) has focussed the attention on an important point - the universalistic assumption of cultural similarities i.e. the ‘common core of shared assumptions’. She wonders if this common core can be assumed to be constant between cultures or whether “each culture encounter establishes its own set of points of contact that is specific to every new meeting of different cultures?” (p. 126). She suggests that this might be the revisionist version of the universalistic position, one in which cultures are seen to overlap in many ways. Then the common core between cultures would not be unique and unchanging but a shifting one.

This ‘revisionist’ way of conceptualising universalism with reference to culture might be an important step towards developing a truer understanding of cultural similarities and differences in the present world. As opposed to an unchanging universalism (or ‘absolutism’ (Segall, Lonner and Berry, 1998) of the old psychiatry, as well as to the extreme relativism of the anthropology, it would more akin to the ‘universalist’ position suggested by Segall, Lonner and Berry (1998). In this way, it is hoped that the polarised positions on either side of the distinction will give way to more fruitful progress of research, one that is better suited to understanding all aspects of mental distress in a changing world.

1.5 Cultural heterogeneity and cross-cultural research

The largely quantitative, nomothetic, paradigm of the etic methodology is based on the assumption that some psychological characteristics, across cultures, are comparable. On the other hand, the interpretative phenomenological qualitative paradigm of the emic methodology is predicated on a culture-specific system of

4 The term ‘universalist’ is confusingly similar to the ‘universalism’ associated with psychiatry.
categories, meanings and explanatory frameworks, which assumes that there is little space for comparison of data. However, Bibeau (1997) elaborates on the limitations of such research. He argues that the tendency to reify and homogenise cultural systems, the lack of integration of social and cultural orders and the disconnection between the local worlds and the global scene are unsuitable in the context of cultural pluralism. Jahoda (1977; 1980), on the other hand, while accepting the respective value of these contrasting research orientations, criticises the application of the *emic-etic* labelling to psychological concepts and argues that this terminology does not contribute to an understanding of people's varying concepts. Weiss, Sharma and Gaur, Sharma, Desai, and Doongaji (1986) also argue that, this distinction may not be present in the 'hybrid conceptual frameworks' of people's ideas about health and illness. It seems, therefore, that this emphasis on cultural groupings undiluted by influences of other, 'outside' perspectives, meanings and concepts is unsuited to cross-cultural research in a contemporary society.

Although, Geertz (1986), amongst others, had emphasised the constantly changing nature of culture, the focus of the 'new' cross-cultural psychiatry has been on the uniqueness and separateness of cultural concepts. Other anthropologists too, from time to time, have pointed to the globalisation of psychiatry (Littlewood, 1995). The pervasive influence of western biomedicine has been shown to influence beliefs, attitudes and behaviours relating to mental illness (Littlewood, 1990). Littlewood points out that, as a consequence of this development, the result of industrialisation and capitalism, syndromes specific to one culture are now becoming increasingly rare. Klienman & Sing, (1997) too, suggest an increase, in China, in the prevalence of disorders once recognised as 'Western' problems. Notwithstanding this evidence, there is a 'continuous emphasis on small scale, bounded and homogenous communities' put by anthropology (Littlewood, 1985) and subsequently, by the 'new' cross-cultural psychiatry that seems to be a far cry from the cultural heterogeneity of the present day. Given that, as Nazroo (1998) points out, cultural traditions are historically located, occurring within particular contexts and changing over time place and person, cultural homogeneity within a specific culture is being increasingly eroded.
Furthermore, the mushrooming of the information age has brought about a rapidly 'creolizing world', to use Bibeau's (1997) term, in which cultural groups are open to many influences.

Hermans & Kempen (1998) explain this phenomenon as a 'deterriorialisation of cultures'. In their view, the increasing expansion of processes that disseminate information, such as the media, travel, migration, multinational corporations etc., has made the delineation of the parameters of separate cultures increasingly difficult. They see three developments as having interconnected separate cultures: (a) increasing cultural connections leading to hybridisation of ideas, b) the emergence of a global world in which there is an inter-penetration of global and local ideas and c) cultural complexity as a consequence of distribution of cultural meaning and practices. This leads, according to Hermans & Kempen (1998), to inter-cultural processes, with the continuous inter-penetration of different cultures. They state that "as a consequence, both the presumed internal homogeneity of cultures and their conception as externally distinctive are called into question" (p. 1112). Therefore, they argue, cultural differences can no longer be conceptualised in terms of culturally distinctive dichotomies.

As a way of examining the different aspects of beliefs, Triandis' (1997) suggests four different levels of analysis for examining 'psychologies' universally in all cultures.

Level 1: Universal psychological laws that apply to all humans. This would apply to the study of biological and genetic features.

Level 2: Universal variables that acquire specific cultural meaning but can be cross-culturally compared. This would apply to the study of the fundamental dimensions of cultural variation e.g. social distance.

Level 3: Culture specific manifestations of the fundamental dimensions of cultural variations. This would apply to the study of indigenous, culturally specific beliefs and concepts.

Level 4: Individual differences. This would apply to the study of behaviours that show strong individual differences e.g. personality traits.

While level 1 and 4 can be examined without reference to culture, predictions at level
2 and level 3 can only be made with reference to culture and social context. While the latter (level 3) incorporates *emic* concepts only, the former (level 2) can be equated to *etic* concepts. While the former are culture specific, idiosyncratic features that can only be understood with reference to one culture, the latter are shared by other cultures and can therefore be used as basis for comparison. Implicit in this theoretical approach is that cultural groups hold both *emic* concepts and *etic* concepts.

Thus, there appear to be emerging two contradictory views of cultural groups in the present world. On the one hand, each group encloses a world of defensible borders, firm boundaries and indigenous belief systems and on the other hand, a world without boundaries, in which there is free movement of ideas and, as a result, an inter-mingling of common belief systems.

More importantly, an acceptance of these different levels of analyses ensures that the *etic* approach does not have the connotation of an 'outsider's' perspective, that is an assumption of the 'new' cross-cultural psychiatry. As earlier discussions have shown, the divergence between the insider's understanding and the outsider's perception is no longer necessarily present, as it might have been thirty years back. Distinctions between indigenous and shared concepts in cultural groups are no longer clear, mutually exclusive or dichotomous. Therefore, not only are *emic* and *etic* concepts complementary rather than alternative, the inter-mingling of cultures has led to an inter-mingling of concepts and beliefs as never before.

As culture can no longer be 'geographically localised' (Robertson 1995), cultural boundaries have become permeable so that there is an impact of the global on the local, or in other words, of the *etic* on the *emic*. These common or *etic* concepts between cultural groups may be the result of the media, the health systems available in the society or the social representations that are widely disseminated by information technology. Unlike the assumptions of the 'new' cross-cultural psychiatrists, the global and local influences on a culture are not necessarily in opposition. Similar to Bibeau (1997) viewpoint, Robertson (1995) also sees global-local concepts co-existing in the same culture.

It seems, therefore, that, as cultures become more permeable, the line between *emic*
and etic concepts becomes increasingly blurred as a result of the re-interpretations and re-structurings of concepts in a post-modern society. This is probably true of most societies in the world today. It is particularly true of multi-cultural societies, like the ones that we have in Britain. These points have major implications for the methodology of cross-cultural research, and more particularly, with reference to migrant populations.

1.6 The methodology of contemporary cross-cultural research

As a result of developments in cross-cultural research, psychology has been left without an agreed and rigorous way to describe and examine variations that might exist across cultures on dimensions that are comparable. A selective integration of methods for cross-cultural research inquiry (such as that suggested by Patel, 1994) requires careful analysis, for behind the questions about the implicit and explicit theoretical underpinnings of cultural relativism lies the issue of the scope of its validity for comparative work.

Firstly, if concepts or behaviour can only be understood with reference to just the one culture (as 'new' cross-cultural psychiatrists have postulated), then there can be no basis for a transformation to concepts and behaviours used for comparison between cultures. There is little place for comparison of data, since the meaning of behaviour is relative only to one cultural context. This point goes deeper than the problem of translation and equivalence, but the latter point, too, remains an obstacle.

Secondly, even if this procedure is proved valid, the indistinct nature of the divide between emic and etic concepts makes the task unclear. The divided nature of an integrated emic/etic investigation would provide a more full picture and would be appropriate where the distinctions between the two are easily distinguishable. That is often not the case in the complexity of cultural groups and concepts.

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5 See Janis Jenkins (1990) analysis on the difficulty of transposing specific concepts of 'expressed emotions' from one culture to another.
Finally, and most importantly perhaps, the difficulty arises from the irreconcilability of the philosophical assumptions as well as the methodologies of these two types of enquiry. Stevenson and Cooper (1997) state that different positions of enquiry are associated with different kinds of knowledge and so, attempts to bridge the divide may be the worst of both positions. Moon Dillon & Sprenkle (1991), too, suggest that rather than adopting a 'dichotomising description of inquiry', a stance of 'post-positivism' should be taken, a compromise between absolute objectivism and relative constructionism. Thus, this approach would fulfil some of the requirements of 'good' research but also investigate knowledge that is relevant and valid. The crucial element, as Stevenson and Cooper suggest, should be to make research an open reflexive process, one that makes clear the researcher's understanding.

These views are in accordance with those of Winter (1989), who argues that although objectivism and relativism drive their respective methodologies, research methods should be used in a reflexive fashion rather than being applied routinely. Although this aspect has often been used to describe qualitative research, it is seen as inappropriate for quantitative research. However, Stevenson and Cooper (1997) argue that it is just as appropriate for quantitative research, bridging the gap between reality and the interpretation of reality. Reflexivity, argues Bryman (1988), allows the choosing of a position of inquiry considered by the researcher to be appropriate to the research being undertaken. This reflexive process is important in order to show that research, rather than being routinely executed, has been constructed thoughtfully.

Therefore, while an inter-disciplinary approach, using both qualitative and quantitative methodology could be productive to the study of cultural groups, the combination of emic and etic methodologies may not be the most appropriate method for examining cultural concepts across cultures. This point has particular relevance when these groups are often the only ones that are accessible for cross-cultural research i.e. those living in large multi-cultural metropolitan cities\(^6\). These concerns

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\(^6\) Indeed, Lonner (1979) has criticised cross-cultural researchers for using mainly 'bilingual, affluent' samples. However, the practicality of such research imposes these limitations.
have not been addressed adequately (and perhaps can never be completely clarified).

As an earlier suggestion by Allport put it: "we should adapt our methods so far as we can to the object, and not define the object in terms of our faulty method" (1963, p.28). In this cross-cultural investigation, therefore, it seems logical to employ a 'universalist', largely quantitative, approach to this research, the underlying assumptions of which will be discussed in greater detail in Chapter 3.

1.7 Summary

Methodological issues, reviewed within the framework of developments in cross-cultural research, have shown an integration of anthropological and psychological perspectives, in the last two decades. This has led to the emergence of the 'new' cross-cultural psychiatry, and a resurgence of the importance of culture in cross-cultural research on mental distress.

In considering the impact of the 'new' cross-cultural psychiatry within the framework of the aims of cross-cultural research, it is argued that its assumption, derived from anthropology, of isolated, culturally homogenous groups, is no longer sustainable in a rapidly globalising world. Therefore, the underlying assumption of a clear distinction between emic and etic concepts is no longer valid, particularly in cultural samples living in metropolitan, multi-cultural settings.

On that basis, this thesis argues that an integration of qualitative and quantitative methodology may not be the most appropriate methodology for an investigation across cultures. This thesis, therefore, proposes to apply a largely etic, quantitative method. However, it is considered important that the rationale behind this methodology be analysed in great detail, in order to explain its suitability. Therefore, the basis for the construction of this research is described in detail, in Chapter 3.
Part II

The concepts of culture, disease and illness
Chapter 1

Part II

The Concepts of Culture, Disease and Illness

1.8 Overview

While it has been argued that what is required is a more appropriate methodology for research across cultures than the one espoused by the ‘new’ cross-cultural psychiatry, the validity and significance of its theoretical assumptions of the importance of culture cannot be denied. Therefore, in Part II of Chapter 1, an analysis is made of the conceptual and theoretical issues underlying the perspectives of both relativism and universalism. This is necessary, firstly, in order to assess the critique posed to cross-cultural research in psychiatry by reviewing the assumptions of the ‘new’ cross-cultural psychiatry; and secondly, to explain the different ways in which culture mediates in all aspects of mental distress, at both the social and individual level. Concepts of culture and mental distress are examined with reference to cultural differences, with a review of studies that have focused mostly on differences in Western and non-Western cultures.

The conceptual and theoretical properties of the term ‘culture’ are reviewed, illustrating the integration of anthropological concepts of culture into cross-cultural psychiatry. An analysis of the theoretical critique of psychiatry’s universalistic position examines the claims of cultural relativism with reference to two explanatory concepts of mental disorder, the biological ‘disease’ and the social ‘illness’ (Kleinman 1977). Although this distinction has limitations, it is argued that such an approach helps to clarify the role of culture plays in mental distress.

1.9 The Conceptualisation of ‘Culture’

The concept of ‘culture’ in the ‘new’ cross-cultural psychiatry, as with its assumptions and methodology is, by and large, that of anthropology. With the emergence of the ‘new’ cross-cultural psychiatry, the line between anthropologists and cross-cultural psychologists has blurred, as both aim to understand the different beliefs and practices in varying cultures. The centrality of this relationship, in transcultural psychology as well as in ‘new’ cross-cultural psychiatry, underlines the
importance and the utility of understanding the concept of 'culture' for cross-cultural psychological research.

Although anthropologists, too, differ as to what should be regarded as the major determinants of culture (Littlewood 1985), in psychology the term seems to defy definition, incorporating as it does a 'package' of variables. Nevertheless, it is anthropology that has provided some of the more definitive concepts of 'culture' and illustrated the relationship between culture and mental distress.

Thus, the several different conceptualisations of 'culture' give an account of the changing focus of interest relating to 'culture', both from a historical and a sociological point of view. These changes chart the dominant concerns in the histories of both the disciplines. Tylor (1871) conceptualised it, in his classic description, as:

"That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society" (Cited in Rack, 1982).

More than a century later, D' Andrade (1984) defined 'culture' as:

"consisting of learned systems of meaning, communicated by means of natural language and other symbol systems having representational, directive, and affective functions, and capable of creating cultural entities and particular senses of reality. Through these systems of meaning, groups of people adapt to their environment and structure interpersonal activities" (p.116).

Triandis' (1980) has posited a more specific conception of 'culture' by trying to locate the parameters of culture. He defined by it three criteria: place (a community), time (a particular period) and language (intelligibility). Other theorists have based their conceptualisation of 'culture' by focusing on just one attribute, i.e. as a code of communication, encompassing communicative behaviour, emotions and language. They have studied it by focusing on the interpretative aspect of 'culture', engaging in semiotic analysis in order to get to the system of meaning (Umiker-Seboek, 1977; Misra & Gergen, 1993). Others, such as Berry & Dasen (1974) have associated 'culture' with systematic differences in cognitive style or have examined dichotomous constructs, such as individualism vs. collectivism (Hofstede, 1980).

These approaches seem to be rather more limited explanations than that intended by anthropologists, and subsequently by 'new' cross-cultural psychiatrists. Fabrega (1982) warns that to limit the concept of culture to purely 'mentalistic structures', such as symbolic systems and cognitions, would be to lose a major part of the
affective and meaningful aspects of it, reducing culture to dry, operationalising of particular variables. Other contemporary anthropologists, such as Ware & Kleinman (1992), in conceptualising culture, also see cultural orientations as being rather more than simply cognitive constructs - they describe them as deeply held beliefs that can be seen as 'affective, aesthetic and moral schemas'.

Fabrega (1992) has argued for a broader view of 'culture', by stating that it lies at the very heart of human existence and that it has played an integral role in human evolution. He takes the view, of evolutionary psychologists, that cultural information, like genetic information, exists in the society before the individual, and like genetic information, is passed on from generation to generation (Plotkin, 1994). Both types of information serve to program behaviour and physiology and both are subject to the process of natural selection. He concurs with McGuire & Troisi (1987), who explored the relationship between social behaviour and physiological regulation, that 'culture' regulates physiology. 'Culture', therefore, is seen as something that is complementary to the biological, rather than separate from it, both being central to human social existence. This last point has obvious implications for the universalist/relativist argument, which shall be analysed in more detail in further discussions.

Anthropology's view of 'culture', predominant until recently, has been one of shared meaning and shared experiences, which were understood as the distinguishing features of cultural groups (Ware & Kleinman, 1992). Thus, the basic assumption of cultural relativism of the 'new' cross-cultural psychiatry referred to these cultural differences. It held that there would be variations in beliefs, behaviours, feelings, traditions, and social practices between all cultural groups and that these features would be common amongst individuals of a group that shared the same culture. Its emphasis, therefore, was on cultural differences in beliefs and behaviour as well as culturally specific beliefs and behaviour (Fabrega, 1974).

In contemporary anthropological enquiry, however, the focus of analysis has shifted somewhat. It is now on the "shared worlds of interpersonal experience of individuals" (Ware & Kleinman, 1992). Although the emphasis here seems to be on the individual within his social context, the focus is not on the individual but on the collective. Klineberg (1980) remarks that this is what marks the distinction between
anthropology, which focuses on the social, and psychology, which focuses on the individual.

This difference in emphasis is re-confirmed in recent conceptualisations from psychologists who have emphasised the constructive characteristic of culture (Shweder & Sullivan, 1993). They place ‘culture’ not outside the individual where it influences behaviour and beliefs but “as an inter-subjective reality through which worlds are known, created, and experienced” (Miller, 1997). The focus of cross-cultural psychological research, with the dual aims of looking for human diversity as well as searching for psychological universals, is therefore on the individual (Jahoda and Krewer, 1997). Thus, ‘culture’, when used in the comparative mode, is seen as a set of variables, many of them linked to ethnicity, which influence behaviour and beliefs of the individual (Segall, 1984; Lonner & Adamopoulos, 1997).

The diversity of conceptions makes it evident that researchers have found the defining and conceptualisation of culture difficult. However, in an attempt to conceptually integrate anthropological and psychological concepts, researchers of the ‘new’ cross-cultural psychiatry generally see culture as a system of symbolic meanings that shape both social reality and the personal experiences of the individual. Therefore, culture is taken, in this thesis, as a “system of meanings that is learned, that provides people with a distinctive sense of reality and which helps shape behaviour and affective responses” (Fabrega 1992b, p.564).

1.10 The relationship between culture and mental distress

The main concern of cross-cultural psychological practice and research is the relationship between culture and mental distress. Anthropologists have given evidence, through the years and working in different cultural groups, that individuals hold culturally specific interpretations of the self and body, and therefore, health and illness (Mead, 1934; Waziri, 1973; 1961; Marsella, DeVos, Francis, & Hsu, 1985; Littlewood & Lipsedge, 1997).

Over the last twenty years, numerous papers from the ‘new’ cross-cultural psychiatrists have shown that culture is pertinent to all human behaviour but particularly to the understanding of mental distress (Kleinman, 1977; Helman, 1980;
Fabrega, 1989). Primarily, the aim of cultural relativists has been to seek a ‘biopsychosocial’ basis for understanding mental distress and people’s understanding of it (Engel, 1977). Therefore, all parameters of psychological distress - cause, manifestation, course, help-seeking and response to treatment - among a people are seen, as a function of their culture, to be variable, different and, therefore, unique to that culture.

Kleinman (1980) implicates two distinct mechanisms that exist at the individual level. One mechanism involves the cognitive appraisal of the illness. As Lipowski (1968) explains, the subjective interpretation and assessment of the illness is seen as threat, loss, gain or of no significance. Secondly, Kleinman states that culture directly affects the psychological and physiological processes in mental disorders. This pathway bypasses cognitive appraisal affecting the body and the mind via symbolic systems and relationships established in early experience. In other words, culturally influenced ‘cognitions, emotions and related mentalistic structures’ (Fabrega, 1989) mediate in the interpretations of the physiological body and therefore, in the conceptualisation, presentation and interpretation of mental distress. Cultural relativists postulate that it is these culturally specific interpretations of self, body and health and illness that give rise to belief systems which “construct causality, pathophysiology, nosology and healing as distinctively as they organise religion, kinship and other categories” (Ware & Kleinman 1992, p. 547).

Furthermore, Fabrega (1992b) states that ‘both psychiatric illnesses and culture meaningfully implicate humans as holistic and symbolic creatures’. Implicit in this assumption is the notion of a relationship that connects the individual, the illness and his culture in a number of ways. The resultant body of research has shown that mental illnesses have a social and symbolic meaning which incorporate perceptions of normality/abnormality, presentation, interpretation, labelling, and diagnosis (Helman, 1990; Ware & Kleinman, 1992; Ware & Weiss, 1994; Littlewood & Lipsedge, 1997). Furthermore, ‘new’ cross-cultural psychiatrists have argued that not only are instances of social deviance determined as disorder purely for social, cultural, political, and economic reasons but that the study of mental illness itself, in the discipline of psychiatry, has been the product of historical, social and political factors (Littlewood, 1990). As a result, not only does the ‘new’ cross-cultural psychiatry decry
psychiatry's universalistic assumptions, it has, with great effect, situated this discipline in its particular historical and cultural context.

In contrast, from the point of view of psychiatry, evidence from studies (Sartorius, 1986; German, 1987) has proved that culture is not the key to understanding health and illness. Although psychiatrists can be aware of social and cultural factors in disease, - since they have pointed to differences in the psychopharmacological responses of cultural groups (Lock, 1987b) - they do not attempt to explicate this relationship. They do not doubt the role of culture but see it as mediating mostly in the incidence of different disorders (Fabrega, 1989). Therefore, while the link of culture to mental illness is central to both practice and enquiry for cultural relativists, for psychiatrists, it is peripheral. The disciplines of psychiatry has based its science on universal ‘building blocks’ or categories of symptoms and illnesses in order to facilitate understanding of biological malfunctioning, and therefore medical care and research (Lock 1987b). Research in psychiatry has been based on assumptions that mental distress, like all other diseases, is grounded in the biological sciences and is universal in appearance and incidence (Kiev, 1972; Sartorius, 1986; German, 1987).

Although the thrust of criticism from the ‘new’ cultural psychiatry has been against these universalistic assumptions, psychiatry, in some part, actually balances, (as pointed out by Littlewood, 1990), between disease, the biological aspect of the disorder, and illness, its social response. Theories and attendant research such as those of ‘learned helplessness and depression’ (Abramson, Seligman, & Teasdale, (1987) and the notion of ‘expressed emotions’ and schizophrenia (Leff, Wigg & Ghosh, 1987) give evidence of its attempt at finding the relationship between disease and illness. However, as the ‘new’ cross-cultural psychiatrists argue, the importance of culture has not been fully realised by psychiatry. Research that gives evidence of the mediating force of culture is reviewed with reference to the twin concepts of disease and illness.

1.11 Disease, illness and distress

In order to illustrate the distinction between universalism and cultural relativism, Kleinman, (1978), the original proponent of the ‘new’ cross-cultural psychiatry,
suggested employing a distinction between the concept of 'disease', regarded as a biological entity, to the concept of 'illness', a subjective experience shaped by conceptual and socio-cultural factors. This dichotomy was not a new one - Kraeplin (1904) had distinguished between the characteristic feature of the disease, 'the form', which was biological and therefore universal, and the 'content', which was social and therefore superficial. The core form of the illness was characteristic of and depended on an underlying disease process and was distinguished from the content of the illness, a manifestation of the individuals' traits, including culture.

Quite apart from the fact that Wilkes (1988) rightly points out that these terms, are social constructions in themselves and therefore culturally biased, it could be argued that this distinction does not prove very useful in understanding how attributes of biological illness implicate social and cultural systems. It does not illustrate well the 'the dialectical interplay of biology and human society' in the presence of illness (Littlewood 1990). If taken from an extremely cultural relativistic position, as Fabrega does (1989), where psychiatric phenomena are disturbances of the self and therefore primarily entail a consideration of symbolic and social features, the concepts are extremely limited. Nevertheless, this dichotomy has been useful in understanding the explanation of the dual aspect of mental disorder - that which can be universally similar but also culturally different.

Although the assumption in psychiatry is that patterns of illness have a single explanation (Hughes 1985), patterns and symptoms are dictated both by a biological process as well as by a range of socio-cultural influences. As Littlewood (1991) has suggested, mental illnesses may be taken as lying anywhere along the range from a biomedical paradigm (where psychopathology is constrained by biology) to a purely sociological paradigm, to be understood only within the local social and symbolic context of the illness. The point at which the disorder situates itself on the continuum between the biomedical and the sociological paradigms is both biologically determined and culturally variable.

Although disease can be viewed as the professional biomedical explanation and illness an explanation grounded in popular culture, Kleinman points out that

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7 This criticism has applied to psychiatry as a whole and is discussed in greater detail in later discussions.
constructs such as *disease* and *illness* are most useful if taken as explanatory concepts, (Kleinman 1977), seen as different interpretations of the same clinical reality. As Helman (1985) sees it, *disease* is "something an organ has; *illness* as something a man has". Engelhardt (1974) views them as representing the relationship between the components of malfunction. While *disease* relates to the malfunctioning of biological or psychological processes, *illness* is the personal and social response to the malfunctioning. It implicates ‘processes of attention, perception, affective response, cognition and valuation directed at the disease and its manifestations’ (Kleinman, 1980) as well as communication and interpersonal interaction within the immediate social context of the individual.

*Illness* is, therefore, both a psychosocial and a culturally determined adaptive response to the *disease*, which might, indeed, have universal or biological symptoms (Lock 1987a). Kleinman (1987) states that the focus of the ‘new’ cross cultural psychiatry, lies on the widening gap between *illness*, which incorporates the cultural contents of meaning and differing conventions, with cross cultural variation in appearance and interpretation of psychiatric disorder, and the *disease*, the biological, universal mechanisms and processes. However, while it may be difficult to distinguish *disease* from *illness*, these two aspects usually undergo changes with reciprocal effect, the dialectic transforming both biology and social relations. One may be more powerful than the other, depending on disorder, its course and context, but beliefs and attitudes relating to both these aspects will be culturally mediated. Thus, *disease* and *illness* cannot be understood fully as being simply explanatory concepts of mental disorder. Both aspects can function as cultural constructs that are shaped by norms, traditions, folklore, and social network and themselves influence the social environment (Kleinman and Kleinman, 1985). At the same time, these constructs are social constructions that quite often have social uses in different cultures (Ware & Weiss, 1994).

The relationship between *disease* and *illness* can most effectively be assessed in examining the role of culture on psychopathology. The following examples illustrate the relevance of both the culturally relativistic perspective of the ‘new’ cross-cultural psychiatry to research as well as the universalistic perspective of research in psychiatry.
1.12 Mental disorder: universal entity, cultural and social construct

The relationship between culture and psychopathology can best be illustrated by studying cultural differences in the symptomatology of mental distress. Firstly, the ways psychiatric illnesses are conceptualised and categorised are distinguished in terms of their symptoms. Secondly, the bulk of evidence from research, both epidemiological and descriptive, has studied the relationship between culture and psychopathology with reference to expressions of distress. Finally, in examining symptomatology, one can see the complex interrelationship between the biological (universal) and the social/cultural (relative) (Kleinman, 1978).

There is evidence, from a variety of different research carried out through the years, that there are similarities between cultures in the symptoms of the most prevalent mental illnesses such as schizophrenia, major depressive disorder and anxiety disorders (Kirmayer, 1989). Studies carried out by both anthropologists (Murphy, 1982), and empirical studies, such as the WHO's International Pilot Study of Schizophrenia (1979), described in Part I of this chapter, have shown that there are substantial similarities in symptoms in different cultural groups for schizophrenia. A core schizophrenic syndrome could be identified in first contact cases in both western and non-western, and in both industrialised and non-industrialised societies (Jablensky et al., 1992). As German (1987) concluded, it was possible to identify schizophrenia, as defined by standardised criteria, in disparate cultures by the use of such instruments as the IPSS.

Although cultural relativists have accepted that some of these similarities have constituted significant findings for understanding schizophrenia, (Kleinman 1987), critics of this approach argue for a greater understanding of cross-cultural differences. Indeed, one of the most important cultural differences relating to mental disorder have been found, in different cultural settings, by research in the prognosis of schizophrenia. Studies have shown that patients in developing countries have a markedly better prognosis than in the developed countries (Waxler, 1979; Mendis, 1986; Leff, Wig, & Ghosh, 1987; Verghese, John, & Rajkumar, 1986; Leff, Wig, Bedi, 1990, Jablensky et al, 1992).
Therefore, it seems that while psychiatry looks for disease, the biological aspect of the disorder assumed to be universal; the 'new' cross-cultural psychiatry looks for illness, the subjective culturally mediated experience of it. This example illustrates not only the tensions between universalism and relativism but also, how perspectives determine the interpretation of findings, with western psychiatry focusing on the 'real' disease and uniformity, cultural relativists focusing on cultural variability in illness symptoms. This example also serves to illustrate a more important point - that despite their divergent perspective, both universalistic and relativistic approaches are necessary for a full understanding of mental distress.

In the case of depression, evidence has shown that there is greater cultural variability in the disorder. Although earlier studies had given evidence that depression was similar in many cultures, (Sartorius, 1986; Kirmayer, 1989), culture is now accepted to have a greater influence on neurosis. Even when examined in Western societies alone, its aetiology can lie at the social end of a continuum, as a unipolar, exogenous or reactive depression (Brown & Harris, 1978) or at the more biological end, as a bipolar or endogenous depression. Therefore, it is a heterogeneous category that could include a range of causes and symptoms (Davison and Neale, 1990). In the study of depression across cultures, greater variance has been found both in the symptomatology and in the prevalence and incidence (Murphy & Leighton, 1965; Singer, 1975; Carstairs & Kapoor, 1976; Murphy, 1982; Weiss, Raguram, Channabasavanna, 1986). Although evidence suggests that the somatic symptoms of endogenous depression seem to be universal (Kleinman & Good, 1985), the somatic aspects of all types of depressive disorder is predominant in non-western societies (Wraziri, 1973; Rao, 1986; Weiss et al, 1986; Kawanishi, 1992).

In addition, studies in different cultures have shown that even when the core symptom may be that of sadness, this dysphoria has different meaning, expression and reaction in different cultures. Both Obeyesekere (1985) working with Sinhala Buddhists in Sri Lanka and Good (1977), working with Shiite Muslims in Iran, give evidence of depression not being associated with hopelessness, as in the Brown & Harris formulation. Therefore, whilst the affect itself might not vary across cultures, the perception and expression of the affect varies considerably Lutz (1985). The difficulty in understanding the significance of these variations, according to Lutz, lie in the fact
that psychology (he calls it ‘Western ethno-psychology’), is rooted in western notions of self.

It is evident, by these examples, that in mental distress situated towards the sociological end of Littlewood’s continuum, where the illness has a larger part than disease, culture plays the primary mediating role. Disorders, such as the mixed somatic-affective disorders, are not always accompanied by a biological pathology but are constructed by lay theories and professional practice within a specific sociocultural context. Research in these disorders illustrate how social parameters, dictated by cultural norms and traditions, mediate not only in professional labeling and diagnosis but also in lay beliefs of mental distress (Helman, 1991; Ware & Weiss, 1994).

Cultural relativists also argue that the core symptom often varies specifically because it is culturally and socially constructed in societies in quite different ways (Littlewood & Judhav, 1994). Examples from research in different cultures illustrate this point. While fatigue is the core symptom in the U.S. and Canada in chronic fatigue syndrome, anger in *hwa-byung* in Korea and dizziness in neurasthenia in China form the primary syndromes (Ware & Weiss, 1994).

While these examples illustrate the significance of culture, they also demonstrate an important aspect of mental distress i.e. the inter-connection between lay, patient and professional beliefs about mental distress. Ware & Weiss’s (1994) example, in their study of neurasthenia in China, shows that there is a connection between lay beliefs and professional responses to those beliefs. They describe how the diagnostic process itself is a social one, so that the diagnostic label is a social construction rather than an objective reality. This ‘diagnostic euphemism’ overcomes many social problems. This helps circumvent the stigma associated with psychological problems (Hinton & Kleinman, 1993). This juxtaposition of cultural construction at the individual, social and professional level, is explained by Kleinman (1986):

‘...neurasthenia can be most fruitfully conceptualised as illness experience – a culturally salient form of chronic somatisation that act as a final common pathway for several distinctive types of pathology, of which major depressive disorder is the principal disease.

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8 A relatively new addition is that of *myalgic encephalomyelitis* or ME in the UK, which is characterised by weakness.
...however...a case can and should be made for retaining neurasthenia as a disease category, especially in those societies like China where it is still popularly used by health professionals” (p. 165).

These examples illustrate that the relationship between aetiology and pathology seems to be arbitrary (Littlewood, 1991). Labeling need not be connected to the ‘real’ attributes of the disorder, according to Kleinman. It is often the result of the perception and the diagnosis of that pathology, both being socially and culturally constructed, as expounded by Marsella and White’s (1982) sociological labelling theory of deviance.

It is clear that although the views of the discipline of psychiatry and its sub-discipline, the ‘new’ cross-cultural psychiatry, are framed in the broad terms of universalism and relativism, the arguments presented by either perspective reveal the culture of either discipline. The dilemma lies in the fact that while the culture of relativists is to look for subjective meaning (Skultans 1993), the culture of scientists is to look for universal specifics (Lonner, 1979).

The main challenge of cultural relativism, however, goes beyond claims of the significance of culture in mental distress. The major criticism of psychiatry, is that in both its practice and research, it searches for the ‘real’ disease where there is no such ‘value-free, culture-free’ entity (Fabrega, 1992a). This point has had the most profound implications for research across cultures, illustrating the bias with which Western psychiatry carries out both practice and research in cultures that are not western.

1.13 The epistemological bias of Western psychiatry

Cultural relativism poses a significant challenge to cross-cultural research and practice in psychiatry, especially because it does not limit its critique to biological determinism and empiricism in favour of cultural relativity. Cultural relativists, in describing culturally defined systems that incorporate health, illness and diagnosis, also challenge psychiatry for being the product of its cultural, historical and social traditions (Kleinman, 1980). As Kuhn (1970) has pointed out, there is ‘no neutral algorithm’, even in science. Bracken (1993) adds that historical, social and political
factors influence scientists and shape theories and therefore, there are no cross-cultural standards by which theories can be judged. Thus, the ‘new’ cross-cultural psychiatry critiques the ‘culture-bound’ nature of psychiatry’s concepts (Littlewood & Lipsedge, 1985). In so doing, it situates the scientific objectivism and biological determinism of psychiatry in its own cultural and social context. Therefore, while western concepts may be valid when applied to Western populations, ‘new’ cross-cultural psychiatrists argue that an epistemological bias exists in applying those concepts to other cultures. This view is particularly illustrative with reference to culture specific patterns of unusual behaviour.

Behaviours specific to one culture and known as culture bound syndromes (e.g. amok in Malaysia, susto in South America, Dhat amongst males from the Indo-subcontinent) can sometimes be a reaction to a perceived, desired, but not an actual disorder (Jadhav, 1996). Littlewood & Lipsedge have shown that as they can often play an important role in expressing and resolving social conflicts, and thus, they are examples of culturally appropriate behaviour to be fully understood only in the right cultural context.

Psychiatry has dealt with the culture specific patterns of unusual behaviour in two ways. One the one hand, they are termed ‘atypical patterns’ of illness, being atypical to those outlined by its classification system. Indeed, the very term ‘culture-bound syndromes’ were used as labels by Western psychiatrists for patterns of behaviour that did not fit Western psychiatric classifications (Littlewood, 1990). On the other hand, culture bound syndromes, although specific to one culture are interpreted as being equivalent to those that are delineated in the psychiatry’s diagnostic categories (Carr, 1978). By playing down the importance of the cultural uniqueness in these variants of recognised western disorders, universalistic assumptions have been more or less preserved in psychiatry (Simons & Hughes, 1985). From the point of view of cultural relativists, it can be assumed that the term ‘culture-bound’ is itself redundant, as all patterns are seen as culturally determined and culture specific.

These challenges have had the most profound implications for psychiatry, as they illustrate the epistemological bias with which Western psychiatry carries out both practice and research in cultures that are not western. Nevertheless, there now seems to be an acceptance that there is a need to go beyond the limitations set by these
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Part II

The Concepts of Culture, Disease and Illness

opposing ideas. While the ‘new’ cross-cultural psychiatry, like psychiatry itself, is a development of ‘certain Western psychiatric preoccupations’ (Littlewood, 1992), it’s main value lies in its attempt to challenge the Western hegemony of concepts and practices, and create a more sensitive, universally valid epistomology. For psychiatry, although its assumed superiority has denied a true understanding of local and cultural beliefs relating to mental distress, it has provided an important basis for the understanding of psychopathology across cultures.

A rapprochement between the two approaches is all the more necessary because, while cultural relativism is a defining feature of the ‘new’ cross-cultural psychiatry, cultural groups themselves may be losing some of their defining characteristics, as argued in Part I of this chapter. Contrasts in Western and non-Western concepts are on the wane (Hermans & Kempen, 1998). The influence of psychiatry itself is becoming more pervasive and its concepts and treatment widely broadcast. More importantly for research, while psychiatry’s universalistic assumptions can be criticised, they cannot be excised completely from contributing to an understanding of disorder, as evidence has shown.

Furthermore, ‘new’ cross-cultural psychiatrists have now come to accept that ‘radical relativism’, would not suffice alone in providing a full comprehension of mental distress. (Fabrega, 1992a). There has been a call, from some of the major proponents of the ‘new’ cross-cultural psychiatry, that a more theoretically based approach to research is needed (Littlewood, 1992b). Kleinman, (1997), on his part, expresses the wish ‘to move away from older anthropological discourse and towards the new frontiers of social theory’. Given that the two sub-disciplines have a common goal - to gain understanding of all aspects of mental distress - their common objective must be to form a useful alliance and advance towards a resolution of all these major issues.

1.14 Summary

Cultural relativistic arguments, advanced by Kleinman, amongst others, have challenged the universalistic assumptions of psychiatry. Much of the impetus behind the claims of these ‘new’ cross-cultural psychiatrists has come from research showing
cultural differences in the ways mental disorders are conceptualised and presented in different cultures.

An important aspect of these relativist theories has been to demonstrate that health, illness and healing in a society operate as a cultural system in which culture mediates between both internal and external systems (Kleinman 1989). Disease and illness are therefore conceptual categories and not discrete entities. Their relationship is extremely complex and because these conceptualisations are themselves culturally modulated, it would be a 'category fallacy' to categorise dimensions of a disorder as one or the other. However, they do provide a useful way of understanding the relationship between the biological, universal aspects of a disorder and its relativistic aspects that are mediated by social and/or cultural influences.

Cultural relativists have demonstrated that Western psychiatry and its concepts are specific to the Western culture and therefore, 'culture bound' knowledge. However, psychiatry, too, has shown that it has made significant contributions to the understanding of mental disorders and some 'new' cross-cultural psychiatrists have come to accept the limitations of an extreme relativist viewpoint. Therefore, the common aims of psychiatry and the 'new' cross-cultural psychiatry must lead to a mutual acceptance of their respective approaches.
CHAPTER 2

Culture and lay models of mental distress
Chapter 2

Culture and lay models of mental distress

2.1 Overview

Chapter 2 aims to examine the construction of lay beliefs about illness, specifically beliefs about mental distress. These lay models of illness are reviewed with reference to cultural differences in western and non-western cultures.

Health and illness beliefs are not transitory notions of illness and disease but are part of a structured framework of beliefs that are shaped according to cultural and social factors (Helman, 1990). Medical anthropologists have postulated that lay beliefs are related to people's explanatory models that in turn influence both illness and health seeking behaviour (Suchman, 1966; Chrisman, 1977; Kleinman, 1980).

The chapter, therefore, analyses the basis on which lay beliefs or models of mental distress are constructed. Underlying assumptions of notions of self, 'other' and natural and supernatural agencies contribute to an understanding of illness, along personalistic and socio-cultural lines (Mauss, 1985; Bal, 1987). These culturally determined formulations incorporate all aspects of mental illness, but especially beliefs about the causes of mental distress, expressions of distress and attitudes related to seeking help for mental distress (Weiss, 1997). Cultural variations are discussed with reference to lay models of illness, reviewing research that has examined Western and non-Western lay models of mental distress.

2.2 Lay models of mental distress

Helman (1990) describes lay models or theories of illness as a composite of cultural notions about the structure of the body, its functioning as well as views on mental illness prevalent in the society. Not only are these lay models of illness part of a complex body of inherited folklore, they arise from a broader concept about the origins of misfortune in that culture. They incorporate both traditional and professional notions of the body and its functions, as well as the health care systems available in the society. Because of the spread of Western psychiatry, the influence of the medical model of the body and its malfunctions (essentially western conceptualisations), is a mediating factor of lay beliefs in both Western and non-
Western societies (Littlewood, 1990). Furnham (1994) has described these lay theories of illness as 'lay models of psychiatry', although, as Helman (1990) remarks, they need not be based on scientifically correct premises. Their importance lies in the fact, as Helman points out, that they help make sense of ideas about illness and what it entails.

Much of the research that has examined how people explain and understand illness has been focused on formulations of illness of the sick person with reference to specific aspects the disorder. As a result, researchers have elaborated different formulations of illness models as a way of understanding people's explanations of mental health. The health belief model of Marshall Becker (Rosenstock, Strecher & Becker, 1988) asserts that people's perception of severity of illness and their own susceptibility guide illness behaviour. This model, however, has been criticised as being of limited use with different cultures, seeing beliefs as barriers to the true knowledge of professionals (Good, 1994). It has, therefore, limited use in multicultural settings, although Quah (1985) has tried to introduce a cultural dimension to the theory. Attribution theories, such as Beck's cognitive therapy (Beck 1979) and Seligman's theory of learned helplessness (Abramson, Seligman & Teasdale, 1987) has examined the relationship between illness and outcomes, but are limited by concepts of mental illness which are mainly Western conceptualisations.

Other studies have examined perceptions of how mental health problems are caused (Furnham & Rees, 1988), how mental health problems are perceived and categorised (Schoeneman, Segerstrom, Griffin, & Gresham, 1993) and how mental health problems can be overcome (Kleinke & Kane, 1996). Still other studies have shown a relationship between conceptions of illness, ethnicity and help seeking behaviour (Nunally, 1972; Hall and Tucker, 1985).

One of the most comprehensive approaches to theories of illness has been Kleinman's concept of explanatory models of illness, (Kleinman, Eisenberg & Good, 1978) which focuses on the cultural dimensions of illness. This is a useful way of understanding how the distress is presented, interpreted and treated (Littlewood, 1990; Krause, 1994; Jadhav, 1996; Weiss, 1997). Initially developed in clinical use and to understand the role of culture in mental distress, it focuses on the meaning of illness and the way
people understand it. Its importance lies in the fact that its focus is on information on cultural beliefs, meanings, and expressions by providing explanations for five aspects of illness: aetiology, timing and mode of onset, process of patho-physiology, history and severity, and appropriate treatment (Kleinman, 1987). Therefore, explanatory models go beyond lay theories or beliefs about the disorder – they incorporate all aspects of the disorder.

There have been several explorations of people’s beliefs about mental distress that emphasise the cultural nature of health beliefs, and some have attempted to investigate cross-cultural comparisons of lay theories of illness. One such approach is that of Eisenbruch (1990), who, like in Kleinman’s (1980) explanatory models, focuses on the cultural dimensions of illness causal beliefs. Basing these dimensions on Murdock, Wilson, & Frederick’s (1978a) world wide survey of illness models, Eisenbruch developed a cross-cultural research instrument that analysed beliefs about the causal attribution of mental distress of lay people, making the comparison between Western and non-Western cultures. Eisenbruch’s (1990) approach provides an understanding of cultural lay beliefs about the causes of mental distress. It differs from Kleinman’s explanatory models in its quantitative approach and in focusing specifically on one aspect of the understanding of mental distress i.e. attributions of causation.

Kleinman also makes the differentiation between patients’ explanatory models of illness, held in the context of a specific disorder, and general beliefs about mental distress. These lay explanatory models, as Kleinman calls them, are characterised by changeability, ‘vagueness, multiplicity of meaning...and lack of sharp boundaries’ and heavily influenced by both personal and cultural factors. Numerous studies have given evidence of the ‘complexity, interconnectedness, multifactoriality and (inaccuracy) of lay people’s beliefs’ (Furnham, 1994), as well as their ‘multiple and manifestly contradictory’ quality (Eisenberg, 1977). Research has found even culturally determined core beliefs of a group can be changeable according to class, caste, gender and political divisions (Bhattacharya, 1983; Ware & Kleinman, 1992).

Although lay belief systems seem unstable, Eisenberg (1977) deems them valuable in providing an understanding of the cultural construction of illness. They also provide
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an important link to explanatory models, since the patient’s illness attributions will influence the way in which the illness is manifested and to whom they turn for assistance. A particularly meaningful aspect of explanatory models has been emphasised by some theorists. They equate the relationship between lay explanatory models and professionally defined categories to that between illness and disease (Eisenberg, 1977; Kleinman, 1980; Hahn, 1984; Helman, 1990). People’s explanations of sickness can, therefore, be equated to the emic perspective, giving an insider’s view to cultural perceptions of illness (Weiss, 1997).

In that sense, lay models or lay theories can be seen as explanations for mental distress grounded in popular culture, although not in a context specific way as in the case of patients’ explanatory models of illness (Kleinman, 1987). Helman (1985b) finds that, if illness is the social behavioural response to the biomedical condition, the disease, explanatory models do have significance, in that they provide explanations for the individual’s perception of the causes and control of illnesses in different societies. Therefore, they have significance for influencing attitudes to therapeutic behaviour (Fitzpatrick & Scambler, 1984).

Anthropologists have emphasised the interconnectedness of the different aspects of mental distress. As Fabrega (1989), posits “…beliefs about mental distress differ with each culture, that illnesses themselves are different, in incidence and/or presentation in distinctive cultures and that these culturally determined health beliefs influence the pathways taken to help seeking” (p. 419). Both Kleinman (1980) and Weiss and colleagues (1995) give evidence of this network of connections. Kleinman’s elaboration of the connection between beliefs, explanatory models and psychological processes is illustrated in what he terms a ‘semantic sickness network’ (See figure 2.1). Similarly, Weiss, Doongaji, Siddhartha, Wypij, Pathare, Bhatawdekar, Bhave, Sheth, and Fernandes, (1992) formulated a framework for the comparative study of explanatory models of illness. In a detailed and comprehensive research undertaken to construct a format for semi-structured interviews to elicit explanatory models, (which Weiss termed the ‘EMIC’), they found that information extracted by the EMIC covered all aspects of the patient’s beliefs and experience surrounding the disorder.

Weiss’ (1997) contribution has been to clarify that that the main features that
characterised people's formulations of illness were perceptions of the causes of mental distress, idioms of mental distress and associated help seeking behaviour. Therefore, it is reasoned that these three features form a reliable basis for assessing and comparing lay explanatory models within and across cultural groups. On this basis, evidence of cultural differences of lay models of illness between Western and non-Western cultures are reviewed with reference to these three aspects of mental distress:

• Beliefs about the causal attribution of mental distress;
• Presentation or symptomatology of mental distress;
• Attitudes to seeking help for mental distress.
Figure 2.1 Popular Explanatory Models, Semantic Networks And Health Care Seeking (Kleinman, 1980)

- Typical symptoms and psychological processes associated with particular types of illness problems
-EXPLANATORY MODELS (patients' EMs and/or family EMs) (sickness labels and cultural idioms for articulating of illness experience)
- Beliefs about causes and significance of particular types of illness problems
- Health seeking choices of available treatment options for particular types of illness
- Typical social problems associated with particular types of illness problems
2.3 Cultural beliefs about the causal attributions of mental disorder

Over the years, theorists have posited that lay theories of illness situate the causes of ill health in one or several of the following: the individual, the natural world, the social world, and the supernatural world (Murdock et al, 1978; Marsella & White, 1982; Landy, 1983; Eisenbruch, 1990; Helman; 1991). Therefore, when examining cultural differences, many of the typical studies in this area have demarcated differences along these dimensions based on western and non-western distinctions. An example can be given of Young (1993), who postulates that the first two feature more strongly in lay and professional explanations in the developed world while the latter two are common features of the developing societies.

Although western Cartesian mind-body dualism – (which might, in a sense, be seen as reflecting the disease/illness dichotomy) - has been contrasted with the multidimensional aspects of other societies, simple and generalised distinctions between cultures are often difficult to make. Popular Indian causal beliefs of minor psychological distress, for example, are often attributed to a purely physiological origin (Weiss et al, 1986). However, by and large, there is broad agreement in the literature that people from the non-Western cultures are likely to have a more holistic approach to mental distress. Therefore, although most studies have investigated different distinctions as Western and non-Western dichotomies, these distinctions can only be made in broad terms, as has been elaborated by earlier discussions.

There is a body of evidence that has shown that fundamental differences exist in the notions of the individual, as epitomised by the body and self, between Western and non-Western cultures (Marsella et al, 1982; Lock 1989; Ware & Kleinman, 1992; Littlewood & Lipsedge, 1997). In the West, the principal locus of thought and action is seen as being within the individual, the ‘autonomous social actor’, especially in the case of illness (Marsella, DeVos, Francis, & Hsu, 1985a). Distress is therefore expressed with reference to individual affect and thought. This western perspective is

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*Much of the research in non-western cultures has been based on eastern cultures, such as China and India.*
evident in the formulations of the Present State Examination (Wing, Cooper & Sartorius, 1974) and the World Health Organisation's IPSS (Kleinman, 1987), as well as in therapies, such as psychotherapy. Indeed, this Western ideology permeates all biomedical scientific enquiry (Littewood, 1990).

In contrast, Marsella and colleagues (1985b) report that in most eastern societies, the differentiation of self is along criteria different to that in western cultures. The essential unit is not the body, and the self is more socially oriented than individual. As Lock (1987) explains, there is "no clear-cut demarcation line between self and other" in the more traditional cultures. This effectively moulds kinship systems, (Firth & Forge, 1969), the major determining aspects of a culture, differently in different cultures (Littlewood, 1985). As a result, as Littlewood explains, beliefs and values 'are articulated primarily in terms of complex systems of kinship'. Although Firth et al (1969) have suggested that the immediate nuclear family is also an important influence on values and behaviour in Western societies and distress can also be seen in relational or family terms, Littlewood argues that, in industrialised societies, kinship is less significant.

This relational nature of emotions and illness raises important implications regarding cultural concepts of 'personhood' and 'selfhood' (Mauss, 1985). 'Personhood' refers to the aspect of an individual's existence in which he/she plays a social role as a member of a collective, while 'selfhood', on the other hand, refers to the mental and physical awareness that human beings have of their own individuality (Krause, 1995). Shweder and Bourne (1991) in referring to the self as 'socio-centric' in non-western societies and 'egocentric' in western societies, postulated that in the Western world, behaviour is centred in the individual while in a non-Western society, illness is not regarded as a personal problem. As a consequence, in the former, the individual is open to the processes of abstraction and reflection. In contrast, they found that, in their study of the Oriyan Indians, cognition is primed to be contextual. The 'self' is understood only in the context of the external. Littlewood (1990) explains how the traditional Hindu notion of the self, (atman), reflects a transcendental being, equivalent to the 'soul', in Christianity. Pedersen (1979) sums it up thus: "The emphasis is not on atman as an individual, self-contained unit, but part of an absolute core of
The latter point illustrates one particular dimension on which western and non-western cultures are often seen in opposition. Although, as Landy (1983) reports, most societies understand the causes of mental health problems by giving both natural and supernatural explanations in most societies, research has found most culturally divergent variations along the latter dimensions. Thus, Western beliefs focus on the physical beliefs of illness while greater weight is given to supernatural causes as the origins of misfortune in the more traditional cultures, such as in India (Pedersen, 1979). In the UK, too, Stopes-Roe & Cochrane (1990) have found that, in contrast to the dominant Western lay beliefs about biomedical or psychological causes, causal beliefs of people from the Indo-subcontinent commonly include religious and supernatural constructs.

Furthermore, research has also shown that, in the notions of Western ideology, particularly that of Western biomedicine, a separation exists between the mental, physical and the spiritual aspects of the individual. (Hatfield, Mohammad, Rahim & Tanweer, 1996), This separation is not evident in the belief systems in non-Western cultures. Studies have found non-western beliefs to be based on an interdependence of ‘somatic processes, supernatural forces and social relations’ (Marsella & White, 1982) which are seen as causal agents rather than the individual. As Fernando (1995) elaborates, non-western cultures can experience both physical and spiritual dimensions to mental distress.

The emphasis on the external (i.e. beyond the body and self) is explained by both Kakar (1982) and Zimmerman (1992). In their understanding, Ayurvedic ideas – the symbolic correspondence between the macrocosm of the Universe and the microcosm of the body - perceive the body and the person as fluid and permeable. This permeability of the boundaries of the body and the person extend beyond the influence of purely natural substances and energies, so that it renders the person penetrable to the influence of others.

While research in the last fifty years has emphasised differences along Western and non-Western lines, it is worth noting that notions of mental illness and its causes were similar in both cultures over several centuries. Religion and religious doctrine, being
of great historical importance in Europe and the Asian sub-continent, played a major role in defining and interpreting ill health and particularly mental health. Writing on 17th century medical practices in England, in a review of ‘Mystical Bedlam: Madness, Anxiety and Healing in Seventeenth-Century England’ by Michael Macdonald, the reviewer notes: “It was not unusual for practitioners and patients to embrace scientific and supernatural explanations for disease simultaneously – explanations that appear contradictory to the modern observer” (Dagi, 1982).

Also prevalent in both continents, as an explanation of madness, were the theories of the hot / cold bodily systems (Littlewood, 1990) as well as of the four humours (Weiss, Desai & Jadhav, 1988). Over several centuries, they shared basic concepts, partly through a process of exchange but also because of the socio-cultural climate. In Europe, the growth of the industrial revolution and the decline of the church transformed the religious perspective of the man into the scientific and particularly the psychiatric (Szasz, 1961). With the responsibility for health shifting to the state, the mind-body dichotomy was maintained on the basis of the biomedical model.

By comparison, in the Indo-subcontinent, the influence and the spread of western therapies for the treatment of mental illnesses have been slow, although the medical model is present even in these therapies, since most psychiatrists from the Indo-subcontinent are educated in the West. However, to this day, mental health professionals are few, even in the big cosmopolitan cities of India and Pakistan. A. Husain, (writing in ‘DAWN’, dated 9th May 1998), gives an example of Karachi, a city of 12 million people, which has around fifty psychiatrists. Nevertheless, in the last decade, research has shown evidence that allopathy, for treatment of all disorders, is over-taking traditional treatments in the Indo-subcontinent (Hunte & Sultana, 1992; Christakis, Ware, & Kleinman, 1994). There is evidence of the widespread use of allopathic medicine given for treatment, even by traditional healers (Christakis et al, 1994).

Notwithstanding this advance of western bio-medical ideas in the Indo-subcontinent, the most notable feature of belief systems of the people from the Indo-subcontinent, over the years, has been its pluralistic nature. It is remarkable not only for its enduring quality but also for the variety of concepts and treatment that constitute attitudes to
mental distress in that culture (Leslie, 1980). In addition, the prominence of religion till today (Jadhav, 1995; Littlewood & Lipsedge, 1997) and the fact that traditional practices still flourish, have resulted in a much more rigid and structured system of beliefs in this culture than exist among the indigenous population in Western cultures (Helman 1990; Blaxter 1983).

Thus along with the Western biomedical model (Ramesh & Hyma, 1981), three conceptually separate traditions dominate. Leslie (1976) classifies them as supernatural causes, disturbance of the humours, and a dysfunction of the physiological processes. Weiss and colleagues (1986) have elaborated on this pluralistic characteristic by pointing out that traditional medicine in India consists of both a folk tradition and a classical tradition. The latter is associated with humoral explanations, the former with more supernatural explanations. Therefore, causes of mental distress can range from arising from particular humoral imbalance (such as the hot-cold dichotomy or semen loss), or as punishments from demons or deities; they can also include astrology, karma, or notions arising from modern western medicine (Weiss 1986). These pluralistic beliefs persist to the present day, both in India (Bhattacharya, 1983), as well in the Asian communities in Britain (Hatfield, Mohamad, Rahim, and Tanweer, 1996).

Over the last twenty years, anthropologists and psychologists have formulated various classifications of belief systems of different cultures, structured to taxonomise culturally constructed beliefs about illness. These systems use differences to clarify distinctions in illness beliefs along different dimensions. These classifications systems have often been used as a basis for assessing differences in cultures, most commonly between Western and non-Western ones. A review is given below of some of the classifications that are particularly relevant to cross-cultural research.

2.3.1. Classification of illness belief systems

Various classifications of culturally constructed beliefs about illness causation have been formulated to provide a comprehensive range of causal beliefs in different cultures.
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Foster (1976) formulated a classification system for lay illness aetiologies, which differentiated between natural and supernatural causes by distinguishing between naturalistic and personalistic belief systems. In naturalistic beliefs, illness is explained with reference to systemic operations, seen as disequilibrium within the individual or the social environment; in personalistic beliefs, illness is due to the intentional intervention of an agent such as another person or a supernatural being (God, gods, sorcerers, witches). In a similar way, Young's (1976a) classification of belief systems differentiated between internalising and externalising beliefs systems, the former emphasising physiological and pathological processes inside the individual and the latter emphasising the aetiology of the illness as being located outside in the social world, including the supernatural world. (See Figure 2.2).

It is clear that these internalising and externalising beliefs systems can also be equated to universalist/relativist perspectives in cross-cultural psychiatry, the former being equated to the perspective of biological determinism in psychiatry, the latter to the anthropological perspective. Young suggests that while most cultures employ both kinds of explanations, internalising explanations characterise 'structurally, complex, literate state societies' while the externalising explanations characterise 'structurally simple' societies. However, he points out that despite "reductionist attempts....... have been made to find connections between biophysical functions and explanatory beliefs, cultures are free to choose or ignore particular phenomena" (p. 147).

Murdock, Wilson and Frederick (1978) used these classification systems as the basis for a combined etic and emic cross-cultural comparison of theories of illness causation. Eisenbruch (1990) also investigated beliefs about mental illness cross-culturally. His classifications combined the framework of Murdock et al with other aspects of folk and supernatural beliefs in order to measure the full range of causal beliefs of mental illness. They included a range of internalising and externalising items as well as naturalistic and personalistic items, as suggested by Foster (1976), Young (1976a, 1976b) and Landy (1983). Research carried out in a multi-cultural setting demonstrated the dimensions of causal beliefs: causes related to western explanations (relating to physiological causes and stress) vs. non-western explanations (relating to physiological causes and supernatural). These explanations could be
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distinguished, in turn, as naturalistic vs. personalistic explanations.

**Figure 2.2 Models of Culturally Constructed Beliefs about Illness Causation**
(after Landy, 1983)

<table>
<thead>
<tr>
<th>Foster (1976) Theories of illness</th>
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<tbody>
<tr>
<td>Causation, categorisation, functions of healer, locus responsibility, levels of causality, prevention.</td>
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**Personalistic**
- Magic and Religion
- Is part of a more comprehensive theory of misfortune
- The agent and the instrument must be specified
- The curer must specify 'who' and 'why'

**Naturalistic**
- Theory is restricted to the disease
- Person 'causes' illness through doing or not doing what he/she is supposed to do

**Young (1976a): Classification of medical systems**

**Internalising**
- Physiological explanations are emphasised
- Etiology is linked to sequence of biophysical signs
- Events are ordered within body from onset of symptoms to conclusion of illness

**Externalising**
- Etiological explanations are emphasised
- Narratives are given in which medically important events take place outside patient’s body
- Links in time identified between agencies/events with causes and effects

**Young (1976b): Analysis of medical systems**

**Practical**
- How the disease occurred
- How it can be treated

**Social**
- Agencies, events, actions and processes are related to the disease

**Ontological**
- Sickness challenges meaning in this world, while medical beliefs organise the event into an episode that restores meaning
- Practical meaning are translated through social meanings into a dramaturgical event

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Despite the intentionally comprehensive nature of these classification systems, they have been criticised by Landy (1983) on several counts, especially for dichotomising natural and supernatural agencies, thus demonstrating their 'western ethnocentric view of nature', one which would be at odds with non-western notions. In addition, although there is much evidence that non-western cultures have numerous perceived causes of the same problem, a combination of causes or interaction between them as compared to western societies, multi-causal explanations exist in both western and non-western cultures (Helman 1990). In both cultures, therefore, causes are not seen as mutually exclusive different aetiologies of Western and non-Western origins but are often linked together. As a result, in Weiss' (1997) view: “Explanatory models refer both to independent, locally rooted concepts as well as to local interpretations of professional ideas; prevailing ideas about illness are not necessarily easy to classify as emic or etic (p. 236).” Nevertheless, Eisenbruch argues that these categorical distinctions in assessing people’s beliefs are useful in that they define the dimensions of people’s explanatory models of mental distress and illness.

Indeed, evidence for similarities and differences between lay theories of illness in different cultural groups have been provided by recent studies in the UK. Mcallister and Farquhar (1992) found that both British and Asian women attributed their ill health to family relationships. Asian women, however, also made attributions to ‘too much heat as a result from eating the wrong food’. In Hatfield and colleagues’ survey (1996) in an Asian community, similar causal attributions of mental health problems were made to attributions made by white British members of the public in a neighbouring borough (Huxley 1993a; 1993b). Both findings showed that people associated social stress and family problems to mental health problems. However, Asians, in the former survey, also attributed their problems to the ‘will of God’.

2.4 Cultural variation in the expression of mental distress

Much of the evidence in transcultural psychiatry and the ‘new’ cross-cultural psychiatry, from both epidemiological and descriptive studies, has focused on the presentation and the expression of mental distress (Sartorius 1986; German, 1987;
Ware & Kleinman, 1986; Ware & Weiss, 1992). That is not surprising since both expression and presentation of a disorder are governed by emotion and language, neither of which can be understood outside the culture (Mumford, 1993). Furthermore, as has been shown in discussions earlier, symptoms of mental disorders have social and symbolic associations that are embedded in the culture (Lewis-Fernandez & Kleinman, 1994) and hold particular signification in the culture. Therefore, the study of cultural variations of presentation of symptoms is crucial to an investigation in the link between culture and all aspects of mental distress.

Culture specific expressions of distress are, as Ekman (1986) has described, built on basic universal emotions. In so doing, they implicate the language, metaphors and symbolic concepts of that culture. Marsella, Tharp, & Cibrowski, (1979) make a further point out, that emotions also fulfil a functional role. They are interpreted according to the functional role they play in the maintenance and enhancement of cultures, as well as in social regulation. This evidence seems to underscore the notion of the cultural relativists, that the meaning and value underlying emotions and behaviour may vary so much between cultures that it affects the very definition of what is and what is not considered a symptom in the first place.

2.4.1 Somatisation vs. psychologisation

One variable that has attracted considerable attention has been that of the somatic expression of emotional or mental distress in non-Western cultures as opposed to the Western cultures. A great amount of research, in the last thirty years, investigating cultural variations, has shown striking differences between cultures in the somatic expression of idioms of distress (Kirmayer, 1989). These studies indicate that non-Western cultures, specifically eastern cultures, express distress as bodily symptoms much more than the Western cultures (Kirmayer, 1984; Ware & Weiss, 1992; Kawanishi, 1992). Indeed, Angel and Thoits (1987) have related somatisation directly to culture.

Several reasons have been given for somatisation in eastern cultures. To begin with, emotional experience is seen to be localised in parts of the body, as in Japanese view.
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of the stomach as the emotional centre of the person (Lock, 1987a) or as in the Ayurvedic theory that emotional shock may block channels of the heart.

The bodily expression of distress has been considered, both in psychiatric diagnosis and empirical enquiry, secondary to the affective symptoms, as for example, in depression. Until recently, the somatic expression of distress has been "problematised by psychiatrists, psychoanalysts and social scientists" in comparison to either an organic explanation or a psychological expression of distress (Kirmayer, 1989). Although somatisation has often been assumed to be subordinate to depression in many cultures (Shweder, 1991), these assumptions have been challenged by Weiss, Raguram, and Channabasavanna, (1995), amongst others. They argued that given that, in the case of some developing countries such as India, somatisation is the predominant symptom rather than secondary to depressive symptoms, depression might well be considered secondary to somatisation.

However, a striking level of somatisation has been found in Asian populations by several studies. These have reported dominance of the reduced frequency of psychological aspects of expression in preference to somatic expression (Wraziri, 1973; Rack, 1979; 1982; Rao, 1986). Somatic symptoms have been found to be related to both levels of anxiety (Nayani, 1989) as well as depression in Asian psychiatric patients in the UK (Bal, 1989) Over the years, various assumptions underlying the phenomenon of somatisation have been made. Henley (1979) attributed the somatisation of Asians to a poor understanding of psychological causation. Skultans (1986) assumed that there was a poor understanding of ideas of psychological explanations.

More recent studies have shown somatisation to be much more prevalent in all cultures. Mirdal (1985) points out that a somatic expression is often an accompaniment to other expressions of distress. He considers the opposition of somatic and emotional/social idioms, which is more prevalent in the West, as problematic. He argues that both somatic, as well as emotional or mental signals, can be evidence of mental distress. This distinctive cultural difference could lie in a cognitive bias, as outlined by Robbins & Kirmayer (1986) in their model of illness cognition, towards either the somatic or psychological expression of distress.
Later studies in primary care in Britain and in North America suggest that the somatic expression of distress is equally common in western societies as in eastern societies (Goldberg & Bridges, 1988; Kirmayer & Robbins, 1996). Great cultural differences between cultures are now not seen to be apparent in somatic expression. Indeed, it is now widely accepted that medically unexplained somatic symptoms are common in all types of patients seen by general practitioners (Bridges, Goldberg, Evans & Sharpe, 1991; Mumford, 1991). This phenomena of somatisation automatically leads to a comparison, between cultures, of the psychological expression of distress as well, i.e. the modes of expression that refer to self, emotion and theories of mind (Kirmayer, 1989).

To a smaller extent than somatisation, studies have shown differences in psychological and socio-moral expressions of distress between Western and non-Western cultures. Research has shown that there is a primacy of psychological explanations in the West, (Kirmayer, 1989). Empirical findings have demonstrated that while western psychology relates its suffering by emotions, thoughts and inner moods, non-western societies express emotions closely interdependent with interpersonal factors as well as somatic processes (Marsella et al, 1982; Kleinman, 1987).

Although Harre (1983) related Western psychological expression to industrialisation, most theorists consider that the differences in both psychological and socio-moral expressions of distress rest on the basic assumptions of differences in cultures of self and ‘other’, as shown in earlier discussions. Both Lock (1987b) and Kleinman (1977) suggest that this is the key distinction i.e. the dichotomy of unitary self or otherwise, which account, as in the conceptualisations of mental distress, for cultural differences in presentation of symptoms. This difference, Lock suggests, is reflected not only in perceptions of ‘self-other’ relationships but also in the understanding of emotions. Therefore, the emphasis on psychologisation in the West is based on notions of individuality, self-expression, and self-actualisation. Accounts of distress place the causes of suffering on inner moods, thoughts and feelings.

In contrast, in more socio-centric cultures, in which the individual is subordinate to social institutions such as family and society, distress is seen in terms of social or
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moral disruption (Kirmayer, 1984). As opposed to western ideas, personal negative affect is considered unimportant compared to the continued stability of family and society (Potter, 1988). Lock’s (1987a) research on the Japanese culture also shows that somatic and emotional distress is treated as expressions of socio-moral dilemmas. However, as both Ekman (1986) and Kirmayer (1984) reason, cultural norms of expression, mediated by the cultural concept of the person, are built on basic universal emotion. Both psychologisation and somatisation are the consequence not only of the individual’s concept of self but also of social acceptance of symptoms. In the more socially oriented cultures, somatisation, rather than psychologisation, assigns the somatiser the ‘sick role’. Thereby, the sickness is validated and interpersonal relationships are re-defined.

Several researchers have suggested that the lack of psychological presentation of distress by Asians to general practitioners is due to a somatic presentation (Brewin, 1980; Rack, 1982; Shaikh, 1985; Bal, 1987). Other studies have implicated language, the most culture specific of all features, for cultural differences in idioms of distress. It is clear that the role of language and metaphor is particularly relevant to the expression of mental distress. In a controversial paper, Leff (1973) claimed that some languages lacked a differentiated lexicon for emotions. The observed absence of specific words for depression and anxiety were associated with a lack of psychological mindedness in cultures. However, in 1988, Leff acknowledged that his schema for the development of emotional differentiation ignored the possibility that bodily complaints might be used symbolically. Mumford (1993), in investigating somatisation in Asians, has also argued that the absence of psychological affect cannot be assumed because of a lack of particular words to denote these states. He gives the example of Urdu (one of the main languages in the Indian sub-continent) as a rich and expressive language for communication of these emotional states.

There is also the issue of perceived stigmatisation that is assumed to determine levels of psychologisation or its twin aspect, somatisation. The stigma attached to psychiatric disorder is felt in all cultures, since its manifestation can lead to loss of face, control, income, etc. (Kirmayer, 1989). Although studies have shown that stigmatisation of the mentally ill exists in the West too (Goffman, 1964; Farina,
the assumption of the fear of stigmatisation has been particularly related to non-Western cultures. This relates to the notion that while Western societies employ a psychological idiom of distress based on the cultural concept of autonomy, in eastern cultures, psychologisation is often both culturally and socially inhibited.

Indeed, this was the conclusion reached by Hinton & Kleinman, (1993) in investigating neurasthenia, in China. They found that the symptoms associated with this disorder were culturally sanctioned idioms of distress particular to a Chinese cultural context in which 'psychologised' expressions of distress are highly stigmatised. Studies in other cultures have suggested that stigma may arise from fear of danger or contagion, or, in some cultures, may be a reflection of wrong doing. It has also been shown that some symptoms are given particular negative social value in a culture and this determines the extent of stigmatisation, such as passivity and withdrawal in North America (Ware & Kleinman, 1992).

In the case of Asians in Britain, the fear of stigmatisation has been assumed to be responsible for low levels of use of health services by the Asian community in the UK (Ineichen, 1990; Gupta, 1990). Research, however, has not yet undertaken specific studies looking at this aspect of mental distress, possibly because of the difficulty of investigating this highly subjective and personal attitude towards seeking help for psychological distress. These are reviewed in the next section, along with the pathways taken to treatment for mental distress.

2.5 Culturally determined attitudes to seeking help for mental distress

The study of the relationship between ethnicity and conceptions of mental illness have explored how people’s explanatory models of illness include causal attribution and presentation of a disorder as well as determining patterns of help-seeking (Kleinman 1980). Examining the inter-connected nature of all aspects of illness has been a feature of many studies on mental distress, because the constructions of mental health and mental disorder determine both behavioural and social responses (Kleinman, 1988; Kirmayer, 1989; Weiss, 1997). For example, conceptions of mental illness have been shown to be associated with attitudes associated with seeking psychological help
(Hall & Tucker, 1985) while the expression of somatic symptoms is considered a major factor in the rate of GP consultation (Bal, 1987).

Although attitudinal differences underlying actual help seeking are assumed to be culturally determined (Cochrane & Bal, 1987), studies investigating the link between attitudinal beliefs and help seeking behaviour have been few. However, the relationship between culture and the conceptions of treatment have been widely reported in a number of studies (Weiss et al, 1986; Bal 1987; McCarthy, 1987; 1988). Christakis, Ware & Kleinman (1994) state that both definition of symptoms and action taken for treatment are influenced by lay consultation and referral and by the social networks of the individual. While this has been assumed to mean that it is the West that offers more choice of treatment (Littlewood, 1990), in fact it is often in developing countries, such as India, where the choices are unlimited. While it is only in “contemporary Western societies, where the power to cure, legitimise, explain, is monopolised by professional healers” (Young, 1976a), in most non-Western countries there is a variety of diagnosis, with a variety of treatments, some that are ‘professional’ and some that are not. The individuals’ attitudes concerning both the disorder and its therapy will determine the path taken for seeking healing (Helman, 1990).

Weiss (1986) reports that, in the sub-continent, folk traditional practices do not proceed on the well-known principles or theories of the medical classical school. Folk practitioners are associated primarily with a supernatural explanation of illness while the classical traditions of medical practices such as Ayurveda and Unani, are associated with humoral explanations. The Ayurvedic tradition is more prevalent in India and the Unani tradition more prevalent in Pakistan. Both traditions exist side by side with allopathy, offered by doctors trained in the biomedical tradition either in their countries of origin or in the West. Ramesh et al (1981) comment that even though overall trends may appear to be moving to the adoption of a more scientific therapy, especially in urban areas, Indian and Pakistani systems and its practitioners are not diminishing. These healers are differentially consulted depending on the individuals understanding or perception of illness (Kapur, 1975).

In the UK, a considerable body of research, over the last fifty years, has investigated
different aspects related to the mental health of ethnic minorities in Britain. Cultural differences between the indigenous population and migrant groups in the UK have had different aims. Some aimed to investigate levels of psychological symptomatology, or incidence of different disorders (Cochrane & Stopes-Roe, 1977, 1981; Cochrane, Hashmi, & Stopes-Roe, 1977). Another stream of studies investigated, through epidemiological studies, the use of services provided within the National Health. These studies looked at rates of hospitalisation (Cochrane, 1977; Cochrane & Bal, 1989), GP consultation (Rack, 1982) and rates of diagnosis of specific disorders (Fernando, 1995). Findings of such research have not, however, produced a clear picture of mental health of the Asian community or the attitudes of the different groups to seek help for mental health problems.

Nevertheless, results of several studies (Cochrane & Bal, 1989; Gupta, 1990; Moodley & Perkins, 1991; Thomas, Stone, Osborn, Thomas & Fisher, 1993) suggest that the pathways into care and experience of health and psychiatric services are different for members of ethnic minority groups, compared to the native white population. In the case of the Asians living in the U.K., studies investigating the incidence of mental illness by looking at the use of health services have revealed their under-representation in British mental hospitals and in psychiatric out-patient clinics (Cochrane, 1977; Cochrane & Bal, 1989). Despite evidence from small studies to the contrary (Brewin, 1980; Mahmud, 1987), Asians seem to consult their general practitioners more frequently than do native Britons (Murray & Williams, 1986; Balarajan, Yuen & Raleigh, 1989; Gillam, Jarman, White & Law, 1989). However, these high consultation rates do not apply when mental illness alone is considered (Balarajan et al, 1989).

Two of the most common assumptions about Asians have already been discussed i.e. the notion that ideas of psychological explanations are poorly understood (Henley, 1979; Skultans, 1986) and the tendency of Asian patients to focus on somatic complaints when consulting GPs. Other theorists suggest that mental illness is managed within the family (Henley, 1979; Cochrane, 1983; Schofield, 1987) or that Asian families do not seek help for mental distress because of fear of stigmatisation (Littlewood and Lipsedge, 1978; Rack, 1982). There is also an assumption that there
is a leaning towards 'alternative healing' or traditional healers (Skultans, 1986). However, Bhopal (1986) found that although a quarter of those from one sample who had visited the sub-continent in the last year had consulted an Asian healer while they were there, there was little evidence that this was happening on a large scale in the UK.

Several different hypotheses have been put forward that might have a bearing on Asians' attitudes to seeking help for mental distress. One hypothesis is that the extended family system has transplanted itself, to a large extent, from the Indo-subcontinent to Britain (Stopes & Cochrane, 1990). This extended family, it is argued provides the support network in times of distress. This has been confirmed both by Birchwood, Cochrane, Macmillan, Copestake, Kucharska, and Cariss, (1992) and by Gupta (1993).

Other surveys have identified poor knowledge of mental health services in the community (Huxley 1993a), while some have found that Asians perceive low levels of support from services with predominantly white British service users (McLean, 1988; MIND, 1990; Hatfield et al, 1996). Since research has shown that the extent of acculturisation is crucial for pathways taken to treatment (Bagley 1971; Cochrane 1983), it is argued that the alienation felt might be due to lack of language, or the perceived lack of culturally appropriate services.

Few studies have focused specifically on cultural differences in attitudes towards help seeking for psychological problems, despite the importance of the practical application of research in this area. Increasingly, concerns are being voiced about the experiences of ethnic minorities and about the nature of the service provided (Webb-Johnson, 1991; Beliappa, 1991). This investigation, therefore, aims to contribute to this important area of research.

2.6 Summary

Research has shown cultural variations in the three important features of lay models of illness - causal beliefs about the causes of mental distress, presentation of distress and attitudes related to seeking help for mental distress. A review of western and non-
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Western differences in lay models of mental distress and the basis on which they are constructed have illustrated that culture mediates in the underlying assumptions of notions of self, 'other', natural and supernatural agencies. This mediates in the understanding of mental distress, although cultural distinctions may be eroding.

Evidence has shown that non-western beliefs about mental illness are more holistic, incorporating spiritual, physical and social dimensions while beliefs in western societies emphasise the body-mind distinction. Non-western cultural groups, in comparison to Western groups, have also been shown to present with somatic expressions of distress and have fewer ways of psychologically expressing their mental distress. Several hypothesis have been put forward for this feature of expression of distress, ranging from lack of expressive language to fear of stigmatisation.

In the same vein, assumptions and conclusions about the attitudes to the seek help and to the treatment of mental distress, in the Asian community in the UK, have most often implicated particular cultural characteristics of this cultural group. These have ranged from the mediation of family support networks to lack of knowledge about services available. Higher GP consultations in comparison to the native population have been explained by the higher levels of somatisation found in this group. Other studies have cast doubt on these assumptions. It is clear, therefore, that more research is needed that specifically investigates Asians' attitudes towards seeking help for mental distress.
CHAPTER 3

The Methodological Framework for the Research
3.1. Overview

Although Kleinman (1987) decries the fact that psychiatry has largely ignored anthropological insights into culture’s role in people’s explanatory models, there is no doubt that the ‘new’ cross-cultural psychiatry’s call for a more ethnographic perspective on cross-cultural research has impacted on research methods in psychiatry and psychology. The outlook of its ‘interpretative and self-reflective eclecticism’ (Littlewood, 1990) has led to an ever-increasing call for a more reflective approach to investigations in different cultures (Berry, 1990; Patel, 1994; Jadhav, 1996; Weiss, 1997).

As a result, the growth of the ‘new’ cross-cultural psychiatry has led to several different ways of enhancing cultural sensitivity on the part of the researchers. While some ‘new’ cross-cultural psychiatrists suggest a purely emic methodology (Kleinman, 1977), others feel the need to move beyond ethnographic and descriptive accounts (Skultans, 1993; Bibeau, 1997). Some researchers suggest a combination of both emic and etic research methods to examine cultural differences (Fabrega, 1992; Patel, 1994) while others argue for a methodology that is both more appropriate for cross-cultural comparisons as well as more quantifiable (Flaherty, Gaviria, Pathak, Mitchell, Wintrob, Richman & Birz, 1988; Leff, 1990).

An important rationale for the latter approach comes from the positivistic stance of psychiatry and psychology. Littlewood (1990), while a major proponent of the emic school of thought, suggested that more quantitative methods needed to be employed if a dialogue was to be sustained between psychiatry and anthropology. Implicit in this statement was an acceptance of the need to make some progress towards an understanding of differences across culture with a research strategy appropriate for ‘good’ research. The impetus for the methodological approach to this research also comes from a desire to find a ‘middle ground’ between scientific empiricism and cultural relativism.

This chapter, therefore, presents the basis for the methodology of this particular research. Although it uses an etic perspective, i.e. it investigates several cultures with
the use of western measurement instruments, it attempts to assess the concepts of mental distress, both emic and etic, in three cultural groups. Although earlier arguments have emphasised their relative, rather than absolute, distinctness, these terms will be used in this research to distinguish between concepts that culturally similar groups share and those that are common amongst dissimilar cultural groups. The rationale behind the methodology of this research, i.e. the choice and basis for cultural samples, type of measurement tools used and types of analysis carried out between the groups, is presented. Firstly, an analysis is made of cultural groups and the features on which their parameters are based. Secondly, specific ways of analysing comparisons i.e. investigating patterns of differences and similarities between three cultural groups are discussed. Thirdly, the choice of measurement instruments is discussed.

3.2 The Quantitative Method in a Cross-Cultural Study

The rationale behind the choice of a quantitative, etic approach in this research was that, in contrast to an emic approach that is bound by both culture and time, this approach allows comparisons between cultures and across time. Furthermore, the nature of emic studies allows investigations only on small sample sizes, such as the study by Fenton & Sadiq (1993). Therefore, while the cultural idioms of a small group of people are explored fully, providing a rich description of beliefs and behaviours, as in the study on Pathan women (Currer, 1986), they lack representativeness as well as replicability. Several theorists have argued for a mixed technique, exploring emic concepts to which etic concepts can be related (details of suggestions in Chapter 1). However, as Leff (1990) has pointed out, this demands enormous resources, both in time and expense. Furthermore, as has been argued earlier at great length, the hybridization of concepts may not allow for this differentiation to be made. Still further, the dilemmas inherent in marrying two different types of knowledge, have not been surmounted. Culturally unique, emic concepts are exactly that, and therefore, relatively impervious
to psychologists, who unlike anthropologists, are not steeped in a particular culture. While giving a valuable insight into one culture, *emic* concepts may not be transformable into more accessible *etic* understanding of concepts. One example that can be given is from research in 'expressed emotions', which attempts to integrate qualitative, phenomenological methodology with quantitative, empirical methodology. The difficulty of transforming the concept of 'over-involvement' as an expressed emotion from a Western understanding to the context of the Indian family and the relationships amongst its members illustrates this point (Jenkins, 1990).

An alternative proposed by Bracken (1993) is the 'post-empiricism' approach, which does not "unlike the traditional anti-positivist approach, suggest that it is wrong to use empirical enquiry or causal explanations with regard to the human or social sphere" (p.270). Rather than discarding the use of standardised questionnaires and interviews in cross-cultural research, he suggests that they would have value if they were to lead to conclusions drawn both tentatively and sensitively. It is in this spirit that this research investigates the concepts across cultural groups living in metropolitan, multicultural settings. Although the approach is *etic*, (and therefore, some 'new' cross-cultural psychiatrists would argue, not valid for a study investigating cultural beliefs), this research takes into account both the aims, as well as the limitations, of cross-cultural research carried out in particular populations.

What is not suggested is a reversal to a culturally insensitive methodology – one that is a quantitative comparison between cultures without regard to the cultural groupings, number of cultures or types of measures. Nor is the suggestion one that entails a paradigmatic shift that completely shuns qualitative methodology (important for the understanding of culturally unique concepts). In the suggestion of Krause (1994), the crucial point is not how much one approach is quantified and the other qualified but rather how the labour is divided. While an *emic* paradigm can provide validity of cultural meanings in one specific culture, the *etic* paradigm can provide reliability of concepts that are shared across cultures. Thus, meanings that might be equivalently understood across cultures can be assessed and examined.

Therefore, this proposition aims to be a more practical, pragmatic approach to
investigating both culture-specific and shared concepts, across sizeable cultural samples, as a step towards understanding similarities and differences in these groups, as is suggested by the ‘universalist’ approach put forward by Segall, Lonner and Berry (1998). Although this methodology might not be appropriate for isolated communities, it is considered appropriate for the samples of the studies included in this investigation. Discussions of the underlying framework for the research are presented below.

A principal issue is whether social responses are mediated solely, or even primarily, by culture or by other factors that impinge on cultural groups. One of the aims of this chapter, therefore, is to consider factors that delineate cultural boundaries. This chapter also considers how comparisons between groups might be carried out in a way that investigates both maximum differences and maximum similarities, which might be useful in teasing out \textit{emic} and \textit{etic} concepts. An important aspect is the reasoning behind the type of measures used for this cross-cultural research. Therefore, this chapter begins by considering the basis on which quantitative methodology has been chosen. It then considers the following questions:

1. Where do the parameters of a cultural group lie? Is ‘culture’ the only mediating factor in the influences on an ethnic minority group?
2. Given that cultural groupings are not isolated homogenous units, how can concepts be examined to ascertain both \textit{emic} concepts (unique to a culture) and \textit{etic} concepts (shared with other cultures)?
3. Given that this is a cross-cultural study, what is the basis on which the choice of measures is made?

\subsection*{3.3 The parameters of cultural groups}

This research focuses on the ethnic minority group referred to as British Asians. It is a heterogeneous one, containing different cultures and religions, with different migration histories as well as different geographical and socio-economic locations.

The fact that research has, by and large, treated this group as genetically and culturally
homogeneous, is the reason given, by some theorists, for the over-all contradictory nature of the findings (Inechein, 1990; Glover, 1991). For example, in research investigating the mental health of British Asians as a whole, some studies found an excess of compulsory admissions for mental disorders (Pinto, 1970; McGovern & Cope, 1987), while other studies (Hitch & Clegg, 1980; Shaikh, 1985) found no differences between the migrant and the indigenous samples. Overall, studies on hospital admission rates for neuroses gave the same inconclusive picture. Cochrane (1981) had found lower national rates in Indians and Pakistanis. However, Carpenter & Brockington (1980) found higher rates of neuroses in Manchester which contrasted with the findings of London (1986) who had found no significant difference between the migrant and the native samples.

On the other hand, studies that investigated this ethnic group by splitting it up into its component sub-cultural groups have not resulted in unequivocal findings either. Cochrane (1987) found low hospital admission rates for both Indian-born and Pakistani-born individuals, but another study of first-time admissions in south east England found high rates for Indians and low rates for Pakistanis (Dean, Walsh, Downing, & Shelley, 1981). A study in Bradford of first-time admissions between 1968-1970 found low rates for Indians and high rates for Pakistanis (Hitch, 1981), but Giggs’ (1986) findings showed the opposite picture on the Nottingham case register, with high rates for Indians and low rates for Pakistanis. The inconclusive nature of these findings emphasises the importance of analysing the basis on which the British Asian cultural groups can be categorised as one group or whether it would indeed be better to investigate this group by its component parts.

Although researchers in cross-cultural psychiatry have assumed that culture was 'out there' ready to be studied, the diversity of conceptualisations of culture are indicative of the problems in defining this variable for research. Secondly, while 'culture' has been operationalised as the ethnicity of the patient (Ware & Kleinman, 1992) in biomedical research, operationalising 'culture', in psychological research, poses major problems. As Fabrega (1992) points out, culture "...has been assumed to refer to non-biological sorts of things when in fact this particular meaning is hopelessly confounded with
what is ordinarily meant by race...replete with genetic and physiological implications" (p. 561). This is, perhaps, not surprising given the biomedical origins of psychiatry and psychology.

However, in recent years, the term 'culture' has typically been used as a term encompassing a set of contextual variables, (political, social, historical, ecological) that are theoretically linked to the development and display of certain behaviour. (Segall, Lonner & Berry, 1998). Although this, and most other conceptualisations of culture, have referred to culture as being defined by what was shared, Littlewood (1990) makes the important point that culture is not only defined by what is common but also by what is different. Anthropologists, such as Helman (1990) point out that almost all societies are made up of more than one culture. There are groups within societies defined by race, religion, class, gender, and a variety of other socio-demographic factors such as rural and urban. In no situation, perhaps, is that more true than that of a multi-cultural society, such as that of Britain in the present day. Needless to say, these discussions apply as much to the Western group of Britons as to the British Asian group and the groups that comprise the British Asian group that are investigated in this study. However, because of the complexities of the groupings of this ethnic minority group, an analysis of the composition of British Asians is considered in detail.

3.3.1 Ethnicity as identity

The cultural group referred to as British Asians are people, residing in the U. K., whose origins lie in the Indo-subcontinent, comprising 2.7 % of the total population and 49.2 % of the ethnic minority population. Within the group loosely termed as Asians, the largest ethnic minority identified in the 1991 Census comprised those who identified themselves as Indian, constituting 1.5 of the total population. Those identifying themselves as Pakistani and Bangladeshi constitute 0.87% and 0.3% of the total population respectively (Office of Population Censuses and Surveys, 1993). The commonly used generic terms, British Asians or South Asians, encompass all three
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groups (Mason, 1995; Smaje 1995) as well as those who arrived later from East Africa. While this demographic picture explains the composition of this ethnic minority group, it is important to clarify that ethnic identity may not indicate other categories of identity (Joshi, 1998). For example, amongst the Indian group, 41.2% were born in the U.K., 36.8% in India, and 16.9% in East Africa (Robinson, 1996).

It is easy to understand why epidemiologists have cautioned the use of the category Asian or South Asian. In Mason's (1995) point of view, it reflects the tendency of the majority to see outsiders as members of a group rather than as individuals. Nazroo (1998), similarly, questions whether 'ethnicity is best viewed as an external definition imposed on ethnic groups by the majority'. Most of the research carried out on cultural groups is on the basis of, what Nazroo terms, 'untheorised identity'. While accepting the extremely difficult and complex nature of this type of enquiry, he argues that a clear theorising of identity is crucial. However, in trying to map out some sort of cultural boundary of each cultural group, the difficulties become very obvious.

The term ‘Indian’ encompasses Muslim, Hindi, Sikh, Parsi, Jewish and Christian as well as Buddhist and Jain, whereas most Pakistanis and Bangladeshis are Muslims. Language transcends national boundaries too. Both Urdu and Hindi, which are colloquially similar, are understood by the majority of people from the Indo-subcontinent, possibly because of the widespread popularity of Indian films made in those languages. English, too, is widely understood, although it is only the middle classes that are fluent in the language. Punjabi is spoken by Punjabis in Pakistan as well as by Punjabis in India while Gujerati is spoken by East Africans as well as some by Hindus from Gujerat in India.

One of the major critiques of studies carried out in this community has been the incorporation of these groups under the term ‘British Asians’ (e.g. Glover, 1991). However, categorising cultural groups according to separate nationalities, e.g. Indians from Pakistanis, would result in national groupings with individuals of different religions and languages, who might well have more in common with those of the same faith and the same language in the other national group. Likewise, both East Africans and Hindus from Gujerat share the Gujerati language but East Africans are
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predominantly Muslim. Given the central role of both religion and language in all aspects of mental distress, highlighted by several theorists (Helman, 1985b; Littlewood & Lipsedge, 1997), it appears that lines cannot be drawn along national boundaries. In addition, the cultures and traditions of Northern India are historically closer to those of Pakistan than those of Southern India.

However, there are other aspects that are not shared between Indian, Pakistani and Bangladeshi ethnic groups living in Britain. They can be contrasted with each other in terms of age structure, geographical distribution within the UK, initial and subsequent employment and housing (Ballard, 1996; Robinson, 1996). They have also had different patterns of migration (Robinson, 1996), as have had the East African group. Furthermore, each of these cultural groups also has amongst them, sub-groups with different levels of acculturalisation, education and bilingualism, which might have more in common with each other than with their own cultural groups.

It is, therefore, not surprising that, in considering the fluid nature of ethnic boundaries, the co-existence of multiple identities and the contextual nature of ethnic identity, Hahn and Stroup (1994) suggest that ‘standard scientific criteria’ may not apply to the measurement of ethnicity. Furthermore, it becomes clear that ethnicity measured solely as identity is problematic. In arguing that the status of migrants contributes to social and economic factors that all the sub-cultural groups have in common, Nazroo (1998) criticises the use of ethnic classifications ‘that allows ethnicity to be treated as a natural and fixed division between social groups’. Thereby, Nazroo emphasises an important shared aspect among these sub-groups. Smaje (1996), too, suggests that ‘ethnicity’ needs to be considered not only as identity but also as structure. This point is discussed in further detail below.

3.3.2 Ethnicity as structure

The socio-economic position relating to migrants has often been implicated in both physical and mental ill-health (Fenton & Sadiq, 1993). Studies on migrant groups,

10 The partition that divided the country in 1947 has left, in many cases, parts of the same extended family in the other country.
starting with Odegaard in the thirties, have shown a higher incidence of psychiatric morbidity (Odegaard, 1932; Hashmi, 1968; Bagley, 1969; Pinto, 1974; King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994) although all these groups have had different settlement histories and socio-economic profiles.

In the UK, earlier findings had shown the migrant group of Asians to have better levels of mental health than the native population, which resulted in the hypothesis of positive selection - i.e. individuals who passed through the migration process successfully were assumed to be psychologically stronger. Later studies have shown that there are ethnic inequalities in physical and mental health, and that these are associated with socio-economic disadvantages (Nazroo, 1997a). The more sombre picture that seems to be emerging of the mental health of Asians, particularly, requires a more careful assessment of their standing in society (Beliappa, 1991).

The demographics of the three sub-cultural groups of Indian, Pakistanis and Bangladeshis differ somewhat. While all three groups have a younger age structure compared to the host society, Indians have an older age structure and higher professional status. Amongst the Indians, 11.4% of employed males are in professional occupations, in comparison to 6.7% of Whites, 5.9% of Pakistanis and 5.2% of Bangladeshis. While the latter group are the most recent arrival in the UK (MacCarthy & Crassiati, 1989), they, along with the Pakistanis, are not only concentrated in manual employment but also have a high unemployment rate (Mason 1995). These two groups are also seen as most at risk of many physical illnesses (Nazroo, 1997a).

However, Smaje (1996), argues that ethnicity cannot be ‘simply emptied into class disadvantage’. Nazroo, similarly, remarks that differences in social class distribution do not totally explain ethnic differences in health. He argues “that there remains some unidentified component of ethnicity that increases (some) ethnic minority groups’ risk of poor health” (p.721). He suggests that this could be because socio-economic factors do not account for other types of disadvantages. These might include diverse factors, such as

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11 Nazroo’s findings here refer mainly to physical health, but recent surveys (Nazroo, 1997b) have also found poor mental health in these ethnic groups.
a lifetime of disadvantage (Davey-Smith, Hart, Blane, Gillis, & Hawthorne. 1997),
living in a racist society (Wilkinson, 1996) or ecological factors (Owen, 1994), such
as living in ‘ghettos’.
On the other hand, it could be argued that the latter point could also be an ‘external
definition’ because, seen from an Asian individual’s point of view, living in an area,
although perceived as a ghetto to outsiders, can provide access to social resources and
a feeling of security. It may, therefore, be seen as an advantage rather than a
disadvantage. What is however, indisputable, if that all immigrants do share the
psychological experience of being the ‘other’, by and largely, one that is often
negatively stereotyped by the host society.

3.3.3 The cultural samples of this research

In order to investigate the role of culture in lay models of mental distress, this
research investigated differences between a Western group, a non-Western migrant
group and a non-Western non-migrant group. In the first two studies, investigations
were carried out between a Western (white Britons) sample residing in and around
London, British Muslim Pakistanis also residing in London and indigenous Pakistanis
residing in Pakistan. In the third study, investigations were carried out between just
two samples: British Asians and Britons.
The British group comprised only of native white Britons. The British Pakistani group
comprised of those individuals who were Muslim and had migrated from Pakistan.
They were predominantly from the Punjab and Sindh, having migrated from rural
areas or small towns. The Pakistani group was drawn from Karachi, the largest
metropolitan city in Pakistan. Although a large part of the respondents had migrated
from India during Partition, many (especially the younger generation) were born in
Karachi. Developing countries, such as Pakistan, are culturally heterogeneous
(Littlewood, 1990), especially in a large metropolitan city such as Karachi. This group
is, however, on some levels, the most homogeneous, comprising of people who have
been born in Sindh or have migrated there from India at partition. They have lived in
Pakistan for most of their lives and for most of them, Urdu is the first language. This group is also largely ‘middle-class’ (and therefore, bilingual in Urdu and English). However, this group does not share the same social environment of the British Pakistanis and the British groups. Although it is assumed that there will be more similarities than differences between this group and that of the British Pakistanis, it is considered a culturally separate group for the purposes of this investigation.

The British Asian group, in the third study, encompassed all those individuals whose origins lie in the sub-continent i.e. (Indians, Pakistanis, Bangladeshis and East Africans). Although the use of the umbrella term ‘British Asian’ has been criticised, they have been taken as one group on the following basis. Firstly, their religious and regional identities cut across their national identities of origin (Punjabis on either side of the border between Pakistan and India; Pakistanis and Bangladeshis are both predominantly Muslim, as are East Africans). Secondly, these ethnic minority groups, have some traditions, as well as languages, in common, (although others are specific to each group), which binds them at some level. Being largely middle class, they are also largely bilingual. Thirdly, their experiences as immigrants shape their identity in their host country. Lastly, and most importantly, research has shown important common beliefs amongst South Asians in the Indo-subcontinent (Hofstede, 1980; Kakar, 1982) and abroad (Roland, 1988; Clarke, Peach and Vertovec 1990). This point is particularly pertinent because, as discussed earlier, research into cultural beliefs about illness may provide a way of operationalising culture in research studies (Ware & Kleinman, 1992).

The demographic description of each of the sample for each study is given separately. However, some points need clarification. Most of the respondents, both in England and Pakistan, were drawn from areas that would be termed middle class. Both the British Pakistani sample and the Pakistanis sample were also largely bilingual. While every effort was made to match income, age and education, many difficulties were encountered in this exercise. Neither ‘occupation’ nor ‘income’ could be assessed across these three groups equivalently. The former has a dissimilar meaning from that in Britain and there is little relationship between levels of income in the UK those of
Pakistan, which obviously are much lower. There is therefore little comparison to be made between income and standard of living (housing, transport, schooling,) between the two countries. It was decided, therefore, to compare ‘income’ across the British Pakistanis and the British sample only.

Although most of the comparisons, in the analysis, are made between the three main cultural groups, further analysis for comparisons of the sub-groups are also carried out. As a result, comparisons between first and second generations sub-groups in the British Pakistani sample and between sub-groups with differing lengths of stay in the UK are carried out in order to assess within-culture variability and to see the effect of acculturation on specific concepts.
3.4 The basis for the cross-cultural comparison of groups

Berry (1969) writes that "to compare two phenomena, they must share some feature in common; and to compare them to some advantage, they should usually differ on some feature" (p. 120). Whereas this might have been the basis of most quantitative research in cross-cultural psychology, the main critique against much of the cross-cultural research so far has been the direct comparisons made between just two cultures, considered by Lonner (1979) as 'dead-end' exercises.

Three cultural groups were chosen on the basis that, while it is not possible, in making a comparison of just two groups to hypothesise differences on the basis of culture, the comparison of three groups allows similarities and differences to be discerned by examining patterns of beliefs or behaviour. As Lonner (1980) explains, "On any behavioral variable, culture A would be either the same as or different from culture B. Since there cannot be an intermediate position in a binary system, there are no other alternatives" (p.153). He suggests that the two degrees of freedom which are available in studying three cultures (rather than one degree of freedom available in two culture comparisons), allows for attitudes and behaviours to be 'clustered, categorised or otherwise found to co-vary in some theoretically valid way in multi-culture studies'. Thus, similarities and differences between cultural groups can be carefully and sensitively examined to confirm (or otherwise) hypotheses relating to assumptions about cultural groups. This point is examined in greater detail below.

In the case of cross-cultural psychological research, researchers have most often used two or several maximally contrasted groups in order to show the effect of culture clearly. One example is Berry's (1966) comparison of the perceptual skill of the Eskimo with those of the Tenme tribe in Africa. Lonner (1980) suggests that if theory testing is the main aim of the investigation, then cultural groups that are widely contrasted should be compared; if application, then groups with minimum differences that have much in common. However, there are problems inherent in both these cases. In the former, the psychological variables or constructs are so confounded that any number of alternative hypotheses could account for differences, if any. In addition,
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and just as importantly, levels of functional, conceptual and metric equivalence have to be present to make a comparison. In the latter, results are confounded by the commonalities shared by the groups.

Therefore, rather than comparisons, patterns of responses will be carefully and sensitively analysed between the three groups, of which two are culturally contrasted (Pakistanis and the British group) and two are culturally similar (British Pakistanis and Pakistanis). This argument is based on the assumption that there are several points of comparison between cultures and that there will be both similarities and differences between the three groups. Thus, this analysis will attempt to assess whether quantitative methodology can access both emic and etic concepts of each group.

Berry (1980), in referring to ethnic groups within another dominant culture, advanced the concept of the 'ethunit', as opposed to the 'cultunit', Naroll's (1980) term to denote a cultural group. It was hoped that this comparison would clarify what was independently functional in cultural groupings to that which was borrowed from other, often the host, culture. Lonner, too, has suggested that this might be a significant step in clarifying shared etic features and idiosyncratic emic features.

Therefore, in this investigation, although the role of culture is assumed to be substantial, and universality is not assumed in advance, an analysis of cultural differences and similarities will be made with reference to the cultural and social context. Along the lines suggested by Segall, Lonner and Berry (1998), and one resembling the 'derived etic' approach, cautious comparisons and interpretations of similarities and differences will be attempted to take both culturally and socially based meanings into account.

In order to assess emic as well as etic concepts, it is assumed that the concepts shared between British Pakistanis and the Pakistani group will be those unique to the South Asian culture and therefore, emic. These will be judged along the broadest dimensions, since sub-groups within these groups might also have their own unique concepts. Those concepts that might be common or similar between the British Pakistani and the indigenous population (or between all three groups) can be judged as etic concepts.
3.5 Measures

The main criticism of the etic technique, (other than that of universalistic assumptions) has been that of the issue of the validity of etic research. As Kleinman and Becker (1991) point out, many research strategies involve an instrument that has been validated and developed exclusively in one culture and is therefore limited in its range of symptoms. There is an imposition of \textit{a priori} notions and ideas from one culture on another culture. They do not give attention to normative uncertainty, centricultural bias while the indeterminacy of meaning is also a major problem (Lewis-Fernandes & Kleinman, 1994). Cultural relativists question the validity of measures, constructed for use in Western cultures, used in other, very different cultural groups. Therefore, primary importance has been given to the choice of the measures in the three studies in this research.

The measures have been chosen along the guidelines of Flaherty, Moises-Gaviria, Pathak, Mitchell, Wintrob, Richman and Briz, (1988). They emphasised that, "instrument selection is the first step in a series of steps leading to an instrument that yields a valid measure of the variable under investigation in all of the cultures being investigated" (p.258). They suggest that instruments should be selected according to the following priorities:

a) instruments already proven to be cross-culturally equivalent.

b) instruments that have been extensively tested and found to be psychometrically sound in one culture but have not been tested in other cultures.

c) instruments that have high face validity but require further psychometric testing in their country of origin followed by cross-cultural validation.

The measurement instruments used in this research include the Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990), the Orientations to Seeking Professional Help questionnaire (Fischer & Turner, 1970), the Mental Health Inventory (Veit & Ware, 1983), The Bradford Somatic Inventory (Mumford, 1989) and the General Health Questionnaire-28 (Goldberg, 1972).
Two of the instruments, the Mental Distress Explanatory Model Questionnaire and the Bradford Somatic Inventory have been specifically constructed for use in different cultures while the GHQ-28 has also been extensively used and validated in several cultural settings. Two of the questionnaires, the Mental Health Inventory and the Orientations to Seeking Professional Help questionnaire, have not been constructed for use in different cultures. The basis for the use of all these questionnaires in the present study is discussed in more detail below.  

3.5.1 The Mental Distress Explanatory Model Questionnaire (MDEMQ)

Eisenbruch's (1990) Mental Distress Explanatory Model Questionnaire is a multicultural instrument, designed with the intention of being a screening instrument for use in both Western and Eastern non-patient samples. Eisenbruch took as his basis the approach of anthropologists (Foster, 1976; Young, 1976, Landy, 1983; Kleinman, 1977; Murdock, Wilson, & Frederick, 1978b), who have explored how people from different cultures explain mental illness. In studying the relationship between ethnicity and conceptions of mental illness in a multi-cultural setting, he found that categories of the MDEMQ provided a combined emic and etic cross-cultural comparison of beliefs of illness causation. This questionnaire was used on the basis of its multi-cultural validity and for the fact that emic and etic concepts could be assessed in each culture.

3.5.2 The Bradford Somatic Inventory (BSI)

The Bradford Somatic Inventory (Mumford, 1989; 1991) was developed to meet the need for a multi-ethnic inventory of common somatic symptoms reported by anxious and depressed individuals in Britain and the Indian Sub-continent. It was developed in English and Urdu simultaneously by a multicultural research group and validated in a Pakistani population in Pakistan (Mumford, Bavington, Bhatnagar, Hussain, Mirza, 1991). Further details of the validity and reliability of measures are given in Chapters 4, 5 & 6.
The General Health Questionnaire (GHQ)

The General Health Questionnaire (Goldberg, 1972) is a self-administered screening instrument designed to detect current diagnosable psychiatric disorders. The GHQ was designed to use in general population surveys, in primary medical care settings or among general medical outpatients. The method has been used in surveys to identify potential cases. The Goldberg scale provides a well-tested method for screening for general psychological and psychiatric disorder. It has been used internationally, and many validation studies have demonstrated its psychometric qualities. Validation studies have been undertaken in many different countries, using directly comparable procedures.

Though the GHQ was not designed to be a cross-culturally sensitive instrument, it has been used in many cross-cultural studies (Oduwole & Ogunyemi, 1989; Chan 1993). It has been used several times with a South Asian population. It was found to be a valid screening instrument in India (Gautam, Nijhawan, & Kamal, 1987; Bandyopadhyay, Sinha, Sen, & Sen, 1988). In Britain, the GHQ has been found to be a valid measure used amongst the Asian population (Cochrane, Hashmi, & Stopes-Roe, 1977; Currier, 1986; Krause, Rosser, Khiani, & Lotay, 1990; Jacob, Bhugra & Mann, 1997).
3.5.4 The Mental Health Inventory (MHI)

The Mental Health Inventory (Veit & Ware, 1983) is a measurement of psychological distress and well-being, developed for use in population surveys. It was developed as a screening instrument to distinguish changes in mental health from changes in physical health and to extend the definition of mental health to include both psychological distress and psychological well-being.

Although not a questionnaire constructed for cross-cultural use, it has been extensively used and has been shown to be psychometrically sound (see Chapter 5, Section 5.3.2.1.2) in a variety of different cultural groups (Ware, Avery and Brook, 1990).

No a priori assumptions were made about concepts or factors that might not apply to the non-western cultures.

3.5.5 Attitudes to Seeking Psychological Help (ASPH)

The Attitudes to Seeking Psychological Help (Fisher & Turner 1970),\(^\text{13}\) is the least suitable, of all the measures, for cross-cultural research. It is not a multi-cultural instrument and its psychometric properties have been called into question by some studies (Surgenor, 1985; Raviv, Raviv, & Yunovitz, 1989). However, its particular focus on attitudes that underlie the actual attitudes to seeking help are particularly relevant to those assumed to be prevalent in the ethnic minority group of British Asians in this country (e.g. stigmatisation, openness, confidence in professionals and recognition of the need for help for mental distress). Therefore, the primary reason for its use is not for cross-cultural comparisons (although comparisons between groups are carried out) but to assess the relationship between the causal beliefs about mental distress and the above attitudes.

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\(^{13}\) The original title of this questionnaire was 'Orientations to Seeking Professional Help'.
3.5.6. Translation of the measurement instruments

All the measurement instruments, in this research, other than the GHQ-28 and the Bradford Somatic Inventory, were translated from English into Urdu. Some limitations of the translation process are detailed here.\textsuperscript{14}

Empirical research carried out in non-English speaking cultures accepts that translation is important and must be carried out according to certain guidelines. Researchers usually try and attain translation equivalence when, after translation from the original language into the target language, followed by back-translation, the original wording is reproduced. Flaherty and colleagues (1988) have given the following dimensions as important for cross-cultural validation in psychiatric research: content equivalence, semantic equivalence, technical equivalence, criterion equivalence and conceptual equivalence.

However, issues of translation and the achieving of literal or conceptual equivalence are not easy to resolve. Kleinman and Becker (1991) have argued that the simple semantic equivalence of a term is not enough. In the latter, there is an assumption of “objective referents which either may not exist in a particular culture or may be represented by differential symbolic forms” (p. 217). Lewis-Fernandes and colleagues (1994) have also shown that conceptual equivalence, after translation from English into Spanish, was not maintained. They, therefore, argue that such measurements do not yield culturally meaningful findings. This highlights the problems, raised by Skultans (1993) (detailed in Chapter 1) of translation in any cross-cultural research. Whether these issues can ever be surmounted, in either emic or etic investigations, is something that remains to be seen.

The participants of the two Asian samples, by and large, were bilingual in English and Urdu. However, some participants\textsuperscript{15} preferred the translated version of the questionnaires. While every effort was made to achieve the truest translation from

\textsuperscript{14} More detailed explanations of the translation process of each questionnaire are to be found in the relevant sections of the three studies.
\textsuperscript{15} A more detailed description of participants administered the questionnaires in Urdu are given in the procedure section of each study.
English to Urdu of the questionnaires, the complexity of the issues around translation demonstrate the virtual impossibility of achieving a perfect translation. However, since individuals who are unable to read English are also, very often, unable to read Urdu, these questionnaires were administered to the participants, rather than being self-administered. This process inevitably meant a negotiation and clarification of meaning. In the final analysis of the results, however, the data for administered questionnaires was removed from the data set in the first two studies.

3.6 Summary

The methodology of this research is predicated on the fact that an *etic* quantitative methodology can be of value in ascertaining both culture-specific concepts and those shared amongst cultures. Sensitivity and reflexivity are of fundamental importance. Therefore, reasons behind the composition of the three cultural samples in this research have been analysed, highlighting inter-cultural and intra-cultural diversity. It has been argued that, in making comparisons of the patterns of responses (i.e. investigating patterns of differences and similarities), between the three groups, *emic* (common to the Asian culture) and *etic* (shared between cultures) concepts could be examined. Finally, the choice of measures, made along the suggestion of Flaherty et al (1988), is considered with reference to their appropriateness for this research.
CHAPTER 4

Study One

Beliefs about the causation of mental distress and attitudes underlying help-seeking
Chapter 4

Study 1: Beliefs about the causation of mental distress and attitudes underlying help-seeking

4.1 Introduction

How people understand and manage mental health and illness, in other words, their ‘mental health literacy’ (Jorm, Korten, Rodgers, Pollitt, Jacomb, Christensen, & Jiao, 1997), examines their beliefs and knowledge about mental health problems and the ability to recognise them and seek appropriate help, from a western biomedical viewpoint. Research in different cultures, however, has shown that people not only seek medical explanations of disease but try to understand the disease within their social and cultural context (Radley, 1994). These cultural interpretations, i.e. the explanatory models people have of mental health and illness, reveal their understanding of mental distress (Kleinman, 1980; Fabrega, 1982; 1992). They include not only the attributions placed on the illness (Ripperre, 1977a; Weiss, Sharma & Gaur, Sharma, Desai, & Doongaji, 1986), but also the way symptoms are presented (Good, 1977; White, 1982; Bal, 1987; Krause, 1989) and subsequent help seeking behaviour (Ripperre, 1977b; Weiss, Raguram & Channabasavanna, 1995; Furnham & Bhagrath, 1993).

Anthropologists have, over the years, emphasised the importance of culturally specific lay theories of illness (Young, 1976; Kleinman, 1980; Marsella & White, 1982; Helman, 1991), described as lay or popular explanatory models of illness (Kleinman, 1987), which loosely link a variety of cultural concepts and personal experiences (Good, 1977). Researchers too, have found culturally determined beliefs to be significant in lay theories of health and illness (Furnham, 1994b; Landrine & Klonoff, 1994; Chalmers, 1996).

While Helman (1990) describes lay theories as being part of a complex body of ‘inherited folklore’ of that culture, there is evidence that they can be modified by a variety of factors. These might range from professional ideas of mental illness (Weiss et al, 1986), the prevalent health systems in the society (Kleinman, 1986) or representations in the media (Helman, 1990). Therefore, although the basis of cultural conceptualisations might not be scientifically correct, there is consistency and logic, within the cultural context, in the explanations they provide of the illness (Marsella & White 1982). Young’s (1993) sees illness beliefs as serving an ontological purpose in that, in communicating and confirming these ideas, cultural beliefs are themselves re-constituted and reconfirmed.
Landy (1983) described most societies as attributing their mental illnesses to both natural and supernatural causes. Helman (1985b) also theorised that lay theories perceive the aetiologies of mental and physical illnesses as residing within the individual, the natural world, the social world and the supernatural world. Evidence suggests, however, that differences exist between all societies in the health beliefs of people.

Whilst there are differences between even such societies as France and Britain (Helman 1990), differences are much more apparent between developed countries in the West and the more traditional cultures of the less developed countries (Young, 1993). In the West, people seek out ‘empirical’ explanations for illness, such as environmental factors, disease, stress more than people in non-western societies (Herzlich, 1979), with the result that natural or patient-centred explanations of illness are common in the Western world. In comparison, in the more traditional cultures of non-western societies, such as Africa (MacLachlin, Ager & Brown, 1996; Furnham, Akande & Baguma, 1999), the Far East (Eisenbruch, 1990) and India (Kakar, 1982), the common lay explanations revolve around social and supernatural aetiologies of illness.

These distinctions were made by Eisenbruch (1990), amongst others (Foster, 1976; Young 1976a; Murdock, Wilson & Frederick 1978a; 1978b), who postulated that cultures made naturalistic and personalistic explanations for illness and that these could be separated along western and non-western cultural lines. However, there have been criticisms of these dichotomies as being artificial, in that they reflect a western ethnocentric idea of causal attributions (Landy, 1983; Furnham, Akande & Baguma, 1999). Other researchers have found evidence that western and non-western belief systems are converging (Chalmers, 1996; Weiss, 1997). Whereas some of the concepts of biomedicine may be differently understood in the western and non-western cultures, it is a model that is highly regarded in the developing countries (Christakis, Ware & Kleinman, 1994). Herzlich and Pierret (1986) also argue that these medical explanations of illness have acquired high acceptance in societies, and therefore, scientific causal explanations are gaining credibility. The Indo-subcontinent particularly, with its colonial past, has a long and complex relationship with western medical concepts and treatments (Arnold, 1993). Consequently, the bio-medical causes that lie at the heart of lay theories
of illness in the West are not exclusive to it, as indigenous beliefs of Indians also include the allopathic or the modern medical model, in which afflictions are believed to be the result of physiological processes (Joshi, 1998).

On the other hand, India also has a long, still persistent, tradition of traditional medical belief system (Waxler, 1984). This system bases its concepts on the hot-cold dichotomy, as well as on the classical Ayurvedic tradition, in which afflictions are thought to result from a disequilibrium of the normal humoral balance (Obeyeskere, 1982). There is also the medical tradition of the Unani Tibb, predominant in Islam, which attributes the disturbance of normal healthy balance to the influences by both internal and external factors (Laderman, 1992). Because these medical explanations focus largely (although not solely, as is the case of biomedicine), on what is seen as the physical aspect of the problem, people also try and understand their illness within a holistic perspective that includes the social and metaphysical realities in their lives (Kohli & Dalal, 1998).

As a result, while attributions to physical factors may be more common in the West (Bishop, 1991), attributions for illness in non-western cultures are often made to supernatural causes. Landrine and Klonoff (1994) found that only it was only beliefs in supernatural causal attributions that differentiated causal beliefs of African, Asian and Latin American cultures from those of the West. Littlewood (1990) points out that, in these cultures, socio-religious and medical beliefs are often closely related. That is certainly the case in traditional Indian culture, in which a range of culture-specific metaphysical attributions forms the basis for constructions of health and illness. These beliefs derive from religious and spiritual beliefs and are of vital importance to many aspects of mental health since, as Littlewood and Lipsedge (1997) argue, the religions of the Indo-subcontinent provide a fundamental way of understanding and looking at the world.

As Kohli and Dalal (1998) explain, the link between metaphysical beliefs in karma, God, gods and spirits and the important events in the life of an individual, particularly in times of illness and suffering, lies at the heart of the main religions of India. In Hinduism, the theory of karma is invoked as an explanation for an array of undesirable life events. This belief holds that good and bad deeds accumulate over all previous lives, so that present
suffering is frequently attributed to one’s own misdeeds in this or past lives. As a result, the belief in karma and fate inculcates an attitude of acceptance. In Islam, the metaphysical belief attributes God’s will as meting out rewards and punishments, not always according to what one deserves. This belief in fate is different from the principle of karma, since it implies that life events are preordained and little can be done to change them. Although these religious beliefs are conceptually different, they are often interchangeable in the lay explanatory models of illness.

While these attributions might be seen as the equivalent of ‘blaming other people for one’s ill-health’ (Helman, 1990) - which in western societies, would mean attributions made to social stress - attributing illness to metaphysical factors, such as God’s will, or fate, plays a more complex role. Bal (1987) views the tradition of beliefs in supernatural causes as providing a credible and socially acceptable way of explaining and understanding illness, in which non-human agencies are seen to work directly or through human actions to punish social and personal transgressions. Thus, there are frequent causal attribution of evil eye and evil spirits in a wide range of health problems (Misra, 1997). Young (1993) also sees these beliefs playing an important social function, by ‘exculpating the putatively sick from the stigma of deviance’. More importantly, perhaps, individuals perceive these beliefs in God, fate or destiny as providing support in the face of distress (Currer, 1986).

It is, therefore, not surprising that many metaphysical beliefs have been found in Indian women with life threatening diseases, such as cancer (Kohli & Dalal, 1998) as well as mental illness, such as depression (Jain, 1988). Several studies conducted on diverse samples in India have also found that it is the vulnerable, such as poor and the disadvantaged, who make the most frequent causal attributions to metaphysical beliefs (Sinha, Jain & Pandey, 1980; Mishra & Mishra, 1986).

Findings from studies in the British Asian community in the UK have also shown religious beliefs relating to mental distress to have durability and value for the Asian individual (Currer, 1986; Mahmud, 1987; Beliappa, 1991; Hatfield, Mohamad, Rahim and Tanweer, 1996). Hatfield and colleagues found, in a large survey carried out amongst the Asian community in ‘Milltown’, that Asians ranked ‘the will of God’, along with
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'social stress' and 'family problems', as the three main factors which 'caused mental health problems'. They point out that while attributions to social stress may not be surprising in a migrant community in which many had experienced some form of racial hostility and intolerance, beliefs in fate or 'God's will' demonstrate the significance of these beliefs. As Fitzpatrick (1979) has pointed out, the survival of culturally determined explanations of illness quite different than those found in the West, demonstrate the importance of these cultural determinants of lay concepts of illness. The persistence of these beliefs in a migrant community may indicate that they have added value to individuals who perceive themselves as vulnerable and who have little control on many aspects of their life, as evidence seems to suggest (Sinha, Jain & Pandey, 1980; Mishra & Mishra, 1986).

These metaphysical attributions of mental distress have also been shown to play a vital role in people's attitudes towards help-seeking and subsequent behaviour. While the relationship between conceptualisations of illness and attitudes towards seeking help has been also been demonstrated in Western societies (Hall & Tucker, 1985), this link has been shown to be particularly strong for Asian women. Both Currer and Mahmud's studies found that predominant attributional beliefs for mental distress were expressed in terms of fate or destiny, arising from religious beliefs (Currer, 1986; Mahmud, 1987). These were associated with a fatalistic attitude towards trying to find a solution to their problem, so that there was a reluctance to seek help for mental distress. This may explain the particular reticence to seek help, noted in Asian women, which is in contrast to the consistent findings in the West, where women are more willing to seek psychological help than men (Price & McNeill, 1992; Fischer & Farina, 1995).

Currer (1986) found in her study that the attitudes held by Asian women towards looking for help for mental distress were shaped by their belief in their fate, as ordained by God. Active help seeking for distress did not form part of the conceptualisation of illness, and as a result, they were resigned to the acceptance of the inevitable. Although this study had a relatively small sample of women of Pathan women who were from extremely traditional backgrounds, there is no doubt that 'fatalism' is a feature of the Indo-subcontinental culture. This attitude of acceptance of one's and other people's suffering
is based not only on religious-philosophical traditions of India, according to Sinha (1990), but also in the nature of the physical environment and the climate that characterises the Indian subcontinent. Although often interpreted, from the western point of view, as passivity, it seems more likely that attitudes towards illness arising from religious beliefs inculcate an attitude of acceptance of one's suffering that is integral to coping with life's problems.

Although there is some evidence that Asians and Westerners do not differ in their attitude to seeking help for mental distress (Furnham & Andrew, 1996), reluctance to contact health services has been reported for the Asian community as a whole (London, 1986; Inechein, 1987). The assumptions are that there are cultural inhibitions in divulging mental health problems (Henley, 1979; Skultans, 1982; Blackmore, 1983). Other researchers point to linguistic difficulties (Donaldson, 1986). However, since metaphysical attributions are not only linked to illness behaviour but also to prognosis (Dalai & Singh, 1992), these beliefs may not only play a fundamental role in explanatory models of mental distress but also provide a psychologically important and crucial coping strategy.

This study set out to investigate cultural differences, if any, in beliefs about the causal attributions of mental distress and to examine differences in the underlying attitudes to seeking help for mental distress. Finally, it aimed to investigate the relationship between the causal attributions of mental distress and attitudes underlying seeking help for mental distress.

4.2 Aims and Hypotheses

This study aimed to investigate whether there were significant cultural differences in the conceptual beliefs of the causes of mental distress between three samples: a British Pakistani sample, a British sample and a Pakistani sample. These beliefs were identified through the Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990). It also investigated differences in underlying attitudes to seeking professional help for mental distress. It then examined the relationship, in each sample, between these causal beliefs
Chapter 4: Beliefs about the causation of mental distress and attitudes under-lying help-seeking of mental distress and underlying attitudes to seeking help for mental distress.

Although, as stated earlier, \textit{a priori} assumptions were kept to a minimum in this research, the following hypotheses were made on the basis of the findings and conclusions drawn from earlier research.

I. The structure and response style across the entire sample will be similar to the causal belief dimensions posited by Eisenbruch (1990). That is, multi-dimensional scaling analysis will show differences in western and non-western explanations, so that attributions to stress and western physiological causes would be separated from attributions to supernatural agents and non-western physiological causes on the first dimension. On the second dimension of the multi-dimensional scaling, naturalistic causes of mental distress would be separated from personalistic causes.

II. Beliefs in western explanations (causes attributed to stress and western physiology) of mental distress will differ significantly across the three cultural groups. This hypothesis is based on the argument that western explanations of illness, disseminated by professional ideas and input from the media will be significantly different in a Western (British) group, an Asian migrant group (British Pakistanis) and an Asian group still resident in the Indo-sub-continent (Pakistanis).

III. Beliefs in traditional non-western explanations (causes attributed to supernatural and non-western physiology) will not differ significantly between the two Asian groups. There will be a significant difference between these two groups, on the one hand, and the Western (British) sample, on the other. The two Asian groups will have higher scores on beliefs related to the non-western causative categories of supernatural and non-western physiological causes of mental distress than the British group.

IV. There will be a significant effect of religion on causal beliefs of mental distress, particularly those related to supernatural. Muslims will have higher beliefs in supernatural causes than Christians.
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V. There will a significant effect of sex, age, education and income on causal beliefs.

VI. In the case of the migrant group i.e. the British Pakistanis, place of birth (first or second generation) and length of stay in the U. K. would significantly affect causal beliefs as measured by scores of the causative categories of the MDEMQ. Compared to the second generation, the first generation Pakistanis would have lower beliefs in the western categories of stress and western physiological causes and higher beliefs in the non-western categories, i.e. supernatural and non-western physiological causes.

VII. The British Pakistani and the Pakistani groups will have a significantly less positive attitude to seeking help for mental distress compared to the British group.

VIII. There will be a significant effect of sex as well as an interaction between culture and sex. British Pakistani women will have a significantly less positive attitude to seeking help compared to both British Pakistani men and British women.

IX. There will be a significant effect of religion, with Muslims having a less positive attitude to seeking help for mental distress compared to other groups other religious groups.

X. There will be a significant effect of age and education on attitudes to seeking help.

XI. In the case of the migrant group i.e. the British Pakistanis, the first generation will have a less positive attitude to seeking help than the second generation.

XII. There will be an effect of length of stay in the U. K. in the British Pakistani sample, with those having resided in the UK having a more positive attitude. The effect of first language will also be investigated.

XIII. Culture, religion, sex and education will be significant predictors of a positive attitude to seeking help for mental distress.

XIV. Causal attributions of mental illness will be significant predictors of a positive attitude to seeking help only for the two Asian groups but not for the British group.
Chapter 4: Study 1: Beliefs about the causation of mental distress and attitudes underlying help-seeking

4.3 Method

4.3.1 Sample of the study

The sample for this study comprised of 73 British Pakistanis, 58 Britons and 77 Pakistanis (i.e. those born and still living in Pakistan) (Table 4.1).

The British Pakistani group and the British group were drawn mainly from three areas in London: Central London, suburbs in the west and the south-west of London (Southall and Kingston upon Thames).

In the case of the British Pakistanis, respondents were approached through two drop-in centres in Southall over a period of eight months. These centres, funded by the local council, provide some teaching in art, sewing and computers but they cater predominantly to the Asian community in the area as a meeting place for people to play cards or to chat in the common room. Out of a total of 100 people approached, fourteen declined (14%) and a further sixteen (16%) were not included because of incomplete questionnaires (those questionnaires were considered incomplete when more than three items were not completed).

There were greater problems in accessing the British sample. This was largely due to the fact that there was a lack of representative community meetings or places (which did not reflect a particular interest group). Furthermore, a door to door strategy was considered unsafe. As a consequence, they were randomly approached through a dentist’s surgery as well as in a park (Russell Square) in Central London. Out of a total of 70 people approached, there were twelve refusals (17.1%).

Respondents in Pakistan were recruited by approaching individuals at two locations. The first was a large outdoor stadium used for people to take their evening walk. People were also approached, with the help of the headmistress of a large school in Karachi, during a school fete. Out of 100 people approached, there were 15 (15%) refusals while 8 (8%) questionnaires were deemed incomplete (Table 4.1).
**Chapter 4**

*Study 1: Beliefs about the causation of mental distress and attitudes under-lying help-seeking*

### Table 4.1 The Distribution of Cultural Groups by Sex, Age, Religion, Marital status, Education and Income

<table>
<thead>
<tr>
<th>Cultural Groups</th>
<th>British Pakistanis % Total</th>
<th>Britons % Total</th>
<th>Pakistanis % Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>26</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Females</td>
<td>47</td>
<td>40</td>
<td>47</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30 years</td>
<td>33</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>31-40 years</td>
<td>13</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>41-50 years</td>
<td>12</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>51-60 years</td>
<td>13</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Over 60 years</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>70</td>
<td>0</td>
<td>67</td>
</tr>
<tr>
<td>Christian</td>
<td>1</td>
<td>30</td>
<td>52.3%</td>
</tr>
<tr>
<td>Sikh</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Parsi</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>No affiliation</td>
<td>1</td>
<td>28</td>
<td>47.7%</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
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</tr>
<tr>
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<td>32</td>
<td>35</td>
<td>60.3%</td>
</tr>
<tr>
<td>Married</td>
<td>37</td>
<td>19</td>
<td>32.9%</td>
</tr>
<tr>
<td>Divorced</td>
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<td>2</td>
<td>3.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>2</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>55</td>
<td>31</td>
<td>53.4%</td>
</tr>
<tr>
<td>Secondary</td>
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</tr>
<tr>
<td>Primary</td>
<td>4</td>
<td>14</td>
<td>28.0%</td>
</tr>
<tr>
<td><strong>Income¹</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3000-5000</td>
<td>10</td>
<td>10</td>
<td>15.2%</td>
</tr>
<tr>
<td>5001-10,000</td>
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<td>4</td>
<td>8.6%</td>
</tr>
<tr>
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<td>8</td>
<td>7</td>
<td>10.3%</td>
</tr>
<tr>
<td>15,001-20,000</td>
<td>10</td>
<td>10</td>
<td>17.2%</td>
</tr>
<tr>
<td>20,001-25,000</td>
<td>14</td>
<td>7</td>
<td>10.3%</td>
</tr>
<tr>
<td>25,001 +</td>
<td>29</td>
<td>20</td>
<td>34.6%</td>
</tr>
</tbody>
</table>

¹(Annual Income for British Pakistanis & Britons in pounds sterling; monthly income for Pakistanis in Rupees)
4.3.2 Measures

4.3.2.1 The Mental Distress Explanatory Model Questionnaire

Eisenbruch's (1990) Mental Distress Explanatory Model Questionnaire (MDEMQ) (appendix 4.1) is a multicultural instrument, designed with the intention of exploring concepts of mental distress for use in both western and non-western non-patient samples. Eisenbruch took as his basis the approach of medical anthropologists, who have explored how people from different cultures explain mental illness, studying the relationship between ethnicity and conceptions of mental illness. He constructed the MDEMQ by drawing on models of culturally constructed beliefs about illness causation (Foster, 1976; Young 1976a; 1976b; Murdock et al., 1978a; 1978b) and a subsequent classification system by Landy (1983). In order to provide a combined *emic* and *etic* cross-cultural comparison of theories of illness causation, he based the construction of the MDEMQ on Kleinman's explanatory model framework.

The resultant questionnaire was structured in terms of a naturalistic category, relating to causal beliefs associated with western physiological explanations, on the one hand and non-western physiological explanations, on the other, and a personalistic causal category, relating to stress causes, on the one hand, and supernatural causes on the other. These four categories, stipulated by Eisenbruch in the structure of the MDEMQ, were confirmed by findings of the pilot study on 261 Australian multi-cultural college students. Multidimensional scaling analysis found four clusters of beliefs of mental distress causation. These clusters of beliefs were found to fall along the two dimensions that had been hypothesised by Eisenbruch. Thus, the first dimension related to differences in western and non-western beliefs i.e. western physiological causal explanations and explanations relating to vs. non-western physiological explanations and explanations relating to supernatural causal beliefs. The second dimension related to naturalistic vs. personalistic distinctions discussed by Foster (1976) and Murdock et al. (1978a), separating both western and non-western physiological beliefs from stress and supernatural beliefs. It is on the basis of these four categories that analysis is made of the
findings of this study (see page 128 for a list of items in each category).

4.3.2.2 The Attitudes toward Seeking Psychological Help questionnaire

The Attitudes toward Seeking Psychological Help questionnaire (ASPH) is a 29-item questionnaire that measures attitudes toward seeking professional help for psychological distress (appendix 4.3). Fisher and Turner (1970) report that in order to construct a continuously scored scale which would reflect attitudes towards seeking professional help for psychological distress, a pool of 47 attitude statements were collected by clinical psychologists working in different clinical settings. From this pool, thirty-one items were gathered by a panel of 14 clinical and counselling psychologists as being particularly relevant to the hypothetical attitude domain and according to whether the item stated a positive or negative attitude. After running two pilot studies by administering the questionnaires to 97 students and 115 students separately, two of the 31 items were removed from the final questionnaires, as they correlated poorly with the total attitude scores, in order to standardise the summated ratings. The remaining 29 items were considered the final version of the ASPH. Eleven of the items were positively worded and eighteen were worded negatively. Negative items were reversed for scoring. A high score indicated a positive attitude towards help seeking. The final scale items were inter-correlated and factor analysed to identify the principal attitudinal dimensions. The four factors found were named: recognition of personal need for professional psychological help; tolerance of the stigma associated with psychiatric help; interpersonal openness regarding one's problems; confidence in the mental health professional (see page 139 for a list of items in each sub-scale). The structure of this questionnaire, seemed to be multidimensional and possessed good psychometric properties, both in Fischer and Turner's original study in 1970 and in later research, when used in diverse populations both in the United States and in other countries (Raviv, Raviv, & Yunovitz, 1989). However, Fischer and Turner advised using total scale scores for a unidimensional measure of help seeking orientation, because these
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scales lacked internal consistency in some samples. Other research has shown the underlying sub-structure to be unstable, since different factors have been found for different samples (deBarot, 1977; Surgenor 1985).

4.3.2.2.1 The rationale for the use of the ASPH in this study

Although there were serious reservations about the use of this questionnaire for the reasons given above, it is one of the few measurement tools that has actually been constructed and used to assess attitudinal beliefs underlying seeking help for mental distress. While a shortened 10-item version of this questionnaire, the Fischer and Turner Pro-Con Attitude Scale is more recent, (Fischer & Farina, 1995), the four sub-scales of the older version of the ASPH address the issues that are particularly pertinent to an Asian sample. The scales, namely, 'recognition of personal need for professional psychological help', 'tolerance of the stigma associated with psychiatric help', interpersonal openness regarding one's problems' and 'confidence in the mental health professional', are manifestly those aspects that are associated with Asians cultural notions of help-seeking. From that point of view, it was reasoned that this instrument may be better suited for an investigation into the attitudes of this sample. In order to investigate whether the sub-scales of the ASPH would be replicated for this sample, a factor analysis of the ASPH was carried out.

This scale was modified in two ways. Firstly, as mentioned earlier, the title of the questionnaire given to the participants was changed from 'Orientations to seeking professional help' to 'Attitudes towards seeking help for mental distress'. This was done in order to assess attitudes that underlie help seeking, such as self-reliance or being open, rather than attitudes related to specifically to professional help. The items in the questionnaire that specifically asked for an attitude towards professional help were left unchanged.

Secondly, the scale, which originally had a four-point Likert-format scale, was adjusted to a seven-point Likert format scale, (to pick up a wider range of nuances in the responses), with responses ranging from 'strongly agree' to 'strongly disagree'. As in the
original study, eleven of these items were positively stated and eighteen were negatively stated. Negative items were reversed for scoring, a high score indicating a positive attitude towards seeking help for mental distress.

4.3.3 Translation of the MDEMQ and the ASPH

All questionnaires were translated into Urdu by a totally bilingual English-Urdu speaker. Emphasis was placed on conceptual equivalence rather than literal translation. The translated Urdu versions were then subjected to a back translation into English by an independent translator, proficient in both English and Urdu. Any differences between the two versions were assessed and negotiated before a final Urdu version was drafted (appendices 4.2, 4.4 and 4.6).

The translation of the MDEMQ into Urdu posed some problems, particularly for the supernatural items. Great care had to be taken that items were couched in terms that would not offend sensibilities of certain religious groups. In comparison to the MDEMQ, the ASPH posed fewer problems from that point of view. However, the complex construction of some of the ASPH items (see items 5 and 23) in English added to problems in achieving an equivalent translation into Urdu.

4.3.4 Procedure

Over a period of eight months in Britain and three months in Pakistan, participants were randomly approached by the researcher, and asked to participate in a study looking at their beliefs about mental distress. Participants who consented to take part were given an information sheet about the research and each participant was asked to sign a consent form. They were then given a set of questionnaires comprising the MDEMQ and the ASPH. A demographic data questionnaire, which requested ethnicity, age, sex, marital status, religion, place of birth, first language, education obtained, income and length of stay in the U.K. was also completed (appendix 4.5). They were asked to self-administer the questionnaires.
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The written instruction given with the MDEMQ were:

"Many people suffer mental distress at some time in their lives. Such distress can be mild or severe. People can experience and manifest mental distress in many ways. They might cope with their problem in different ways. How likely is it that each of the listed causes in the first questionnaire (the MDEMQ) would contribute. Please circle your response that could range from 'highly likely' to 'highly unlikely'. There is no right or wrong answer. Please respond to every item even if you are not sure. You are also welcome to comment on any item and invited to add any comments that you might like to make".

The scale used for responses to this questionnaire was a seven-point Likert format scale, with responses ranging from 'highly likely' to 'highly unlikely'.

The written instructions given with the ASPH scale were:

"Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement or disagreement with it by circling your response that could range from 'strongly agree' to 'strongly disagree'. Please express your frank opinion on rating the statements. There are no wrong answers. The only right ones are whatever you honestly feel or believe. It is important that you answer every item."
4.4 Results

The results presented in this section are based on sub-samples from the main samples described in the preceding sections i.e. British Pakistanis (only Muslims) (70), Britons (58) and Muslim Pakistanis (67). Questionnaires administered verbally in Urdu to three participants in this study were deleted from the data set before analysis of data, reducing the British Pakistani sample to 64.

Analyses relating to the causal attributions of cultural groups are presented first, followed by results relating to attitudes underlying help seeking for mental distress. These analyses are followed by results demonstrating the relationship between these two aspects of mental distress.

4.4.1. Causal Attributions of Mental Distress

4.4.1.1 Analysis of the MDEMQ

The total N for this analysis was 192. Mean substitution was made for those cases with just a single missing variable in a multi-variate variable. Adjustment was made for outliers, except for one variable (MDEMQ2) with more than 10 outliers on the one score. These scores were retained because scores for this variable were seen to have a normal distribution.

4.4.1.1.1 Internal Consistency of the MDEMQ

Alpha coefficients of internal reliability of the MDEMQ as a whole, computed for this sample was .97 for the British Pakistani sample, .95 for the British sample and .94 for the Pakistani sample. Alpha coefficients of internal reliability calculated for each of the three cultural groups, thereby testing the internal consistency of the four causative categories of the MDEMQ are given in Table 4.2.
Table 4.2 Alpha reliabilities of MDEMQ causative categories for British Pakistani, British and Pakistani samples

<table>
<thead>
<tr>
<th>Category</th>
<th>British Pakistanis</th>
<th>British</th>
<th>Pakistani</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress causal beliefs</td>
<td>.92</td>
<td>.91</td>
<td>.77</td>
</tr>
<tr>
<td>Western physiological causal beliefs</td>
<td>.78</td>
<td>.82</td>
<td>.78</td>
</tr>
<tr>
<td>Supernatural causal beliefs</td>
<td>.95</td>
<td>.93</td>
<td>.91</td>
</tr>
<tr>
<td>Non-western physiological causal beliefs</td>
<td>.70</td>
<td>.79</td>
<td>.71</td>
</tr>
</tbody>
</table>

All four categories were found to have high levels of internal consistency in each sample. The stress and supernatural attribution categories had the highest internal reliabilities for the British and the British Pakistani sample while only the category of supernatural causal attributions had the highest reliability for the Pakistani sample.

4.4.1.2 Multidimensional Scaling Analysis

A multidimensional scaling analysis was performed on the data collected from the MDEMQ for the sample. This was done firstly, to illustrate and verify the relationship between the forty-two causal beliefs; secondly, to investigate if Eisenbruch's two-dimensional version of western vs. non-western beliefs and naturalistic vs. personalistic beliefs was replicated for this cross-cultural investigation.

Multidimensional scaling analysis of the data for the entire sample was carried out, as the primary aim of this analysis was to display the relationships among western and non-western causal beliefs and to depict belief patterns of a culturally mixed sample. This was a preliminary analysis before any statistical analysis done between the cultural groups to study differences. This analysis does not require the data to fulfil criteria of homogeneity of variance and normality of distribution. A two dimensional solution was obtained on
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Figure 4.1 Multi-dimensional Scaling of the MDEMQ items for the entire sample

Key:
- Stress causal beliefs
- Western physiological causal beliefs
- Supernatural causal beliefs
- Non-western physiological causes
the basis of Kruksal's/Young's stress configuration.

The plot of the multidimensional scaling analysis (refer to figure 4.1) indicated a distinction between western and non-western categories of causes hypothesised by Eisenbruch, along Dimension I. Along the horizontal axis, stress and western physiology items separated to the right from all supernatural and non-western physiology items to the left, with the exception of one item, (17 - one of the person's vital organs being disrupted). The distinction along Dimension II, the vertical axis, was less distinct. All items relating to personalistic causal beliefs i.e. stress and supernatural causes, were not separated from naturalistic i.e. western and non-western physiological causal beliefs of mental distress.
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4.4.1.3 Differences in causal attributions of mental distress in the three cultural samples

A multivariate analysis of variance was performed on the four causative categories, (according to Eisenbruch's classification), in the MDEMQ in order to test for the differences in scores to see the effect of culture. Analysis of causal beliefs was done for:

i) culture

ii) sex

iii) age

iv) religion

v) levels of education

vi) Income

To further investigate main effects, a series of univariate F tests were performed on the separate category scores. Where appropriate, the significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made.

Prior to conducting statistical tests, normality of variance and homogeneity of variance test assumptions were verified. Results are presented in table 4.3.

Table 4.3 Multivariate and univariate analysis of variance of main effect of culture on the categories of the MDEMQ

<table>
<thead>
<tr>
<th>Culture</th>
<th>Effect of Culture</th>
<th>Pillais F(2,190)=8.07***</th>
<th>Stress</th>
<th>Western Physiology</th>
<th>Supernatural</th>
<th>Non-western physiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brit. Pakistanis (means &amp; sd)</td>
<td>F(2,190)=21.82***</td>
<td>F(2,190)=7.33***</td>
<td>44.75 (12.87) a</td>
<td>30.83 (9.66) a</td>
<td>46.79 (21.21) a</td>
<td>15.14 (6.03) a</td>
</tr>
<tr>
<td>British (means &amp; sd)</td>
<td></td>
<td></td>
<td>51.84 (10.73) b</td>
<td>33.93 (6.86) b</td>
<td>43.79 (16.91) a</td>
<td>14.67 (5.15) a</td>
</tr>
<tr>
<td>Pakistanis (means &amp; sd)</td>
<td></td>
<td></td>
<td>56.53 (8.29) c</td>
<td>35.90 (6.97) c</td>
<td>57.80 (18.57) b</td>
<td>18.47 (5.00) b</td>
</tr>
</tbody>
</table>

Sig. level *** p<.001 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
4.4.1.3.1 Effect of Culture across the three cultural samples

From table 4.3, using Pillai's criteria, it can be seen that the combined DVs are significantly affected by culture, with $F(2,190)=8.07, p<.001$. As hypothesised (hypothesis II), there were significant differences between all three cultural groups in western explanations of mental distress. The main effect of culture was due to a significant difference in means in British Pakistani, British and Pakistani respondents scores in the stress category with $F(2,190)=21.82, p<.0001$ and the western physiology category $F(2,190)=7.33, p<.001$. Means indicated that the British Pakistani group scored lowest in stress and western physiology categories while the Pakistani group scored highest in these categories (Table 4.3).

However, contrary to prediction (hypothesis III), significant differences in non-western explanations of mental distress were found between British Pakistanis and Pakistanis and not between the two Asian groups, on the one hand, and British group, on the other. There were significant differences in variance for the supernatural category $F(2,190)=9.97, p<.001$ and for the non-western physiological category $F(2,190)=9.93, p<.001$. Means indicated that while the British Pakistani group scored higher than the British group in the supernatural and the non-western physiological category, their scores were significantly lower than those of the Pakistani group (Table 4.3).

4.4.1.3.2 Effect of age, sex, religion, education and income across the three cultural samples

Contrary to prediction (hypothesis IV), there was no main effect for religion $F(2,190)=1.69$. Also contrary to prediction (hypothesis V), there was no main effect for sex $F(2,190)=.95$, education $F(2,190)=1.90$ or income$^{16}$, $F(2,190)=.77$ for the combined variables or any main effects on the separate categories of causal beliefs.

As predicted (hypothesis V), a main effect of age was found to be significant for the

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$^{16}$ Analysis for differences in income were done only between the British Pakistani and the British group.
combined variables F(2,190)=3.02, p<.05. An effect of age was also found to be significant for the categories of stress F(2,190)=9.50, p<.001, western physiological causes F(2,190)=6.73, p<.01 and for the category of supernatural causes F(2,190)=2.93 but not for the category of non-western physiology F(2,190)=19 (Table 4.4). Means indicated that those under 35 years of age had higher scores on the stress and western physiological categories than those over the age of 35. With age co-varied out, the effect of culture was still significant for the categories of stress F(2,190)=16.86, p<.001 and western physiological category F(2,190)=6.44, p<.001.

Table 4.4 Multivariate and univariate analysis of variance of age on the categories of the MDEMQ

<table>
<thead>
<tr>
<th>Effect of Age Pillais F(1,191)=3.02*</th>
<th>Age (n=192)</th>
<th>Stress</th>
<th>Western Physiology</th>
<th>Supernatural</th>
<th>Non-western physiology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>F(1,191)=9.50***</td>
<td>F(1,191)=6.73**</td>
<td>F(5,191)=2.93*</td>
<td>F(1,191)=38</td>
</tr>
<tr>
<td>Means &amp; sd</td>
<td>(i)</td>
<td>52.94 (11.31)</td>
<td>34.61 (7.83)</td>
<td>51.60 (19.87)</td>
<td>16.33 (5.30)</td>
</tr>
<tr>
<td></td>
<td>(ii)</td>
<td>47.64 (11.99)</td>
<td>31.47 (8.68)</td>
<td>46.47 (19.75)</td>
<td>15.95 (6.34)</td>
</tr>
</tbody>
</table>

Sig. level ***p<.001 * P< .05 (i) under 35 years of age (ii) Over 35 years of age

4.4.1.4 Differences in the causal attributions of sub-groups of the British Pakistani sample only, by place of birth and length of stay in the U. K.

A Multivariate Analysis of Variance was also performed on the four causative categories in the MDEMQ, in the British Pakistani sample, in order to investigate differences in scores across:

i) first generation and second generation Pakistanis

ii) length of stay in Britain

The results of the multivariate analysis of variance and univariate F tests, means and sds are presented in table 4.5.
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Table 4.5 Multivariate and univariate analysis of variance of MDEMQ categories of British Pakistani group by place of birth and length of stay in the UK (n=67)

<table>
<thead>
<tr>
<th>Effect</th>
<th>Stress</th>
<th>Western Physiology</th>
<th>Supernatural</th>
<th>Non-western Physiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of birth Pillais</td>
<td>F(1,66)=5.40**</td>
<td>F(1,66)=10.95***</td>
<td>F(1,66)=8.99***</td>
<td>F(1,66)=5.13**</td>
</tr>
<tr>
<td></td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
</tr>
<tr>
<td></td>
<td>(i) 42.63 (12.71)</td>
<td>28.70 (9.01)</td>
<td>42.75 (19.04)</td>
<td>14.25 (5.94)</td>
</tr>
<tr>
<td></td>
<td>(ii) 50.94 (11.69)</td>
<td>37.44 (8.97)</td>
<td>59.94 (23.15)</td>
<td>18.19 (5.67)</td>
</tr>
<tr>
<td>Length of Stay Pillais</td>
<td>F(1,66)=7.36**</td>
<td>F(1,66)=6.56**</td>
<td>F(1,66)=4.86*</td>
<td>F(1,66)=4.57*</td>
</tr>
<tr>
<td></td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
</tr>
<tr>
<td></td>
<td>(iii) 39.59 (11.59)</td>
<td>27.33 (7.37)</td>
<td>40.00 (18.09)</td>
<td>13.44 (5.75)</td>
</tr>
<tr>
<td></td>
<td>(iv) 48.07 (12.67)</td>
<td>32.97 (10.33)</td>
<td>51.27 (22.13)</td>
<td>16.21 (6.03)</td>
</tr>
</tbody>
</table>

Sig. Level **p<.001 ***p<.01 *p<.05  
(i) First generation  (ii) Second generation  (iii) Under 15 years  (iv) Over 15 years

4.4.1.4.1 Effect of place of birth and length of stay in the UK across the sub-groups in the British Pakistani sample

As predicted, there was a main effect of place of birth for the combined variables $F(1,66)=5.20$, $p<.01$. There was an effect of place of birth, in all four causative categories: stress causes $F(1,66)=5.40$, $p<.01$, western physiological causes $F(1,66)=10.95$, $p<.001$, supernatural causes $F(1,66)=8.99$, $p<.001$ and non-western physiological causes $F(1,66)=5.13$, $p<.01$. Contrary to prediction (hypothesis VI), second generation British Pakistanis had higher scores on all four causative categories. (Means in Table 4.5).

Against hypothesis (hypothesis VI), there was no main effect of length of stay for the combined variables $F(1,66)=2.11$, $p>.05$. However, there was an effect of length of stay, with higher scores for people who had lived in the U.K. for longer than 15 years as compared to those who had lived here less than 15 years, in all four causative categories, stress $F(1,66)=7.36$, $p<.01$, western physiological causes $F(1,66)=6.56$, $p<.01$, supernatural causes $F(1,66)=4.86$, $p<.05$ and non-western physiological causes $F(1,66)=4.59$, $p<.05$. (Means in Table 4.5).
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4.4.1.5 Item analysis of the MDEMQ

Analyses of endorsement percentages were conducted of all the items of the MDEMQ. This was done to enable a closer investigation of differences in endorsement patterns across the three cultural groups, to see which items were more or less salient to which cultural group. All scores of 5, 6 or 7 were re-coded as 1 and taken as positive endorsements of an item.

To further investigate the main effect of culture, a series of univariate F tests were performed on the separate items. The significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made (Table 4.6).
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### Table 4.6 F values, means and endorsement percentages of MDEMQ items of British Pakistani, British and Pakistani samples

<table>
<thead>
<tr>
<th>MDEMQ Items</th>
<th>Brit. Pakistan</th>
<th>British</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress items</td>
<td>F(2,195)=</td>
<td>Mean</td>
<td>%</td>
</tr>
<tr>
<td>1. Bad experiences during childhood</td>
<td>11.47****</td>
<td>4.36 a</td>
<td>60.3</td>
</tr>
<tr>
<td>2. Intentionally physically harmed by person</td>
<td>6.34**</td>
<td>4.45 a</td>
<td>52.1</td>
</tr>
<tr>
<td>3. Exposure to a fright or shock</td>
<td>19.65****</td>
<td>3.67 a</td>
<td>25.0</td>
</tr>
<tr>
<td>4. Pace of modern life</td>
<td>5.64**</td>
<td>3.49 a</td>
<td>25.4</td>
</tr>
<tr>
<td>18. Having had an accident</td>
<td>8.71**</td>
<td>3.76 a</td>
<td>40.3</td>
</tr>
<tr>
<td>22. Death of a relation or close friend</td>
<td>13.29****</td>
<td>4.32 a</td>
<td>44.4</td>
</tr>
<tr>
<td>32. Migration to a new country</td>
<td>10.23***</td>
<td>3.40 a</td>
<td>33.3</td>
</tr>
<tr>
<td>33. Not having enough money</td>
<td>14.94****</td>
<td>3.89 a</td>
<td>33.8</td>
</tr>
<tr>
<td>36. Too much work or study</td>
<td>10.87***</td>
<td>3.81 a</td>
<td>38.9</td>
</tr>
<tr>
<td>39. Conflict or break-up of family relationships</td>
<td>19.05****</td>
<td>4.56 a</td>
<td>53.5</td>
</tr>
<tr>
<td>41. Unemployment</td>
<td>10.42****</td>
<td>4.34 a</td>
<td>47.9</td>
</tr>
<tr>
<td>Western Physiological items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Bad nerves in the body</td>
<td>3.89*</td>
<td>3.09</td>
<td>19.4</td>
</tr>
<tr>
<td>9. The effects of old age</td>
<td>8.60****</td>
<td>3.60 a</td>
<td>31.9</td>
</tr>
<tr>
<td>10. Infection</td>
<td>3.35*</td>
<td>3.10</td>
<td>20.5</td>
</tr>
<tr>
<td>11. Genetic or inherited defect</td>
<td>4.47**</td>
<td>4.17 a</td>
<td>45.2</td>
</tr>
<tr>
<td>12. Being born this way</td>
<td>4.23**</td>
<td>3.80 a</td>
<td>29.6</td>
</tr>
<tr>
<td>15. Physical illness</td>
<td>3.27*</td>
<td>4.06</td>
<td>37.0</td>
</tr>
<tr>
<td>16. Chemical imbalance in the brain</td>
<td>4.42*</td>
<td>4.49</td>
<td>53.4</td>
</tr>
<tr>
<td>24. Brain damage or head injury</td>
<td>13.56****</td>
<td>4.25 a</td>
<td>45.2</td>
</tr>
</tbody>
</table>

*Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
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<table>
<thead>
<tr>
<th>MDEMQ Items</th>
<th>Brit.</th>
<th>Pakistani Mean</th>
<th>British Mean</th>
<th><strong>p</strong></th>
<th>Pakistani Mean</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-western physiological items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Being hot but not from climate or temperature</td>
<td>11.28***</td>
<td>2.68 a 15.1</td>
<td>2.55 a 5.2</td>
<td>3.67 b 31.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Wind or gas or currents flowing through body</td>
<td>4.93**</td>
<td>2.47 a 8.2</td>
<td>2.30 a 3.4</td>
<td>3.09 b 16.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Eating food which is wrong for that person</td>
<td>3.12*</td>
<td>3.36 30.1</td>
<td>3.08 7.4</td>
<td>3.78 31.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. The person's body being out of balance</td>
<td>7.52***</td>
<td>3.77 a 35.6</td>
<td>3.72 a 22.8</td>
<td>4.59 b 61.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supernatural items</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Contact with something or someone taboo</td>
<td>6.16***</td>
<td>2.71 a 13.7</td>
<td>2.94 a 20.1</td>
<td>3.56 b 26.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. The person had bad or ominous dream</td>
<td>19.17***</td>
<td>2.81 a 17.8</td>
<td>3.05 a 17.2</td>
<td>4.20 b 50.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Bad luck or chance</td>
<td>10.99***</td>
<td>2.72 a 17.8</td>
<td>2.63 a 13.8</td>
<td>3.80 b 41.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Doing the wrong thing during pregnancy</td>
<td>5.16**</td>
<td>3.20 a 26.9</td>
<td>2.86 ab 13.1</td>
<td>3.74 ac 32.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Failure to properly observe births rituals</td>
<td>3.34*</td>
<td>2.69 13.7</td>
<td>2.43 8.6</td>
<td>3.08 16.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Birth control against religion and culture</td>
<td>2.05</td>
<td>2.42 11.0</td>
<td>2.67 12.1</td>
<td>3.08 22.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Doing the wrong thing when menstruating</td>
<td>6.90**</td>
<td>2.50 a 5.5</td>
<td>2.09 ab 1.0</td>
<td>3.01 ac 11.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Astrological destiny</td>
<td>12.52***</td>
<td>2.26 a 6.8</td>
<td>1.79 a 3.4</td>
<td>3.02 b 23.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. The person's karma</td>
<td>2.27</td>
<td>2.00 6.8</td>
<td>2.00 5.2</td>
<td>2.46 15.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. A dangerous unprovoked spirit</td>
<td>3.91*</td>
<td>2.09 11.0</td>
<td>2.03 5.2</td>
<td>2.68 9.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Spirit angry because someone doing wrong</td>
<td>2.79</td>
<td>2.17 11.0</td>
<td>2.07 4.8</td>
<td>2.60 14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Person's soul leaving the body</td>
<td>1.02</td>
<td>2.12 7.0</td>
<td>2.05 1.7</td>
<td>2.37 6.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Contact with something / someone dangerous</td>
<td>6.85***</td>
<td>3.07 a 21.4</td>
<td>2.70 a 13.8</td>
<td>3.67 b 35.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Doing something forbidden by cultural rules</td>
<td>10.13***</td>
<td>3.03 a 26.8</td>
<td>3.49 a 31.0</td>
<td>4.21 b 59.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Someone unwittingly casting a spell</td>
<td>7.83***</td>
<td>2.49 a 12.5</td>
<td>2.00 ab 6.3</td>
<td>3.11 ac 28.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Someone wanting to hurt person by casting spell</td>
<td>5.68***</td>
<td>2.61 a 15.6</td>
<td>19.6 ab 3.4</td>
<td>2.91 ac 19.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Someone engaging a witch/shaman to cast spell</td>
<td>4.08*</td>
<td>2.46 12.7</td>
<td>2.03 6.9</td>
<td>2.84 14.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42. The person seeing/feeling something ominous</td>
<td>9.50***</td>
<td>2.95 a 18.3</td>
<td>3.03 a 20.7</td>
<td>4.01 b 44.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***p<.001***p<.01* p<.05  
Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
4.4.1.5.1 Endorsements of the MDEMQ items across the three cultural sample

With only <.01 level of significance being considered meaningfully significant, thirteen items, of all 42 items of the MDEMQ indicating causal beliefs about mental distress, were not significantly different between the cultural groups (nos. 8, 10, 13, 14, 15, 16, 23, 25, 28, 29, 30, 31 and 40). Means indicated that Pakistanis scored highest on all items and that, for most items, there were significant differences between the British Pakistanis and Britons, on the hand, and the Pakistanis, on the other.

Comparisons of endorsements between the British Pakistani group and the Pakistani group on the one hand, and the British group on the other, indicated that:

There were relatively low endorsements of all items in the stress category by the British Pakistanis. These items were all highly endorsed by two groups (British and Pakistani), with the highest endorsement from the Pakistani group. Item 1, (bad experiences during childhood) item 22 (death of a relation or close friend) and 39 (Conflict or break-up of family relationships) had higher than 85% endorsement from the Pakistani sample.

In the western physiological category, British Pakistanis again gave the lowest endorsements for all items. All items were most highly endorsed by the Pakistani group except, notably, item 16 (Chemical imbalance in the body), and item 24 (brain damage or head injury). These two items were most highly endorsed by the British group.

In the non-western physiological category, British Pakistanis endorsed these items more highly than the British group but not as highly as the Pakistani group. The items were most highly endorsed by the Pakistanis, except for item 14 (person's body being out of balance), which had the highest endorsement from the British group.

In the supernatural category, the above pattern was repeated. All items had the highest endorsement by the Pakistani group, followed by the British Pakistani group. The lowest endorsements were from the British group.
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4.4.2 Attitudes Underlying Seeking Help for Mental Distress

4.4.2.1. Analysis of the ASPH

Total N was 192. Mean substitution was made for those cases with just one missing variable in a multi-variate variable. Adjustment was made for outliers. Total N was further reduced to 191 because of 1 case with multivariate outliers, which were deleted from the data set. Results of assumptions of normality and homogeneity of variance-covariances matrices were satisfactory.

4.4.2.2 Analysis of the unidimensional score of the ASPH measuring a positive attitude to seeking help

In order to investigate differences between cultural groups in an over-all positive attitude to seeking help for mental distress, analysis was done of the total score of the ASPH, a high score indicating a positive attitude to seeking help for mental distress.

4.4.2.2.1 Internal Reliability of the ASPH total score

Alpha coefficients of over-all internal reliability of the ASPH, overall score for a positive attitude, computed for this sample was .84 for the British Pakistani sample, .81 for the British sample and .71 for the Pakistani sample.

4.4.2.3 Differences in the total score of the ASPH across the three cultural groups

An analysis of variance was performed on the total score of the ASPH, indicating a positive attitude to seeking help for mental distress, for:

i) Culture
ii) sex
iii) age
iv) education
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v) religion
vi) income

The significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test so that the observed significance level is adjusted for the fact that multiple comparisons are being made. F values are presented in Table 4.7.

Table 4.7 Analysis of variance of the total score of ASPH of the three cultural group (n=191)

<table>
<thead>
<tr>
<th>Culture</th>
<th>Sex</th>
<th>Age</th>
<th>Education</th>
<th>Religion</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score of ASPH</td>
<td>F(2,190)=2.94</td>
<td>F(1,190)=7.71**</td>
<td>F(1,190)=4.63**</td>
<td>F(3,190)=2.24</td>
<td>F(2,190)=2.31*</td>
</tr>
</tbody>
</table>

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

4.4.2.3.1 Effect of culture across three cultural groups

Against prediction (hypothesis VII), Anovas performed on the total score of the ASPH items, the unidimensional score measuring a positive attitude to seeking help for mental distress by culture showed no significant main effect for culture $F(2,190)=2.94$ (p>.06). There was main effect for sex $F(1,190)=7.71$, p<.001. Contrary to prediction, (hypothesis VIII), means indicated that women had a more positive attitude to seeking help for mental distress than men (female mean=131.02 sd 18.02; male mean=123.13 sd 19.11). There was an interaction of sex by culture $F(2,190)=3.94$ p<.05.

As predicted, (hypothesis IX), there was a main effect for religion but not at <.01 level of significance $F(2,193)=2.31$, p<.05.

As predicted (hypothesis X), there was a main effect for age $F(5,190)=4.63$, p<.01. Means indicated that those under 35 years of age had a less positive attitude to seeking professional help (mean 126.19 sd 18.5) than those over 35 of age (mean 132.48 sd 20.86). There were no significant interactions.
4.4.2.4 Differences in the sub-groups of the British Pakistani sample on the total score of the ASPH by place of birth, length of stay and first language

An analysis of variance was performed on the total score of the ASPH, in order to investigate differences in scores across
i) first generation and second generation Asians
ii) length of stay in Britain
iii) first language.

4.4.2.4.1. Effect of place of birth, length of stay and first language in the British Pakistani sample on the total score of the ASPH

There were significant differences between first and second generation Pakistani immigrants to Britain in a positive attitude to seeking help for psychological problems, $F(1,66)=10.64, p<.001$. Contrary to prediction (hypothesis XI), first generation Pakistanis had a more positive attitude to seeking help for psychological distress (mean: 129.54 sd 20.83) than the second generation (mean: 114.13 sd 12.41).

As predicted (hypothesis XII), there was an effect of length of stay on a positive attitude to seeking help $F(1,66)=4.87, p<.01$, with those having lived in the UK more than 15 years having a less positive attitude to seeking help for mental distress (mean: 120.74 sd 19.81) than those having lived in the UK less than 15 years (Mean: 131.82 sd 21.71). There was no effect of first language $F(1,66)=.26$.

4.4.2.5 Factor analysis of the ASPH

Factors extracted for this sample were different from the sub-scales of the ASPH hypothesised by Fisher and Turner (1970). (See Appendix 4.7). Analysis was subsequently carried out on the four original sub-scales of the ASPH i.e. recognition of need for professional help, stigma tolerance, interpersonal openness and confidence in mental health practitioner.
4.4.2.6 Alpha reliabilities of sub-scales of the ASPH for British Pakistani, British and Pakistani samples.

Alpha coefficients of internal reliability calculated for each of the three cultural groups, thereby testing the internal consistency of the four original ASPH sub-scales showed moderate to low levels of consistency for the original sub-scales. While the first sub-scale, ‘recognition of need for help’ had acceptable levels of consistency for the three cultural samples, ranging from .66 to .62, the consistency levels of the other three sub-scales ranged from .54 to .44. As one of the reasons for the low consistency levels could have been the narrow range of variability because of the small $n_s$ of each sample, reliability analysis of each sub-scale was carried out for the three samples together. These are presented in Table 4.8.

Table 4.8 Alpha reliabilities of ASPH sub-scales for entire sample

<table>
<thead>
<tr>
<th>Sub-scales of the ASPH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of need for psychotherapeutic help.</td>
<td>.65</td>
</tr>
<tr>
<td>Stigma tolerance</td>
<td>.59</td>
</tr>
<tr>
<td>Interpersonal Openness</td>
<td>.58</td>
</tr>
<tr>
<td>Confidence in Mental Health Practitioner</td>
<td>.58</td>
</tr>
</tbody>
</table>

4.4.2.6.1 Internal consistency of sub-scales extracted from the ASPH.

The reliabilities of the four sub-scales of the ASPH (Table 4.8) were found to have moderate levels of internal consistency for this sample. These sub-scales of the ASPH were used to analyse group differences.

4.4.2.7 Differences in the sub-scales of the ASPH in the three cultural samples

In order to test for the differences in scores of effect of culture, a multivariate analysis of variance was performed on the four sub-scales of the ASPH:
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Analysis was done for:

i) culture
ii) sex
iii) age
iv) religion
v) levels of education

To investigate further main effects, a series of univariate F tests were performed on the separate category scores. The significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made.

Prior to conducting statistical tests, normality of variance and homogeneity of variance test assumptions were verified.

Table 4.9 Multivariate and Univariate analysis of variance of sub-scales of ASPH by culture

<table>
<thead>
<tr>
<th>Sub-scale</th>
<th>Culture (n=191)</th>
<th>British Pakistanis</th>
<th>British Pakistanis</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>means</td>
<td>sds</td>
<td>means</td>
</tr>
<tr>
<td>Recognition of need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(2,190)=3.83**</td>
<td></td>
<td>32.74</td>
<td>7.01</td>
<td>35.79</td>
</tr>
<tr>
<td>Stigma tolerance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(2,190)=5.55***</td>
<td></td>
<td>21.70 a</td>
<td>5.05</td>
<td>23.32 b</td>
</tr>
<tr>
<td>Interpersonal Openness</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(2,190)=3.70*</td>
<td></td>
<td>29.30</td>
<td>6.67</td>
<td>32.32</td>
</tr>
<tr>
<td>Confidence in Professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(2,190)=.96</td>
<td></td>
<td>41.43</td>
<td>8.34</td>
<td>41.88</td>
</tr>
</tbody>
</table>

***p<.01  **p<.025  *p<.05  Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)

4.4.2.7.1 Effect of culture on sub-scales of the ASPH across the three cultural samples

As predicted, using Pillais criteria, there was a main effect of culture for the combined
variables $F(2,190) = 3.70 p<.025$. There was a significant effect of culture for recognition of need for help $F(2,190) = 3.80, p<.025$, for stigma tolerance $F(2,190) = 5.55 p<.01$ and for interpersonal openness $F(2,190) = 3.70 p<.025$. Post hoc test indicated that scores were significantly different for the sub-scale of stigma tolerance only. Means indicated that the Pakistani group had significantly higher scores on this sub-scale than the British Pakistani group but was not significantly different from the British group. There were no significant differences in the sub-scale of confidence in mental health professional $F(2,190) = .96$. (Table 4.9 for $F$ values of multivariate analysis of variance and univariate analyses and means).

Table 4.10 Multivariate and Univariate analysis of variance of sub-scales of ASPH by sex, age, religion

<table>
<thead>
<tr>
<th>Effect</th>
<th>Pillai</th>
<th>Recognition of need</th>
<th>Stigma tolerance</th>
<th>Interpersonal Openness</th>
<th>Confidence in Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>3.31**</td>
<td>$F(2,190) = 6.29**$</td>
<td>$F(2,190) = 5.27*$</td>
<td>$F(2,190) = .21$</td>
<td>$F(2,190) = 7.18**$</td>
</tr>
<tr>
<td>Age</td>
<td>4.81***</td>
<td>$F(2,190) = .11$</td>
<td>$F(2,190) = 4.17*$</td>
<td>$F(2,190) = .06$</td>
<td>$F(2,190) = 14.37***$</td>
</tr>
<tr>
<td>Religion</td>
<td>1.81</td>
<td>$F(2,190) = 3.56**$</td>
<td>$F(2,190) = .54$</td>
<td>$F(2,190) = 2.09$</td>
<td>$F(2,190) = .11$</td>
</tr>
</tbody>
</table>

Sig. level ***p<.001 ** p<.025 *p<.05

4.4.2.7.2 Effect of sex, age and religion on sub-scales of the ASPH across the three cultural samples

Manovas done on sex showed a significant main effect for combined variables $F(1,190) = 3.31, p<.05$ as well as for recognition of need $F(2,190) = 6.29 p<.001$, stigma tolerance $F(1,190) = 5.27, p<.025$ and confidence in mental health professionals $F(1,190) = 7.18, p<.001$. (Table 4.10). Means indicated that males had lower recognition of need (males mean=31.86 sd 7.16; females mean=34.51 sd 7.23 sd), lower stigma tolerance (males mean=22.09 sd 4.59; females mean=23.87 sd 5.46) and lower confidence in mental health professionals than women (males mean=39.31 sd 7.77; females mean=42.10 sd 8.02). There was no effect for interpersonal openness.
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There was an interaction of culture and sex for the sub-scale of confidence in mental health professional only $F(1,190)=4.67, p<.01$. Means indicated that British Pakistani men had lower confidence in mental health professionals (mean=39.15 sd 8.52) than British Pakistani women (mean=42.77 sd 8.02) as did Pakistani men (mean=36.79 sd 6.50) compared to Pakistani women (mean=42.25 sd 6.82). British men had higher scores confidence in mental health professionals (mean=43.44 sd 7.02) than British women (mean=41.15 sd 6.08).

There was a significant main effect for age for combined variables $F(1,190)=4.81, p<.025$, and for stigma tolerance $F(1,190)=4.17, p<.01$ as well as for confidence in mental health professionals $F(1,190)=14.37, p<.001$. Those over 35 years of age had higher scores for stigma tolerance (means: 28.68 sd 6.0) compared to those under 35 years of age (means: 24.36 sd 5.41). Those over 35 years of age also had higher scores for confidence in mental health professionals (means 43.68 sd 7.54) compared to those under 35 years of age (means: 39.85 sd 6.71).

There was a significant main effect for religion for recognition of need only $F(2,190)=3.55, p<.025$. No significant main effect of education was found for the combined variables $F(3,190)=1.27$, but there was a significant effect of education for interpersonal openness only $F(1,190)=2.88, p<.05$. There was no significant main effect for combined variables for income $F(5,190)=1.18$ or for any of the sub-scales. There were no significant interactions.

4.4.2.8 Differences in the ASPH sub-scales of British Pakistani sub-groups by place of birth and length of stay in the U.K.

A multivariate analysis of variance was performed on the four sub-scales of the ASPH in the British Pakistani sample, in order to investigate differences in scores across:

i) first generation and second generation Asians

ii) length of stay in Britain

The results of the multivariate analysis of variance and Univariate F tests are presented in table 4.11.
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Table 4.11 Multivariate and univariate analysis of variance of sub-scales of ASPH for British Pakistani group by place of birth and length of stay in the UK (n=67)

<table>
<thead>
<tr>
<th>Effect</th>
<th>Recognition of need</th>
<th>Stigma Tolerance</th>
<th>Interpersonal Openness</th>
<th>Confidence in Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillais F(1,66) = 5.33**</td>
<td>F(1,66) = 9.33**</td>
<td>F(1,66) = .05</td>
<td>F(1,66) = 6.88***</td>
<td>F(1,66) = 13.22***</td>
</tr>
<tr>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
</tr>
<tr>
<td>(i)</td>
<td>34.11 (6.44)</td>
<td>21.82 (4.96)</td>
<td>30.49 (6.87)</td>
<td>43.32 (7.87)</td>
</tr>
<tr>
<td>(ii)</td>
<td>28.47 (7.19)</td>
<td>21.94 (5.37)</td>
<td>25.58 (6.11)</td>
<td>35.52 (7.04)</td>
</tr>
<tr>
<td>Length of Stay</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pillais F(1,66) = 2.15</td>
<td>F(1,66) = 5.84**</td>
<td>F(1,66) = .00</td>
<td>F(1,66) = 5.06**</td>
<td>F(1,66) = 2.86</td>
</tr>
<tr>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td>Means and sds</td>
<td></td>
</tr>
<tr>
<td>(i)</td>
<td>36.14 (6.01)</td>
<td>21.87 (5.24)</td>
<td>31.54 (6.90)</td>
<td>43.46 (8.07)</td>
</tr>
<tr>
<td>(ii)</td>
<td>31.14 (7.94)</td>
<td>21.71 (4.97)</td>
<td>27.80 (6.71)</td>
<td>40.07 (8.32)</td>
</tr>
</tbody>
</table>

Sig. Level **p<.001 ***p<.01 (i) First generation (ii) Second generation (iii) Under 15 years (iv) Over 15 years

4.4.2.8.1 Effect of place of birth, length of stay and first language on sub-groups of the British Pakistani sample.

As predicted, there was an effect of place of birth. From table 4.11, it can be seen, using Pillais' criteria, that the combined variables are significantly affected by place of birth, with F(1,66)=5.33 p<.01, for recognition of need F(1,66)=9.33 p<.001, interpersonal openness F(1,66)=6.88 p<.001, and confidence in mental health professionals F(1,66)=13.22 p<.0001. Contrary to prediction, first generation British Pakistanis had higher scores on recognition of need, interpersonal openness and confidence in mental health professional than second generation British Pakistanis. There were no significant differences for stigma tolerance F(1,66)=.05.

As also predicted, there was an effect of length of stay. However, there was no significant effect of length of stay for combined variables F(1,66)=2.15. There was a significant difference for the sub-scales of recognition of need F(1,66)=5.84 p<.01 and interpersonal openness F(1,66)=5.06 p<.01 only. Those who had been in the UK less than 15 years had higher scores for both sub-scales than those who had lived in the UK for less than 15 years (Means in Table 4.11).
4.4.2.9 Item analysis

Analysis of variance and item analysis was conducted of all the items of the ASPH in order to enable a closer investigation of the differences in endorsement patterns across the three cultural groups. This thereby indicated which items were more or less salient to which cultural group. All scores of 5, 6 or 7 were recoded as 1 and taken as positive endorsements of an item. The endorsement percentages were thus calculated and are presented in table 4.13.

To further investigate the main effect of culture, a series of univariate F tests were performed on the separate items. The significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made (Table 4.12).
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Table 4.12 F values, means and endorsement percentages of the ASPH items by British Pakistanis, British and Pakistanis

<table>
<thead>
<tr>
<th>ASPH ITEMS</th>
<th>British Pakistanis</th>
<th>British</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor I - Recognition of need for psychotherapeutic help</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A person with a strong character can get over mental conflicts</td>
<td>8.90***</td>
<td>4.26 a</td>
<td>32.1</td>
</tr>
<tr>
<td>5. There are times when I have felt completely lost and would have</td>
<td>3.04***</td>
<td>4.50 a</td>
<td>61.0</td>
</tr>
<tr>
<td>welcomed professional advice for a personal and emotional problem.</td>
<td>1.78</td>
<td>4.41 a</td>
<td>23.5</td>
</tr>
<tr>
<td>6. Considering time and expense involved in psychotherapy, it would</td>
<td>1.95</td>
<td>4.40 a</td>
<td>45.7</td>
</tr>
<tr>
<td>have doubtful value for a person like me.</td>
<td>0.98</td>
<td>4.63 a</td>
<td>58.3</td>
</tr>
<tr>
<td>9. Emotional difficulties, like many things, tend to work out</td>
<td>12.20***</td>
<td>3.68 a</td>
<td>26.3</td>
</tr>
<tr>
<td>by themselves.</td>
<td>1.21</td>
<td>4.21 a</td>
<td>34.5</td>
</tr>
<tr>
<td>18. I would want to get psychiatric attention if I was worried</td>
<td>8.98***</td>
<td>3.17 a</td>
<td>20.0</td>
</tr>
<tr>
<td>or upset for a long period of time.</td>
<td>3.74*</td>
<td>4.87 a</td>
<td>67.0</td>
</tr>
<tr>
<td><strong>Factor II - Stigma Tolerance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I would feel uneasy about going to a psychiatrist because of</td>
<td>2.69</td>
<td>3.70 a</td>
<td>37.7</td>
</tr>
<tr>
<td>what some people might think.</td>
<td>1.89</td>
<td>3.30 a</td>
<td>22.5</td>
</tr>
<tr>
<td>14. Having been a psychiatric patient is a blot on a person's life.</td>
<td>2.10</td>
<td>4.96 a</td>
<td>8.4</td>
</tr>
<tr>
<td>20. Having being mentally ill carries with it a burden of shame.</td>
<td>55</td>
<td>3.96 a</td>
<td>32.8</td>
</tr>
<tr>
<td>27. Had I received treatment in a mental hospital, I would not feel that</td>
<td>3.74</td>
<td>4.36 a</td>
<td>47.5</td>
</tr>
<tr>
<td>it ought to be kept secret.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. If I thought I needed psychiatric help, I would get it no</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>matter who knew about it.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***p<.001 **p<.01 *p<.05 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
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<table>
<thead>
<tr>
<th>ASPH ITEMS</th>
<th>British Pakistanis</th>
<th>Britons</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(2,190)</td>
<td>Means</td>
<td>%</td>
</tr>
<tr>
<td><strong>Factor III - Interpersonal Openness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I would willingly confide matters to an appropriate person if I thought it might help me or a member of my family.</td>
<td>2.84</td>
<td>5.10</td>
<td>70.2</td>
</tr>
<tr>
<td>10. There are certain problems which should not be discussed outside of one's immediate family.</td>
<td>2.95</td>
<td>4.36</td>
<td>49.6</td>
</tr>
<tr>
<td>13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.</td>
<td>11.68***</td>
<td>4.78 a</td>
<td>55.0</td>
</tr>
<tr>
<td>17. I dislike a personal - professionally trained or not - who wants to know about my personal difficulties.</td>
<td>78</td>
<td>3.32</td>
<td>20.5</td>
</tr>
<tr>
<td>21. There are experiences in my life I would not discuss with anybody.</td>
<td>2.11</td>
<td>4.96</td>
<td>48.9</td>
</tr>
<tr>
<td>22. It is probably best not to know everything about oneself.</td>
<td>36</td>
<td>3.64</td>
<td>31.4</td>
</tr>
<tr>
<td>29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers and priests.</td>
<td>1.05</td>
<td>3.19</td>
<td>26.8</td>
</tr>
<tr>
<td><strong>Factor IV - Confidence in Mental Health Practitioner</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Although there are clinics for people with mental troubles, I would not have much faith in them</td>
<td>1.46</td>
<td>3.58</td>
<td>26.0</td>
</tr>
<tr>
<td>2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
<td>3.61*</td>
<td>5.13</td>
<td>73.9</td>
</tr>
<tr>
<td>8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.</td>
<td>3.14*</td>
<td>3.08</td>
<td>20.9</td>
</tr>
<tr>
<td>11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
<td>2.13</td>
<td>4.05</td>
<td>40.4</td>
</tr>
<tr>
<td>12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>3.04</td>
<td>4.80</td>
<td>65.0</td>
</tr>
<tr>
<td>15. I would rather be advised by a close friend/relative than by a psychologist, even for an emotional problem.</td>
<td>24</td>
<td>4.32</td>
<td>43.1</td>
</tr>
<tr>
<td>16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.</td>
<td>2.63</td>
<td>4.10</td>
<td>52.0</td>
</tr>
<tr>
<td>19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
<td>.66</td>
<td>3.0</td>
<td>18.3</td>
</tr>
<tr>
<td>23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I would find relief in psychotherapy.</td>
<td>62.14***</td>
<td>5.02 a</td>
<td>67.0</td>
</tr>
</tbody>
</table>

***p<.001 **p<.01 *p<.05 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)

140
4.4.2.9.1 Endorsements of the ASPH items across the three cultural samples

With only <.01 level of significance being considered meaningfully significant, only five items, of all 29 items of the ASPH indicating attitudes to seeking help for mental distress, were significantly different between the cultural groups (nos. 4, 13, 23, 24, and 26). Four of these items (items 4, 13, 24 and 26) indicated self-reliance in preference to seeking help for mental problems and means indicated that they were endorsed more highly by the two Asian two samples than the British sample. There were significant differences between the British Pakistanis and the British group, on the hand and the Pakistani group on the other, for one item (item 23 - finding relief in psychotherapy), with significantly lower means for the latter group.

Comparisons of endorsements between the British Pakistani group and the Pakistani group on the one hand, and the British group on the other, confirmed these differences and indicated that:

In examining the endorsement percentages between the cultural groups, contrary to prediction, most of the directly negative items (1, 15, 17, 19) did not show any great differences in the endorsements of the three groups. Those items for which differences were most significant were items that referred to the individual coping with mental distress rather than seeking professional help (Table 4.12).
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4.4.3 The relationship between culture, causal beliefs of mental distress and attitudes towards seeking help for mental distress

4.4.3.1 Factors associated with a positive attitude towards help seeking for mental distress.

Rank order correlation coefficients were calculated between the ASPH total score and culture, sex, age, income, religion, education, first language and marital status. There were significant overall correlations between total scores for a positive attitude and sex (Spearman’s rho=.21, p<.001), religion (rho=.19, p<.01), education (rho=.15, p<.05) and income (rho=.21, p<.01). There was no overall correlation between culture and total score measuring a positive attitude to seeking help for mental distress (rho=.05ns), or for age (rho=.13ns).

4.4.3.2 Socio-demographic variables as predictors of a positive attitude towards seeking help.

A regression model was constructed using the total score measuring a positive attitude towards help seeking as the dependent variable, and four factors that were significantly associated with the total score as predictor variables, in order to determine which variables independently contributed to the variance in the scores. The predictor variables were sex, religion, education and income. Two of these were dummy variables: sex and religion (Cohen & Cohen, 1985).

In the stepwise multiple regression procedure, the predictor variable with the highest significant correlation with the dependent variable is entered first. The second variable to be entered is the one that will result in the largest significant increase in the total amount of variance explained, over and above what the first variable contributed. This procedure continues until every variable that can add significantly to the amount of variance explained is included. At the end of each step, every variable is reassessed, to test whether its contribution is still significant, given the effect of all other variables in the equation. If the variable is not significant, it is removed from the regression equation.
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Table 4.13 Multiple linear regression analysis of socio-demographic variables, using the total score for a positive attitude towards seeking help as the dependent variable

<table>
<thead>
<tr>
<th>Predictor Variables of a positive attitude to help-seeking</th>
<th>B</th>
<th>Beta</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>-5.072</td>
<td>-.119</td>
<td>-1.332</td>
</tr>
<tr>
<td>No religious affiliation</td>
<td>6.286</td>
<td>.120</td>
<td>1.298</td>
</tr>
<tr>
<td>Education</td>
<td>3.310</td>
<td>.130</td>
<td>1.348</td>
</tr>
<tr>
<td>Christian</td>
<td>11.259</td>
<td>.235</td>
<td>2.442**</td>
</tr>
</tbody>
</table>

Multiple R = .30
R Square = .09
F(3, 121) = 2.41*

**p<.05 *p<.01 Females = 1 Males = 2
Religious affiliat = 1 No Religious affil = 2, Non-Christs = 1, Christian = 2.

Three of these variables were found in the final regression equation, indicating that religion, sex, and education contributed independently to the total score for a positive attitude to seeking professional help. Religion was a significant predictor of a positive attitude towards help-seeking for mental distress, with Christians having a significantly more positive attitude to seeking help than Muslims, the reference group (Table 4.13).

Although the βs are given in the table, they are not particularly useful in the context of nominal scale coding because, they vary with changes in the relative n's. The raw score regression coefficient of a dummy variable is more useful as these are differences between means and thus do not depend on the relative sizes of the n's. The t values provide significance tests of the difference between the reference group mean and the mean of each of the other groups (see Cohen & Cohen, 1983, pp. 194-195).
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4.4.3.3 Causal beliefs of mental distress and a positive attitude to seeking professional help for mental distress in the three cultural groups

4.4.3.3.1 The association between causal attributions of mental distress and attitudes towards seeking help for mental distress

An inter-correlation between beliefs about the causes of mental distress and attitudes associated with seeking help were done separately for the British Pakistani, the British and the Pakistani groups.

In the British Pakistani group, significant and negative inter-correlations were found between both supernatural causal beliefs and interpersonal openness (Pearson’s r = -.43, p<.001) and non-western physiological beliefs and interpersonal openness (r = -.32, p<.01). With age, sex and education controlled for, correlations between supernatural causes and interpersonal openness were (r = -.34, p<.01), and between non-western physiological causes and interpersonal openness (r = -.31, p<.025). There were no other significant correlations.

In the Pakistani group, western physiological beliefs were significantly correlated with interpersonal openness (r=.35, p<.001). Beliefs in supernatural causes were significantly and negatively correlated with recognition of need for professional help (r = -.25, p<.025). With age, sex and education controlled for, correlations between western physiological causes and interpersonal openness were (r = .32, p<.01),

There were no significant inter-correlations between causal beliefs of mental distress and attitudes association with seeking help for the British sample.

4.4.3.3.2 Causal attributions of mental distress as predictors of a positive attitude towards seeking help

In order to test the hypothesis that causal attributions of mental distress would predict a positive attitude towards seeking help for mental distress in the two Asian groups and not in a Western (British) group (hypothesis XIV), a simultaneous multiple regression was constructed for British Pakistanis, British and Pakistani groups separately. The total score measuring a positive attitude towards seeking help was the dependent variable and the
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four categories of causal beliefs were the predictor variables.

Table 4.14 Multiple regression analysis of causal attribution of mental illness using a positive attitude to seeking help as the dependent variable

<table>
<thead>
<tr>
<th>Causal Beliefs</th>
<th>British Pakistanis</th>
<th>Britons</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Beta</td>
<td>T</td>
</tr>
<tr>
<td>Stress</td>
<td>-2.7</td>
<td>-1.7</td>
<td>8.34</td>
</tr>
<tr>
<td>Supernatural</td>
<td>-2.2</td>
<td>-2.3</td>
<td>1.166</td>
</tr>
<tr>
<td>Western Physiology</td>
<td>.82</td>
<td>.39</td>
<td>1.744</td>
</tr>
<tr>
<td>Non-western Physiology</td>
<td>-1.02</td>
<td>-3.0</td>
<td>-1.539</td>
</tr>
</tbody>
</table>

Multiple R .38
R Square .15
Adjusted R Square .09
F=2.63*

Multiple R .26
R Square .06
Adjusted R Square .00
F=94

Multiple R .50
R Square .25
Adjusted R Square .20
F=4.88**

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

As predicted causal attributions of mental illness were significant predictors to a positive attitude to seeking professional help for the two Asian samples. They accounted for 15% of the variance for the British Pakistani sample, (multiple R=.38, R²=.15) and for 25% of the variance for the Pakistani sample (multiple R=.50, R²=.25). (Table 4.14)

More specifically, beliefs about western physiological causes significantly predicted a positive attitude to seeking professional help while supernatural causes significantly and negatively predicted a positive attitude towards seeking help for the Pakistani sample only.

As predicted, causal attributions of mental illness were not significant predictors to a positive attitude towards seeking help for the British sample, accounting for 6% of the variance (multiple R=.26, R²=.06)
4.5 Discussion

Distinctions in western and non-western explanations of causal beliefs of mental distress, as posited by Eisenbruch (1990), were verified by the multidimensional scaling analysis done on the data from this sample. Western explanations were distinct from non-western explanations of the causes of mental illness (epitomised in stress and western physiological causal beliefs on the one hand and supernatural and non-western physiological causal beliefs on the other).

However, the distinction between naturalistic (western and non-western physiological causes) and personalistic beliefs (stress and supernatural causes), as found by Eisenbruch, was much less clear for this sample. This latter finding bears out criticisms made by Landy (1983) that distinctions along such dimensions are not necessarily straightforward. Causes that are supernatural can also be perceived as ‘natural’ in non-western cultures. These distinctions may be further blurred in multi-cultural settings, attesting to the difficulty of separating emic and etic concepts of health and illness.

These initial findings were confirmed by further analyses, carried out to investigate the similarities and differences between the three samples, British Pakistani, the British and the Pakistani sample. Distinctions in causal categories, along western and non-western lines, as posited by Eisenbruch, were not confirmed, as differences in all causative categories of mental distress beliefs did not separate the two Asian groups from the Western (British) group.

As hypothesised, responses to western explanation of mental distress differed significantly, at the .01 level of significance, between all three cultural groups. These differences had been predicted on the basis that all three groups were separate ‘cultural’ groups. However, it was the Pakistani group, and not the British group, that scored highest on both western causative categories i.e. stress and western physiological categories, with the British Pakistanis scoring the lowest of all three cultural groups.

The highest score of the Pakistani group for both the stress and western physiological categories, although against expectation, is not altogether surprising. Many of the items comprising the category of stress refer to some form of social breakdown, such as
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'Conflict or break-up of family relationships'. Indeed, as the separate endorsements of items of the MDEMQ showed, Pakistanis scored higher than 85% on three of these stress items (Bad experiences during childhood, Death of a relation or close friend and Conflict and break up of family).

However, the most striking feature of the scores of the stress category of causal beliefs was the notable similarity between the relatively high attribution of stress causal beliefs in all three groups, but particularly the British and the Pakistani groups. This result demonstrates the somewhat heuristic nature of western/non-western explanations, as postulated by Eisenbruch (1990). This category of the MDEMQ included both person-oriented and social-oriented distress items. While the category itself was predicated on internally based psychological distress, assumed to be primarily Western, it also incorporated items that focussed on the relationship between distress and the social environment. The high scores of Pakistanis on this category are in line with Kakar's (1982) analysis, that shows Indian culture (akin to that of the Pakistanis) to be society oriented.

On the other hand, there is also some evidence to suggest that popular understanding of the causes of depression amongst the native British population also focus on interpersonal difficulties (Fumham & Kuyken, 1991). Research carried out in the UK has also shown similarities between cultural groups with regard to causal beliefs relating to the social aspect of people's lives. While British Asians identified both social stress and family problems as being the two most dominant causes of mental illness (Hatfield et al, 1996), so did a comparable white British group (Huxley, 1993a).

Findings about causal beliefs in the western physiological category were similar to the results found for the stress category. Against prediction, it was the Pakistani group that had the highest means and gave the highest endorsements for all items in this category, with two exceptions. However, in comparison to all other items, item 15 (Chemical imbalance in the body), and item 16 (brain damage or head injury) were most highly endorsed by the British group. This last finding confirmed the relatively narrow focus of western bio-medical notions of mental distress, since these two items got the highest endorsements of all the items of the MDEMQ from the British group. The British
Pakistanis again gave the lowest endorsements for all items in this category, with significantly lower scores than the British sample.

In making a comparison between British Pakistani and the British groups only, the differences found in both the stress category and the western physiological category remain significant even when age and education are controlled for. Although these differences had been predicted, it might be surprising considering that much of the British Pakistani minority group has resided in Britain for the last five decades and many of the younger generation are British-born. It might have been expected that influences from both a medical health system based on bio-medical principles, as well as western notions of psychology in the media, would lead to more similarities between the two cultural groups. However, beliefs in these two causal categories within the ethnic minority group have remained low compared to the indigenous population.

Contrary to prediction, British Pakistanis' scores, in the traditional concepts of mental distress, were different from those of Pakistani, with significantly lower scores, at the .01 level of significance, for these two categories compared to Pakistanis. Pakistanis' scores were significantly higher compared only to those of the British group. Although the British Pakistani group scored higher than the British group, differences between the British Pakistani group and the British group for supernatural causes of mental illness (gods, hand of fate, destiny) and non-western physiological causes (food, balance of humours, etc.), were not significant.

It could be argued that these results give evidence of the fracturing of indigenous beliefs held by the migrant group. Indeed, there was an effect of length of length of stay in the UK in the British Pakistani sample, on western beliefs about mental distress, so that a longer stay increased beliefs of the British Pakistani group in western causal beliefs. This acculturation effect has been found by several studies in other migrant groups, notably by Berry (1998).

As these findings have demonstrated, it was the Pakistani sample that has had the highest scores in all four causative categories. These results may be truly reflective of the medically pluralistic setting of Pakistanis, in which all four causative categories exist within the etiologies of allopathic, humoral and sacred medicine (Leslie, 1976).
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Bhattacharya (1986) terms this the assimilative character of medically pluralistic settings, in which people from the sub-continent view the medical systems as more or less interchangeable, without the compartmentalisation evident in the Western culture societies. In the case of the British Pakistani group, however, it seems that in residing in another culture and within a Western medical system, this broadly holistic outlook in causal attributional beliefs has been modified.

Against prediction, there was no main effect of religion of the supernatural category of causal attributions. Against prediction, there were no main effects of sex, education or income. As predicted, there was a main effect of age on the western causal beliefs, with those under the age of 35 having higher beliefs in these explanations of mental distress.

As predicted, there were significant differences between first and second generation British Pakistanis for all causal categories, at less than the .01 level of significance. Second generation Pakistani seemed to hold more beliefs related to the western explanatory model than the first generation Pakistanis. However, contrary to expectation, the second generation also had significantly more beliefs in traditional causal beliefs, such as supernatural and non-western physiological causes, than first generation Pakistanis. The recognition by the younger British Pakistanis of the more traditionally eastern conceptions of the causes of mental illness, coupled with their beliefs in the biomedically based western beliefs, showed that second generation immigrants had their own cultural explanations. These were quite different from, yet linked to, both the eastern and western, cultures. Although it may be counter intuitive that their beliefs were more traditional than those of their elders, these results illustrate the complexity of lay beliefs and demonstrate that culturally-specific causal beliefs can be modulated by a whole range of socio-cultural influences.

These differences might also be an indication of the role of social facilitation in answering questionnaires. While it is possible that this might be the explanation for all the findings in this study, this point might be particularly relevant to findings of the more traditional concepts, which show an interaction of culture and age. Low means for older members of the British Pakistani group might be evidence of the fact that these types of beliefs, although deeply held, might be difficult to express. Furthermore, social
desirability may make it more difficult for older participants to express honestly their beliefs about the causes of mental illness.

In the case of the findings relating to the British Pakistani sample in this study, it could be argued that these findings could not be generalised, with any confidence, to the Pakistani immigrant population as a whole in the UK. Generally speaking, socio-economic factors (e.g. education levels) are not comparable between this ethnic migrant group as a whole and the host population. On the other hand, any differences found between these two highly educated groups in this study may well have been due to the cultural beliefs of these two groups, and quite separate from other socio-demographic factors. There are, however, problems in generalising results when real socio-cultural differences are eliminated in standardising samples between cultural groups.

Analysis of the ASPH measuring a positive attitude to seeking help for psychological problems showed that, contrary to prediction, neither British Pakistanis nor Pakistanis had a less positive attitude to seeking help than the British group. This finding confirms the assertion by Christakis, Ware and Kleinman, (1994) of the high value accorded to bio-medical treatments in the cultures of the developing countries. It also confirms the conclusions of Ramesh and Hyma (1981), who found that overall trends appear to be the inclusion of a more 'scientific' therapy into a varied range of help seeking for mental distress in the sub-continent.

Certainly, it could be argued that the British Pakistani group has been influenced both by the changing values in their own countries as well as by the values of their host society. More generally, the 'psychologisation' of many aspects of life and health by the media and the increasing acceptability of seeking psychotherapeutic solutions for these problems could account for one of the major influences on a positive attitude to seeking help for mental illness in all cultural samples. Most importantly, perhaps, in the U. K., where the norm is health-care services under the NHS, attitudes to seeking help for psychological problems were probably mediated by the fact that the scientific model of treatment is more widely available than other forms of treatment as well as being free. As predicted, the effect of religion was found to be significant on attitudes towards help seeking. However, a significance effect of religion, at the .01 level of significance was
found for only one sub-scale, recognition of need for seeking help. Means indicated that Muslims had a lower score than Christians or those with no religious affiliation. While this attitude may be seen as an inhibition to recognise the need for help, from a Western point of view, it can also be interpreted as predominantly an attitude of acceptance of the inevitable, as all that is meted out to an individual is by God's will. The role that religion plays, in shaping attitudes towards seeking help, was confirmed in the finding that Christians and those with no religious affiliation significantly predicted a positive attitude towards seeking help for mental distress compared to the reference group of Muslims. The over-all results demonstrated that a positive or a negative attitude towards seeking professional help is not necessarily a unidimensional measure. Although no differences had been found between cultural groups towards a positive attitude to seeking help for mental distress, significant differences existed between the three cultural group for stigma tolerance. Surprisingly, British Pakistanis had significantly lower scores on stigma tolerance than the Pakistani group, indicating a greater awareness of stigma associated with seeking help for mental distress, perhaps because of less established support networks in the UK. Although there was an effect of sex on attitudes to seeking help for mental distress, it was contrary to prediction because men had an over all less positive attitude to seeking help for mental distress than women. They also had lower recognition of need, lower stigma tolerance and lower confidence in mental health professionals than women. These differences were found across all three cultural groups. Therefore, it could be assumed that men generally have difficulty in being open about problems. Multiple regression confirmed that sex was a significant predictor of a positive attitude towards seeking help, showing an inverse relationship between men and a positive attitude. This result confirms those of earlier findings which have demonstrated that women are more willing to seek psychological help than men (Price and McNeill, 1992; Fischer and Farina, 1995). Further analysis showed that it was only the men of the two Asian samples that had significantly lower scores than the females in confidence in mental health professionals. This finding contradicts the hypothesis and finding of earlier research (Mahmud 1987), showing Asian women to be particularly reluctant to seek help, and may be the result of
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this sample being predominantly middle-class. While women in the migrant community of British Asians have generally been found to be particularly disadvantaged, (Rudat, 1994), these disadvantages might not apply to the middle classes of this community. Indeed, women in the British Pakistani sample were no different from the British female sub-sample.

Differences between first and second generation British Pakistanis were found in an overall positive attitude towards seeking help as well as in the sub-scales of recognition of need for professional help, interpersonal openness and confidence in mental health professionals. However, differences in these measurements were not those that had been predicted. The first generation of British Pakistanis had a more positive attitude to seeking help than the second generation as well as higher scores for three of the sub-scales. However, notably, there were no differences for stigma tolerance between first generation and second generation British Pakistanis. The fact that older and younger generations of British Asians have the same awareness of stigmatisation associated with seeking help may be illustrative of a particular attitude underlying help-seeking in this minority group.

Nevertheless, considering the fact that the second generation would not only be younger, but also educated to a higher level and more acculturated to the western culture, this finding is surprising. Either the younger members of this group are genuinely more sceptical of the western ideas of treatment for psychological distress or just find it easier to express this scepticism compared to the older members of the community. Indeed, findings for length of stay confirmed that those who had lived in the UK for less than 15 years had a more positive attitude to seeking help compared to those who had lived in the UK for more than 15 years. Needless to say, the relationship between expressed attitude and one that actually guides a particular behaviour is a complex one, and problems often noted in attitude research could, perhaps, be even more acute in cross-cultural research area.

There were a number of inter-correlations between the two aspects of mental distress i.e. beliefs and attitudes to seeking help, in the two Asian groups. For the British Pakistanis, supernatural and non-western physiological causes were significantly and negatively
associated with interpersonal openness. Pakistanis, too, showed a significant and negative inter-correlation between supernatural causes and recognition need for professional help and a significant inter-correlation between western physiological causes and interpersonal openness.

It is to be expected that people with more beliefs in supernatural or non-western physiology as the causes of mental distress would not have a positive attitude to seeking help for psychological problems. However, as predicted, these associations were significant only for the two Asians groups. These findings also seem to suggest that rather than all causal beliefs, it is the more traditional beliefs about mental illness that influence underlying attitudes contributing to a negative attitude to seeking help. In the case of British Pakistanis, it seems plausible that under-utilisation of health services in this community may be explained by underlying attitudes determined by traditional concepts of mental distress.

Causal beliefs of mental distress were found to be significant predictors of a positive attitude to seeking help for mental distress in the British Pakistani sample, (accounting for 15% of the variance), as well as for the Pakistani sample (accounting for 25% of the variance). More specifically, it was in only the Pakistani sub-sample that supernatural causes were significant and negative predictors of a positive attitude to seeking help, while western physiological causes significantly predicted a positive attitude to seeking help for mental distress. In contrast, the causal beliefs of mental distress held by Britons were not significant predictors to attitudes to seeking help for psychological problems. This finding is a particularly interesting one because it is indicative of the strength of the values and beliefs of the more traditional cultures. Although these beliefs are relatively difficult to assess directly, these results show their impact on attitudes towards seeking help treatment for mental distress and clarify the role of causal beliefs on attitudes underlying seeking help for mental health problems in the two Asian groups. These findings also demonstrate that, rather than applying 'culture' as a mere label, cultural beliefs of health and illness can provide a useful way of operationalising culture, as has been suggested by Ware & Kleinman (1992).

The importance of the choice of measurement tools constructed for the use of cross-
cultural investigation has been highlighted in this study. One of the first problems that emerged in the use of the MDEMQ was that the participants were not clear about the meaning of the term 'mental distress'. The researcher was asked, on a number of occasions and by participants in all three groups, whether 'mental distress' meant 'mental illness'. Secondly, while the MDEMQ provided a comprehensive range of studying different cultural beliefs, the problems in classifying a wide range of beliefs became apparent in this study. For example, some of the items of the MDEMQ could be classified as both a western or non-western belief (e.g. being born this way). Furthermore, as findings of this study have shown, other socio-demographic variables, other than culture, influence causal beliefs of mental distress. It is important, therefore, to emphasise, as Eisenbruch himself points out, that these taxonomies of beliefs should be taken as useful ways of understanding people's beliefs rather than distinct categories.

This may be particularly pertinent in the present day context and especially in a multicultural society such as in the UK. While a migrant community may show an acculturation effect in its beliefs, the beliefs of eastern cultures have also influenced western beliefs. Many non-western concepts form part of western health beliefs of today, such as the emphasis on more holistic or alternative healing. This could be why some of the non-western causal belief might have been scored highly by the British group.

While this might also account for the fact that younger people in the British Pakistani sample also had higher scores in this traditional category, the concept itself, taken on by another culture, might be quite different. For example, with the increasing influence of eastern philosophy on western thought, the belief that 'a person's karma' might be the cause of mental distress might be found in both western and non-western explanations, but they would be interpreted in quite different ways. These examples again illustrate the difficulty of distinguishing culture-specific concepts from concepts that have become inter-mingled with those of another culture and are, therefore, shared by cultural groups.

In the case of the ASPH, several methodological shortcomings emerged, both in the content and in the structure of its scales. Difficulties had been expected, since the ASPH is not constructed as a tool for cross-cultural investigation and its use had been justified purely because of the apparent relevance of its structure to attitudes of British Pakistanis.
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to seeking help for mental distress.

Not unsurprisingly, the factors of the ASPH were different from those extracted originally by Fischer and Turner (1970). As this questionnaire had also been found to have unstable dimensions in other studies (De Barot, 1977; Surgenor 1985), it is to be expected that the problems of valid and stable sub-scales become intensified in cross-cultural investigations.

The inconclusive results, from analysis of the original sub-scales of the ASPH, could be attributed to the ambiguous nature of some of the items of the ASPH. Answering negatively to some of the items might lead to a higher total score (denoting a positive attitude to seeking help) but would not, necessarily, mean a more positive attitude to seeking help for psychological problems. Some examples are ‘Emotional difficulties, like many things, tend to work out by themselves’, ‘Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns’, ‘It is probably best not to know everything about oneself’. Furthermore, items such as ‘I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family’ might have different meaning for the cultural groups. The ambiguity of some of the items that made up each sub-scale made its interpretation difficult.

To conclude, the over-all findings suggest that the British Pakistani group had more similarities with the British group than with the culturally more similar group, the Pakistanis. The holistic nature of beliefs found in previous research in people from the Indo-subcontinent (and found amongst the Pakistani group in this study), did not remain unchanged in the migrant group of the British Pakistani in the UK. Furthermore, there were unexpected differences between sub-groups within the British Pakistani sample, such as the first and second generation and there was also an effect of length of stay. As these findings have demonstrated, not only are beliefs of cultural groups multidimensional and cultural parameters, in terms of distinctions in categories of beliefs, difficult to delineate, but findings have also demonstrated the importance of other factors, such as age and education on causal beliefs of mental distress.

There was little evidence that Asians on the whole have a less positive attitude towards seeking help for mental distress than Westerners (Britons). Importantly, however,
findings showed that causal attributions made about mental distress by the two Asian groups only, mediated in underlying attitudes towards seeking help for mental distress. The next study, therefore, aimed to broaden this investigation by examining other influences on the causal beliefs of mental distress of cultural groups. Hence, the following study examined the relationship between levels of mental distress in cultural groups, causal beliefs about mental distress and differences in attitudes to actual pathways that might be considered appropriate to seeking help.

4.6 **Summary**

This study examined patterns of differences and similarities in beliefs about causal attributions of mental distress and attitudes underlying help-seeking between three cultural groups, British Pakistanis living in the UK, a British sample and Pakistanis living in Pakistan.

**Hypothesis I:** As predicted, multi-dimensional scaling analysis displayed similar differences between western and non-western beliefs of mental distress, as postulated by Eisenbruch. Against prediction, naturalistic causes of explanations of mental distress were not separated from personalistic causes of explanations.

**Hypothesis II:** As predicted, beliefs in western explanations (causes attributed to stress and western physiology) of mental distress differed significantly, at the .01 level of significance, across the three cultural groups.

**Hypothesis III:** Against prediction, however, differences between western and non-western cultures in non-western causal causal categories of attributions, as postulated by Eisenbruch (1990), were not confirmed by the findings of this study. Beliefs in traditional non-western explanations (causes attributed to supernatural and non-western physiology) differed significantly between the British Pakistani group and the British group, on the one hand, and the Pakistani group on the other.

**Hypothesis IV:** Against the hypothesis, religion did not have an effect on causal beliefs of mental distress.

**Hypothesis V:** Against prediction, there were no main effects for sex, education or
income on causal attributions of mental distress. As predicted, however, there was a main effect of age.

Hypothesis VI: As hypothesised, there were significant differences between first and second generation British Pakistanis in the causal attributions of mental distress. However, contrary to prediction, it was the second generation that had higher scores for all categories of causal beliefs than the first generation.

Hypothesis VII: Against prediction, the British Pakistani group and the Pakistani group did not have a significantly less positive attitude to seeking professional help for mental distress than the British group.

Hypothesis VIII: As predicted, there was a main effect for sex on a positive attitude to seeking help. Contrary to expectation, women had a more favourable attitude to seeking help than men.

Hypothesis IX: As predicted, there was a main effect of religion, at the .01 level of significance, but only for the sub-scale of recognition of need for help.

Hypothesis X: Against prediction, there were no main effects for age, education or income on the scores of a positive attitude to seeking help.

Hypothesis XI: As predicted, there were significant differences between first and second generation British Pakistanis on the scores of a positive attitude for seeking help. Contrary to expectation it was the first generation Pakistanis that had a more positive attitude to seeking help than the second generation.

Hypothesis XII: As predicted, there was a main effect of length of stay, with those having been in the UK for more than 15 years having a less positive attitude for seeking help than those having lived in the UK for more than 15 years.

Hypothesis XIII: As predicted, multiple regression showed religion, along with sex and education, to be a significant predictor of a positive attitude to seeking help.

Hypothesis XIV: As hypothesised, causal attributions of mental illness were significant predictors of a positive attitude to seeking professional help only for the British Pakistani and the Pakistani groups but not for the British group.
CHAPTER 5

Study two

Levels of mental distress, causal attributions and attitudes towards help-seeking pathways
5.1 Introduction

Although the way in which people explain their illness is strongly related to wider cultural health beliefs (Herzlich & Peirret 1986), specific health beliefs also often reflect particular personal, social, economic and political circumstances (Skelton & Croyle, 1991). Kleinman (1980) separates the explanatory models of mental illness of patients from lay explanatory models that people hold, the former shaped by the passage and processes of the illness, the latter by wider beliefs of health and illness. It, therefore, seems plausible that attributions of the causes of mental distress in a lay population will be associated with the mental health of that population. This point may be particularly relevant to research in a population from the Indo-subcontinent, given that the ethno-cultural beliefs of health and illness behaviour have particular importance for this cultural group (Bal, 1987; Littlewood & Lipsedge, 1997).

Few studies have investigated specifically the association between the mental health of cultural groups and their causal attributions of mental distress. Whereas a great increase has been noted in cross-cultural mental health research as a result of extensive migration from non-western cultures into the West (Littlewood & Cross, 1980), it has focused on two particular aspects. Firstly, research has investigated links between ethnicity and mental health (King, 1978; Dean, Walsh, Downing & Shelley, 1981; Gupta, 1991; Birchwood, Cochrane, Macmillan, Copestake, Kucharska & Cariss, 1992); secondly, it has investigated links between migration and mental health (Odegaard, 1932; Morgan & Andrushko, 1977; Hitch & Clegg, 1980; Cochrane & Bal, 1989; Sundquist, 1994; Picarda & Inechein, 1995). These comparisons are valuable, assessed as they are in terms of cultural differences and the possible results of the effects of migration. This study aims to examine, in the context of both culture and migration, the link, if any, between the mental health of individuals from distinct cultural groups, their causal attributions and their attitudes to help-seeking for mental distress.
Chapter 5

Study 2: Levels of mental distress, causal attributions and attitudes to help-seeking pathways

In the case of migrant groups in the UK, research on their psychological health compared with the indigenous British population has provided a complex and often contradictory picture. Earlier research, generally indicated a higher incidence of psychiatric morbidity in all minority groups (Hashmi, 1968; Bagley, 1969; Pinto, 1974; Bagley, 1971) but these studies did not address demographic differences in populations, such as sex ratios, age structure, social class, which are often found to be associated with mental health. Other studies that focused predominantly on mental hospital rates of admission attested to the higher rates of admissions in minority groups and also, in standardising age and sex, provided more reliable data (Cochrane, 1977; Cochrane & Bal, 1989). However, researchers acknowledged that hospital rates of admission could not be taken as an accurate measure of the mental health of a particular community, since they could conceal much information that was important (Cochrane, 1981).

Investigations carried out at the community level, such as the large national survey conducted by Cochrane and Stopes-Roe (1981) of the mental health and related adjustment indices of Asians in the UK, found that British Asians experienced substantially fewer mental health problems than the indigenous population. Other research also has found less mental illness among people from the Indo-subcontinent (Inechein, 1987; Leff, 1988). In contrast, more recent studies have raised concerns about the mental health of this ethnic minority group (MacCarthy & Crassati, 1989; Raleigh, 1991; Webb-Johnson, 1991; Beliappa, 1991; Fenton & Sadiq 1993; Hatfield et al, 1996; Berthoud & Nazroo, 1997). Still other studies, such as that of Wilson & MacCarthy (1994), carried out at primary care level, have found no differences in Asian and indigenous British samples’ psychiatric morbidity. As a result of these conflicting findings, issues that have been raised about the mental health of this minority group have implicated several factors (Inechein, 1990). It is not clear, whether low levels of mental distress in the Asian community are the result of under-representation, under-reporting or poor detection of psychological distress. This particular investigation attempted to disentangle some of the issues in investigating the mental health of a sample of the general population.
Chapter 5

Study 2: Levels of mental distress, causal attributions and attitudes to help-seeking pathways

It seemed important, that in order to examine the relationship between generalised forms of psychological distress and the mode of expression of groups at general population level, a number of conceptual issues needed to be resolved.

Firstly, a primary concern was that an assessment of mental distress should focus on the mental, rather than physical, health status. One of the screening instruments most commonly used in the British Asian population (Cochrane, 1977; Cochrane & Stopes-Roe, 1981; Bal, 1987; Furnham & Shiekh, 1993), the Langner-22 (Langner, 1962), does not seem to distinguish changes in mental health from changes in physical health (Ware, Johnstone, Avery & Brooke, 1979; Ware, Brook, Davies-Avery, 1980). Although its validity for cross-cultural research has been established by several of these studies (Cochrane, 1977; Cochrane & Stopes-Roe, 1981; Furnham & Shiekh, 1993), it could be argued that it is not the ideal screening tool in an Asian population, in which somatic expression is assumed to be the norm (Bal, 1987).

This issue lies at the heart of the debate that has surrounded the measurement of mental distress in this community, viz. the inhibition of the expression of psychological distress in the Asian culture. The assumption is that lack of psychological presentation in the cultures of the subcontinent result in low levels of psychological symptomatology (Leff, 1988) and low levels of psychological distress in British Asians (Bal, 1987). However, whereas a preponderance of somatic presentation has been found in British Asians at primary care level, researchers have argued that mental distress in a lay population is often not expressed in the same terms as those who contact health services (Veit & Ware, 1983).

Secondly, the measurement instrument used in a lay population should focus on generalised feelings of affect. Whereas some of the screening instruments used in the British Asian population, such as the Self-Rating Questionnaire (Wilson & McCarthy, 1994) and the General Health Questionnaire (Currer, 1986; Krause, Rosser, Khiani & Lotay, 1990) focus on specific symptoms of psychological distress, people in general populations rarely report symptoms of even the most common symptoms of psychological distress (Veit & Ware, 1983).
Finally, should mental health in a lay population be measured as a unitary measure or does it have several dimensions? While the Langner-22, for example, contains only negative items, and measures one dimension of mental health i.e. mental distress, studies have presented evidence for dimensionality within the psychological distress dimension (Bradburn, 1969; Dohrenwend, Shrout, Egri, & Mendelsohn, 1980). Screening instruments containing both positive and negative items have given evidence for a psychological wellbeing dimension distinct from dimensions of psychological distress (Ware, Johnston, Davies-Avery, & Brook, 1979; Goldberg, Steele, Johnson, & Smith, 1982). Veit & Ware (1983), in fielding a new screening tool, the Mental Health Inventory, also found mental distress in lay populations to be multi-dimensional, comprising of five dimensions, which together gave a comprehensive measurement of the mental health of a lay population.

While the picture, to date, of the mental health of the British Asians in the UK, remains one of great complexity, so does that of their associated attitudes towards seeking help or treatment for mental distress. Conclusions about their attitudes towards seeking help for mental distress have generally been based on assumptions about their social and cultural traditions. In this area, too, research has generally tended to disregard any links between concepts of mental illness and the treatment considered appropriate for it in the migrant group of British Asians.

Research has generally assumed that Asians have a reluctance to seek professional help for mental distress (Henley, 1979; Rack, 1982; Schofield, 1987; Balarajan, Yuen, & Raleigh, 1989) and that, alternatively, it is their families that provide strong support systems (Cochrane et al, 1987). Although Stopes-Roe and Cochrane’s (1990) study, gave evidence of the still strong support networks of Asian families that have migrated to the UK, Beliappa’s (1991) investigation, amongst Asians in Haringey suggests that the family is not universally perceived as supportive. Other studies have noted an expressed preference, of Asians, for spiritual healers or prayers because they find the existing services inadequate or inappropriate (Beliappa, 1991; Hatfield et al, 1996), although there is little evidence to support this preference (Johnson, 1986; Bhopal, 1986; Inechein, 1987).
The supposed reluctance of British Asians to seek help is all the more surprising since the medically pluralistic setting of the Indo-subcontinent is an acknowledged feature, where a range of health care providers offer different forms of treatment. These are consulted according to the forms of understanding that people have in dealing with illness (Weiss, Sharma, Gaur, Sharma, Desai, & Doongaji, 1986). However, even in the Indian scenario, Weiss and colleagues concluded that patterns of distress might be a stronger predictor of choice of healer than the conceptual models of illness.

Other research in India has found that a variety of demographic variables, such as occupation and income, were better predictors of patterns of help-seeking than factors that might be assumed to be important, such as religious tradition. Bhattacharya (1983) suggests that choice of healer might depend on additional factors, rather than on the cognitive models employed by patients. She describes an interaction between the pluralism of patients' models of illness and the pluralism of treatment options.

It seems, therefore, that help-seeking involves both ideological and practical considerations (Weiss, 1997). Kleinman (1980) postulated explanatory models to be anchored 'in the different explanatory systems and social structural arrangements comprising the separate sectors ...of local health care systems'. This may be the reason why, in the UK, with a health care system such as the NHS that readily provides just one option for seeking help, Asians have an above average rate of general practitioner consultation (Donaldson, 1986; Gillam, Jarman, White, & Law, 1989; Balajaran et al, 1989).

As regards seeking help for mental distress, however, there seems to be a reluctance in the British Asian population to contact health services (Inechein, 1990). Contrary to supposition, this inhibition to seeking bio-medical treatment for mental problems is not found only in the non-western cultures, as surveys have shown that most respondents, in the West, have negative views about the effectiveness of medication for mental disorders, such as depression (Smaje, 1995). Older patients, too, in both cultures hesitate to consult psychiatric services. Nevertheless, as earlier discussions have shown, there is no doubt that a particular unwillingness has been noted in contacting professional services for mental health problems.

The current study set out to explore further people’s lay explanatory models of mental distress. Therefore, it aimed to examine the causal attributions of mental distress associated with the mental health of three cultural groups, and subsequent attitudes towards actual help seeking pathways for mental distress.

5.2 Aims and Hypotheses

The study aimed to explore the multidimensional nature of mental health in this sample, associated causal attributions of mental distress and attitudes to pathways considered appropriate for seeking help for mental distress.

The sample comprised of three cultural groups, British Pakistanis, Britons and Pakistanis residing in Pakistan. As was the case in the first study, the British Pakistani group living in the UK was the main focus of the study, with the other two groups as reference groups. In order to analyse patterns of responses between the cultural groups, comparisons were made between the migrant group and the host community as well as between migrants and non-migrants Pakistanis. It was hypothesised that:

I. Mental health in a lay population would be multi-dimensional i.e. have dimensions of psychological distress as well as psychological wellbeing, which would be confirmed by factor analysis of the Mental Health Inventory (Veit & Ware, 1983).

II. There would be a hierarchical order of mental health dimensions for this sample, as proposed by Veit & Ware (1983) i.e. there would be one higher order factor and three lower order factors relating to psychological distress and one higher order factor and two lower order factors relating to psychological wellbeing. It is also hypothesised that each higher order factor would be highly correlated with its lower order factors.

III. There would be differences in the scores of the dimensions of mental health of the three groups. It was hypothesised that British Pakistanis would have higher scores
Chapter 5

Study 2: Levels of mental distress, causal attributions and attitudes to help-seeking pathways

for psychological distress and lower scores on the Mental Health Index and for psychological wellbeing compared to both the British and the Pakistani groups. This hypothesis was based on the evidence of the relationship between migration and poor mental health (Sundquist, 1994; Picarda & Inechein, 1995).

IV. There would be an effect of age, sex, religion and income on the scores of the Mental Health Inventory.

V. There would be a significant difference between first and second generation British Pakistanis in the scales of the MHI with first generation having higher scores than the second generation. There would also be an effect of length of stay in the UK in the British Pakistani sample. Those having been in the UK longer would have higher scores on psychological distress than those with shorter stay.

VI. There would be an effect of income in the British Pakistani group. Those with lower income would have higher scores on scales of psychological distress than those with higher income.

VII. Differences in mental health between British Pakistanis, Britons and Pakistanis, (as measured by the MHI) would be associated with causal attributions of mental distress (as measured by the MDEMQ) of the three groups. This hypothesis is predicated on the fact that, as Kleinman (1987) has posited, individuals’ lay explanatory models change with illness.

VIII. That the two Asian groups, compared to the British group, would have a more negative attitude towards seeking help for mental distress. They would, therefore, consider it more appropriate to be self-reliant and accepting in preference to seeking help for mental distress, (as found in the earlier study, Chapter 4).

IX. The two Asian groups would consider it more appropriate to say prayers or talk to a family member/s as a way of seeking help for mental distress than Britons.

X. That the two Asian groups, compared to the British group, would have a more positive attitude to consulting an alternative healer/hakim, because of the more traditional concepts of the causes of mental distress.
XI. That the British Pakistani and the British groups would have a more positive attitude towards consulting a GP or a doctor for mental distress, as well as for taking medication, than the Pakistani group. This hypothesis is predicated on the fact that this pathway is a freely available option in the UK (as opposed to Pakistan).

XII. That the British group would consider consulting professional help (psychologist, a psychotherapist or a psychiatrist) for mental distress as more appropriate compared to the two Asian groups. This hypothesis specifically tests the assumptions, of earlier research (e.g. Henley, 1979), that Asians do not have a positive attitude to seeking professional help for mental distress.

XIII. There would be no significant differences between first and second generation British Pakistanis for any of the help-seeking pathways.

XIV. That there would be a relationship between the causal attributions of mental distress, levels of mental health and attitudes towards the pathways considered appropriate to seek help for mental distress. It is hypothesised that, other than culture, age, sex, religiosity, income and education would differentially predict choice of help-seeking pathways for mental distress.

5.3 Method

5.3.1 Sample

The sample for this study comprised of 54 British Pakistanis, 90 Britons and 99 Pakistanis (i.e. those born and still living in Pakistan) (Table 5.1).

The British Pakistani group and the British group were drawn mainly from three areas in London: Central London, suburbs in the west and the south-west of London (Southall and Kingston upon Thames).

In the case of the British Pakistanis, as in the first study, respondents were approached through drop-in centres in Southall. Out of a total of 75 people approached, six (8%)
declined and a further fifteen (20%) were not included because of incomplete questionnaires (those questionnaires were considered incomplete when more than three items were not completed).

As was the case in the first study, because of the problems of accessing a British sample, participants were randomly approached while waiting at a dentist’s surgery as well as in a park (Russell Square) in Central London. Out of a total of 100 people approached, there were seven refusals (7%) and three (3%) incomplete questionnaires.

Respondents in Pakistan were approached, as in the first study, in a large playing field/stadium used for people to take their evening walk. 120 people were approached. Of these, 12 (10%) refused while 9 (7.5%) questionnaires were deemed incomplete. (Table 5.1).
Table 5.1: Distribution of Subjects by sex, age, religion, marital status, education and income

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<tr>
<th></th>
<th>British Pakistanis</th>
<th>% Total</th>
<th>Britons</th>
<th>% Total</th>
<th>Pakistanis</th>
<th>% Total</th>
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<td>40</td>
<td>44.6%</td>
<td>36</td>
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</tr>
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</table>

* (Annual Income in £ Sterling for British Pakistanis and Britons; Monthly income in Rupees for Pakistanis).
Chapter 5: Study 2: Levels of mental distress, causal attributions and attitudes to help-seeking pathways

5.3.2 Measures

5.3.2.1 The Mental Health Inventory

The Mental Health Inventory (MHI) (Veit & Ware 1983) (appendix 5.1) is a 38-item measure of psychological distress and wellbeing, developed for use in general populations. In constructing the MHI, Veit and Ware aimed to examine the multi-dimensional nature of mental health i.e. whether psychological distress and psychological wellbeing were separate dimensions (as argued by Bradburn, 1969), and whether these concepts themselves were multi-dimensional.

The conceptual basis of the construction of the MHI rested on the following questions: Do items of the MHI group into two distinct constructs - one denoting negative mental states and therefore, psychological distress, and the other denoting positive mental states, and therefore, psychological wellbeing? Or do these two constructs tend toward bipolarity, with factors defined by both negative and positive mental health states? Lastly, are the different dimensions of psychological health correlated or independent? They therefore aimed, in constructing the Mental Health Inventory, to increase the precision of instruments by measuring the changes only in mental health, by including characteristics of psychological wellbeing as well as those of psychological distress.

5.3.2.1.1 The construction of the MHI

The MHI focuses on psychological symptoms of mood and anxiety and loss of control of feelings, thoughts and behaviour. The MHI uses 15 items from Dupuy's General Wellbeing Schedule (1979); twenty-three items relating to psychological distress were drawn from other scales. It was fielded in four large samples having quite different characteristics (n=5,089). Results in the original experiment supported a two-factor model composed of a general underlying psychological distress versus wellbeing factor. The higher order psychological
distress and wellbeing factors were defined by five correlated lower order factors, named as anxiety, depression, loss of behavioural/emotional control, general positive affect and emotional ties. (see Figure 5.1).

The scores of the MHI can be aggregated into an overall measure known as the Mental Health Index or the sub-scales can be scored and interpreted separately. Most of the response scales have six options. When combining all the scores, the scoring of the positive section is reversed.

Figure 5.1 The Mental Health Inventory Structure
5.3.2.1.2 Validity and Reliability

Results of the factorial structure of the MHI were confirmed in cross-validation tests by Veit & Ware using samples of populations with quite different characteristics and provide strong psychometric support for a hierarchical model of the MHI. These internal consistency scales ranged from .92 to .96 for the two higher order factors and the Mental Health Index and from .83 to .91 for the five lower order factors.

The Mental Health Inventory has most often been used to predict use of various forms of health services. A strong association has been shown between MHI scores and the use of ambulatory mental health services (Ware, Manning, Duan, Wells & Newhouse, 1979). Later forms of the Mental Health Inventory has been used to predict use of mental and general health care services (Manning, Newhouse & Ware 1982; Wells, Manning, Duan, Ware & Newhouse, 1982; Veit & Ware, 1983), the influence of personality disorder, acute distress and dysfunction and psychotherapeutic processes. It has also been used in methodological studies, (McHorney, Ware & Raczek 1993; McHorney, Ware, Rogers et al, 1992), clinical trials (Cleary, Epstein & Oster 1991) clinical research (Fowler, Wennberg, Timothy et al, 1989) and clinical practice (Jette, Davies, & Cleary, 1986).

5.3.2.1.3 The rationale for the use of the MHI in this study

Although the MHI has not been used to explore cross-cultural differences in mental health, it has been used in culturally diverse populations in the United States and shown to have good psychometric properties. (Veit & Ware, 1983; McHorney et al, 1992).

Secondly, because the construction of the MHI was originally based on assessing the mental health of general population for an insurance company (see Veit & Ware, 1983), it was constructed specifically to measure the psychological health in lay populations. Although Veit and Ware postulated psychological constructs of the MHI as a result of their validation studies, it was meant to measure undifferentiated psychological symptomatology in general
Thirdly, again as a result of the original insurance experiments, this questionnaire has been shown to be particularly suitable for ascertaining the use of mental health services (Manning et al, 1982; Wells et al, 1982; Veit & Ware, 1983),

Finally, this study attempted to test a screening tool with good psychometric properties for use in a cross-cultural study, (Flaherty et al., 1988 - see Chapter 3, Section 3.5).

In this study, two items were changed slightly by omitting terms that were typically American, in order make these items of the MHI more appropriate for use amongst a UK and Pakistani population.

The following two items were changed:

From i) ‘How much of the time, during the past month, have you felt downhearted and blue?’ to ‘How much of the time, during the past month, have you felt downhearted?’

From ii) ‘During the past month, how often did you get rattled, upset or flustered?’ to ‘During the past month, how often did you get upset or flustered?’

5.3.2.2 The Mental Distress Explanatory Model questionnaire

The construction of The Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990) (appendix 4.2) has been described in detail in Chapter 4, Section 4.3.2.1. The four causative categories of causal beliefs postulated by Eisenbruch, relating to stress, supernatural, western physiological and non-western physiological causal attributions, will be examined, in this study, in relation to mental health and help-seeking pathways.

5.3.2.3 The Pathways to Seeking Help questionnaire

This measurement consisted of ten questions incorporating ten choices of pathways for help-seeking for mental distress (appendix 5.3). This questionnaire will be referred to as ‘Pathways to Seeking Help’ questionnaire (PSH).
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The choices were based on findings from the first study in this investigation as well as the findings and assumptions of earlier research (Rack, 1982; Bhopal, 1986; Balajaran et al., 1989; Inechein, 1990; Hatfield et al, 1996), about British Asians' attitudes towards help-seeking pathways. They included:

- Self reliance and acceptance in preference to seeking help for mental distress;
- Saying prayers;
- Talking to family member/s;
- Talking to a mullah, pir or priest;
- Consulting a hakim, vaid or alternative healer;
- Consulting a doctor/general practitioner;
- Taking medication\(^{17}\);
- Consulting a psychologist;
- Consulting a psychotherapist;
- Consulting a psychiatrist.

5.3.2.4 Translation of the MDEMQ, MHI and PSH.

All the questionnaires, and the vignettes, were translated into Urdu by a proficient English and Urdu speaker. Emphasis was placed on conceptual equivalence rather than literal translation. The translated Urdu versions were then subjected to an independent back translation into English. Any differences between the two versions were assessed and negotiated before a final Urdu version was drafted (Urdu version of the MHI: appendix 5.2; Urdu version of the MDEMQ: appendix 4.2; Urdu version of the PSH: appendix 5.4).

The translation process of the MDEMQ has been described in Chapter 4 Section 4.3.4. The translation of item of the MHI was relatively straight-forward as the language used in this questionnaire is one that is used in every day parlance e.g. How much have you been

\(^{17}\) This choice was phrased in general terms in order to elicit general attitudes towards bio-medical therapies.
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bothered by nervousness, or 'nerves' during the past month? The term 'nerves' is understood in colloquial Urdu as it is English.

The one item that required care in translation was item 8. ‘During the past month, have you had any reason to wonder if you were losing your mind, or losing control over the way you act, think, talk or feel, or your memory?’ The difficulty lay in the fact that, in the context of an Asian society, to lose control over the way one acts and talks, has rather more serious connotations than in a western society. Therefore, it was decided to translate this item as: ‘During the past month, have you any reason to wonder if you were losing your mind or losing your memory’?

5.3.2.5 Procedure

Over a period of six months, both British Pakistani and British participants were approached randomly and asked to participate in a study looking at beliefs about mental distress/illness and attitudes towards the treatment of mental illness. Pakistanis were randomly approached during a period of three months in Karachi. Participants who consented were given an information sheet about the research and each participant was asked to sign a consent form.

A demographic data questionnaire, which requested ethnicity, age, sex, marital status, religion, place of birth, first language, education obtained, income and length of stay in the U.K. was also completed (appendix 5.5 and 5.6). They were then given a set of questionnaires comprising the MDEMQ, the MHI, and the PSH and asked to self-administer the questionnaires.

In the current study, one small change was made to the MDEMQ, whereby the term ‘mental distress’ was changed to ‘mental distress/illness’ in the introduction to the questionnaire (see below). This was done firstly, in order to clarify the meaning of this term (as some participants in the first study had found this term unclear) and secondly, to see whether this change, which would denote actual mental disorder, would have an influence on the causal beliefs of mental distress.
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The written instructions given with the MDEMQ were:

"Many people suffer mental distress/illness at some time in their lives. Such distress/illness can be mild or severe. People can experience and manifest mental distress/illness in many ways. They might cope with their problem in different ways. How likely is it that that each of the listed causes in the first questionnaire (the MDEMQ) would contribute. Please circle your response that could range from 'highly likely' to 'highly unlikely'. There is no right or wrong answer. Please respond to every item even if you are not sure. You are also welcome to comment on any item and invited to add any comments that you might like to make".

The written instructions given with the Mental Health Inventory were:

"Please read each statement and indicate your response by ticking in the appropriate bracket (as in the example given). It is important that you answer every item."

A sheet attached to Pathways to Seeking Help questionnaire, contained the following:

'What would you consider the most appropriate way of seeking help for mental health problems. Consulting a doctor or GP? Talking to a mullah, pir or priest? Consulting a psychologist? Consulting a hakim, a vaid or another alternative healer? Saying prayers? Consulting a psychiatrist? Self-reliance and acceptance in preference to seeking help for mental distress? Taking medication? Talking to family member/s? Consulting a psychotherapist? Please tick the box that best represents your attitude to each of the choices given overleaf.'

Each question could be answered by ticking a 5 point scale from 1 = 'most inappropriate' to 5 = 'most appropriate'.

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5.4 Results

The results presented in this section are based on sub-samples from the main samples described in the preceding sections i.e. British Pakistanis (only Muslims) (54), Britons (90) and Muslim Pakistanis (90). Questionnaires administered verbally in Urdu to five participants from the Pakistani sample in this study were deleted from the data set before analysis of data thus reducing this sample to 85.

As in the first study, results relating to differences in the mental health of cultural groups are presented first, followed by results relating to the association between causal attributions of mental distress and the mental health of groups. These analyses are followed by results showing the relationship between culture, causal attributions, mental health and help-seeking pathways.

5.4.1. Analysis of the Mental Health Inventory

Total N was 229. Mean substitution was made for those cases with just one missing variable in a multi-variate variable. Adjustment was made for outliers which could be adjusted one unit up or down.

5.4.1.1 Factor analysis of the MHI

An exploratory factor analysis, followed by a confirmatory factor analysis, was conducted on the 38 item-responses of the MHI. The aims, to test the first two hypotheses, were:

- To examine whether the items of the MHI produced two distinct constructs - psychological distress (consisting of only negative items) and psychological wellbeing (consisting of only positive items) - or whether the items measured a bi-polar dimension of psychological distress.
- To investigate the theoretical number of factors which would adequately fit the data.
Exploratory factor analysis was carried out separately on data of the three cultural groups. This initial factor analysis revealed a different factor structure for the British group from that of the British Pakistani and the Pakistani sample. Factors extracted for the British Pakistani and the Pakistani sub-samples showed similar structure to each other, with loadings of the same variables on the factors in the exploratory factor analysis. Furthermore, in the confirmatory analysis, while factor loadings of the British sample indicated a more uni-dimensional bi-polarity of mental health, those extracted for the two Asian groups as a whole, corresponded closely to those predicted by the two dimensional hypothesis of Veit & Ware. Therefore, in view of the fact that group differences are minimised in factor analysis (Tabbachnik & Fidell, 1996), the decision was made to factor analyse the 38-item responses of the two Asians sample only (British Pakistani and Pakistanis). As in the last study, this was done in order to maximise cases as well as produce a solution with the greatest scientific utility, consistency and meaning. This solution could thereafter be analysed and interpreted for cross-cultural differences between the two Asian groups and the British group, if factor analysis replicated the MHI sub-scales.

In the principal component analysis of 38 mental health items, 42.71% of the variance in the correlation matrix was accounted for by the first factor, which had an eigenvalue of 16.29. Loadings on the first factor ranged from .22 to .80, indicating that the first factor accounted for a substantial proportion of the variance in each item. The results support the notion that the MHI measures a general underlying mental health factor; however, a substantial proportion of the variance is unaccounted for in this uni-dimensional model. Therefore, a second factor was extracted, which had an eigenvalue of 2.45. The total matrix variance explained increased from 42.71% to 49.28%.

To improve adequacy of extraction and interpretability of factors, a confirmatory factor analysis was performed for the whole sample, with both orthogonal and oblique rotation. The two-factor solution with oblique rotation accounted for the data better than the uncorrelated model by reducing the number of large residual correlations.
5.4.1.1.1. The two factor model of the MHI

As hypothesised (hypothesis I), the items groupings indicated by the factor loadings observed in the two factor solution for this sample replicated the two factor solution of the MHI (psychological distress and psychological wellbeing) found by Veit and Ware (1983). All items describing negative states correlated highest with the first factor, which was termed 'psychological distress'. All items describing positive states correlated highest with the second factor, which was termed 'psychological wellbeing'.18 ‘Psychological distress’ and ‘psychological wellbeing’ were taken as the definition of the two higher-order factors measuring the two-dimensionality of mental health (Table 5.2).

---

18 It is to be noted that items 8, 14, and 18 are items that make up the factor of behavioural loss in the original analysis. Like the positive items, they are positively scored but they are hypothesised (in original analysis) to load onto the factor of psychological distress.
Table 5.2 Factors loading in the two factor model of the MHI

<table>
<thead>
<tr>
<th>Items of the MHI</th>
<th>F I</th>
<th>F II</th>
</tr>
</thead>
<tbody>
<tr>
<td>35. How often, during the past month, did you find yourself having difficulty trying to calm down?</td>
<td>.75</td>
<td>-.44</td>
</tr>
<tr>
<td>33. During the past month, have you been anxious or worried?</td>
<td>.74</td>
<td>-.53</td>
</tr>
<tr>
<td>32. During the past month, how often did you get upset or flustered?</td>
<td>.74</td>
<td>-.57</td>
</tr>
<tr>
<td>36. During the past month, how often have you been in low, or very low, spirits?</td>
<td>.73</td>
<td>-.67</td>
</tr>
<tr>
<td>25. How much have you been bothered by nervousness, or ‘nerves’ during the past month?</td>
<td>.73</td>
<td>-.23</td>
</tr>
<tr>
<td>20. How often have you felt like crying, during the past month?</td>
<td>.71</td>
<td>-.52</td>
</tr>
<tr>
<td>30. During the past month, how much of the time have you been moody about things?</td>
<td>.71</td>
<td>-.56</td>
</tr>
<tr>
<td>9. Did you feel depressed during the past month?</td>
<td>.71</td>
<td>-.38</td>
</tr>
<tr>
<td>2. How much of the time have you felt lonely during the past month?</td>
<td>.69</td>
<td>-.55</td>
</tr>
<tr>
<td>27. How often, during the past month, have you felt that nothing could cheer you?</td>
<td>.69</td>
<td>-.59</td>
</tr>
<tr>
<td>18. How much of the time, in the past month, have you felt emotionally stable?</td>
<td>-.68</td>
<td>-.52</td>
</tr>
<tr>
<td>13. During the past month, have you felt tense or ‘high strung’?</td>
<td>.67</td>
<td>-.42</td>
</tr>
<tr>
<td>19. How much of the time, during the past month, have you felt downhearted?</td>
<td>.67</td>
<td>-.52</td>
</tr>
<tr>
<td>38. During the past month, have you been under, or felt you were under any strain, stress or pressure?</td>
<td>.66</td>
<td>-.55</td>
</tr>
<tr>
<td>14. During the past month, have you been in firm control of your behaviour, thoughts, emotions, feelings?</td>
<td>-.64</td>
<td>.57</td>
</tr>
<tr>
<td>3. How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month?</td>
<td>.62</td>
<td>-.31</td>
</tr>
<tr>
<td>8. During the past month, have you had any reason to wonder if you were losing your mind, or losing your memory?</td>
<td>-.61</td>
<td>-.50</td>
</tr>
<tr>
<td>11. How much of the time, during the past month, have you been a nervous person?</td>
<td>.61</td>
<td>-.31</td>
</tr>
<tr>
<td>29. During the past month, how much of the time have you felt restless, fidgety or impatient?</td>
<td>.61</td>
<td>-.34</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Items of the MHI</th>
<th>F I</th>
<th>F II</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. How often, during the past month, did you feel that nothing turned out for</td>
<td>.59</td>
<td>-.34</td>
</tr>
<tr>
<td>you the way you wanted it to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. During the past month, how often did you feel you had nothing to look</td>
<td>.55</td>
<td>-.41</td>
</tr>
<tr>
<td>forward to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. During the past month, how often did you feel that others would be better</td>
<td>.54</td>
<td>-.35</td>
</tr>
<tr>
<td>off if you were dead?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. During the past month, how often did your hands shake when you tried to do</td>
<td>.51</td>
<td>-.12</td>
</tr>
<tr>
<td>something?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. During the past month, did you ever think of taking your own life?</td>
<td>.50</td>
<td>-.18</td>
</tr>
<tr>
<td>31. How much of the time, during the past month, have you felt cheerful, light</td>
<td>-.51</td>
<td>.84</td>
</tr>
<tr>
<td>hearted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. During the past month, how much of the time were you a happy person?</td>
<td>-.60</td>
<td>.82</td>
</tr>
<tr>
<td>17. How much of the time, during the past month, have you felt calm and</td>
<td>-.57</td>
<td>.79</td>
</tr>
<tr>
<td>peaceful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. During the past month, how much of the time has living been a wonderful</td>
<td>-.31</td>
<td>.76</td>
</tr>
<tr>
<td>adventure for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. How much of the time, during the past month, did you feel relaxed and free</td>
<td>-.42</td>
<td>.74</td>
</tr>
<tr>
<td>of tension?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. How much of the time, during the past month, has your daily life been full</td>
<td>-.34</td>
<td>.73</td>
</tr>
<tr>
<td>of things that were interesting to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. How happy, satisfied, or pleased have you been with your personal life</td>
<td>-.53</td>
<td>.73</td>
</tr>
<tr>
<td>during the past month?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. During the past month, how much of the time have you enjoyed things you</td>
<td>-.40</td>
<td>.70</td>
</tr>
<tr>
<td>usually do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. During the past month, how much of the time have you felt that the future</td>
<td>-.33</td>
<td>.70</td>
</tr>
<tr>
<td>looks hopeful and promising?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. When you got up in the morning, this past month, about how often did you</td>
<td>-.37</td>
<td>.69</td>
</tr>
<tr>
<td>expect to have an interesting day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. How much of the time, during the past month, were you able to relax without</td>
<td>-.53</td>
<td>.67</td>
</tr>
<tr>
<td>difficulty?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. How often, during the past month, have you been getting up feeling fresh</td>
<td>-.52</td>
<td>.62</td>
</tr>
<tr>
<td>and rested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. During the past month, how much of the time did you feel that your personal</td>
<td>-.56</td>
<td>.60</td>
</tr>
<tr>
<td>relationships, loving and being loved, were full and complete?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. During the past month, how much of the time have you felt loved and wanted</td>
<td>-.45</td>
<td>.57</td>
</tr>
</tbody>
</table>
5.4.1.2 Factor analysis for the five factor model

In order to examine whether these two high-order dimensions of mental are themselves multi-dimensional, further exploratory factor analysis was carried out, again on the scores of the two Asian samples. This revealed six factors in the data with an eigenvalue exceeding 1. In order to test the hierarchical model of the MHI, confirmatory factor analysis, with orthogonal and oblique rotation was carried out on all the items of the MHI, restricting the loadings to .30. The total matrix variance explained increased from 49.28 % (for the two-factor model) to 60.67 % in the five-factor solution. For the five-factor solution, it was the uncorrelated model i.e. orthogonal rotation that accounted best for the data. An item that had the highest factor loading on the factor was hypothesised to define the factor (Table 5.3).

Factor I, with an eigenvalue of 16.22 accounted for 42.70% of the variance and could be interpreted as ‘Satisfaction’.

Factor II, with an eigenvalue of 2.50, accounted for 6.57 % of the variance and could be interpreted as ‘Unhappiness’

Factor III, with an eigenvalue of 1.81, accounted for 4.76% of the variance and could be interpreted as ‘Calmness’.

‘Factor IV, with an eigenvalue of 1.45, accounted for 3.84 % of the variance and could be interpreted as ‘Anxiety’.

Factor V, with an eigenvalue of 1.06, accounted for 2.79 % of the variance and could be interpreted as ‘Suicidal thoughts’. 
Table 5.3 Factor loadings of the five-factor model of the MHI.

<table>
<thead>
<tr>
<th>Factor 1 – Satisfaction (eigenvalue 16.22, 42.70% of variance)</th>
<th>Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. During the past month, how much of the time have you felt that the future looks hopeful and promising?</td>
<td>.73</td>
</tr>
<tr>
<td>5. How much of the time, during the past month, has your daily life been full of things that were interesting to you?</td>
<td>.72</td>
</tr>
<tr>
<td>12. When you got up in the morning, this past month, about how often did you expect to have an interesting day?</td>
<td>.68</td>
</tr>
<tr>
<td>26. During the past month, how much of the time has living been a wonderful adventure for you?</td>
<td>.68</td>
</tr>
<tr>
<td>31. How much of the time, during the past month, have you felt cheerful, light hearted?</td>
<td>.62</td>
</tr>
<tr>
<td>34. During the past month, how much of the time were you a happy person?</td>
<td>.61</td>
</tr>
<tr>
<td>1. How happy, satisfied, or pleased have you been with your personal life during the past month?</td>
<td>.55</td>
</tr>
<tr>
<td>10. During the past month, how much of the time have you felt loved and wanted?</td>
<td>.50</td>
</tr>
<tr>
<td>16. During the past month, how often did you feel that you had nothing to look forward to?</td>
<td>-.44</td>
</tr>
<tr>
<td>23. During the past month, how much of the time did you feel that your love relationships, loving and being loved, were full and complete?</td>
<td>.43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2 – Unhappiness (eigenvalue 2.50, 6.57% of variance)</th>
<th>Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. How often, during the past month, have you felt so low that nothing could cheer you up?</td>
<td>.72</td>
</tr>
<tr>
<td>9. Did you feel depressed during the past month?</td>
<td>.71</td>
</tr>
<tr>
<td>33. During the past month, have you been anxious or worried?</td>
<td>.68</td>
</tr>
<tr>
<td>36. During the past month, how often have you been in low, or very low, spirits?</td>
<td>.63</td>
</tr>
<tr>
<td>24. How often, during the past month, did you feel that nothing turned out for you the way you wanted it to?</td>
<td>.61</td>
</tr>
<tr>
<td>20. How often have you felt like crying, during the past month?</td>
<td>.61</td>
</tr>
<tr>
<td>30. During the past month, how much of the time have you been moody or brooded about things?</td>
<td>.59</td>
</tr>
<tr>
<td>19. How much of the time, during the past month, have you felt downhearted?</td>
<td>.53</td>
</tr>
<tr>
<td>2. How much of the time have you felt lonely during the past month?</td>
<td>.51</td>
</tr>
<tr>
<td>32. During the past month, how often did you get upset or flustered?</td>
<td>.45</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Factor 3 – Calmness (eigenvalue 1.81, 4.76% of variance)</th>
<th>Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. During the past month, how much of the time have you felt restless, fidgety or impatient?</td>
<td>-.63</td>
</tr>
<tr>
<td>17. How much of the time, during the past month, have you felt calm and peaceful?</td>
<td>.61</td>
</tr>
<tr>
<td>7. During the past month, how much of the time have you enjoyed the things you usually do?</td>
<td>.59</td>
</tr>
<tr>
<td>37. How often, during the past month, have you been getting up feeling fresh and rested?</td>
<td>.58</td>
</tr>
<tr>
<td>22. How much of the time, during the past month, were you able to relax without difficulty?</td>
<td>.56</td>
</tr>
<tr>
<td>6. How much of the time, during the past month, did you feel relaxed and free of tension?</td>
<td>.55</td>
</tr>
<tr>
<td>38. During the past month, have you been under or felt you were under any strain, stress or pressure?</td>
<td>-.52</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 4 – Anxiety (eigenvalue 1.45, 3.84% of variance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. How much of the time, during the past month, have you been a very nervous person?</td>
</tr>
<tr>
<td>3. How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month?</td>
</tr>
<tr>
<td>15. During the past month, did your hands shake when you tried to do something?</td>
</tr>
<tr>
<td>25. How much have you been bothered by nervousness, or your ‘nerves’ during the past month?</td>
</tr>
<tr>
<td>8. During the past month, have you had any reason to wonder if you were losing your mind, or losing your memory?</td>
</tr>
<tr>
<td>13. During the past month, have you felt tense or ‘high strung’?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 5 – Suicidal thoughts (eigenvalue 1.06, 2.79% of variance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. During the past month, did you ever think of taking your own life?</td>
</tr>
<tr>
<td>21. During the past month, how often did you feel that others would be better off if you were dead?</td>
</tr>
<tr>
<td>14. During the past month, have you been in firm control of your behaviour, thoughts, emotions, feelings?</td>
</tr>
<tr>
<td>18. How much of the time, during the past month, have you felt emotionally stable?</td>
</tr>
<tr>
<td>35. How often, during the past month, did you find yourself having difficulty trying to calm down?</td>
</tr>
</tbody>
</table>

5.4.1.3 The hierarchical model of the MHI

As hypothesised (hypothesis II), the hierarchical model of the MHI for this sample revealed a higher order factor of psychological distress, comprising three lower order factors, interpreted as ‘unhappiness’, ‘anxiety’ and ‘suicidal thoughts’ and a higher order factor of psychological wellbeing comprising of two lower order factor, interpreted as ‘satisfaction’ and ‘calmness’. All negative items loaded onto the lower factors of psychological distress,
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except for three items 16, 29 and 38, which loaded onto the positive sub-scales. All positive items loaded onto the lower order factors of psychological wellbeing.

As the confirmatory factor analysis shows, although a largely hierarchical model of the MHI was found for the five-factor model extracted for this sample, the lower order factors were different from those found by Veit & Ware (1983). Therefore, the original scales of the MHI were used for subsequent analysis.

Veit and Ware had postulated a higher-order factor of psychological distress, comprising three lower-order factors named Anxiety (10 items), Depression (5 items) and Loss of Behavioural/Emotional Control (9 items). The higher-order factor of psychological wellbeing comprised the lower-order factors named General Positive Affect (11 items) and Emotional Ties (3 items) (Table 5.4).

Table 5.4 Sub-scales of the Mental Health Inventory

<table>
<thead>
<tr>
<th>Factor 1 – Anxiety</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11. How much of the time, during the past month, have you been a very nervous person?</td>
<td></td>
</tr>
<tr>
<td>25. How much have you been bothered by nervousness, or your 'nerves' during the past month?</td>
<td></td>
</tr>
<tr>
<td>13. During the past month, have you felt tense or 'high strung'?</td>
<td></td>
</tr>
<tr>
<td>33. During the past month, have you been anxious or worried?</td>
<td></td>
</tr>
<tr>
<td>35. How often, during the past month, did you find yourself having difficulty trying to calm down?</td>
<td></td>
</tr>
<tr>
<td>3. How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month?</td>
<td></td>
</tr>
<tr>
<td>29. During the past month, how much of the time have you felt restless, fidgety or impatient?</td>
<td></td>
</tr>
<tr>
<td>32. During the past month, how often did you get upset or flustered?</td>
<td></td>
</tr>
<tr>
<td>15. During the past month, did your hands shake when you tried to do something?</td>
<td></td>
</tr>
<tr>
<td>22. How much of the time, during the past month, were you able to relax without difficulty?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 2 – Depression</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>30. During the past month, how much of the time have you been moody or brooded about things?</td>
<td></td>
</tr>
<tr>
<td>36. During the past month, how often have you been in low, or very low, spirits?</td>
<td></td>
</tr>
<tr>
<td>19. How much of the time, during the past month, have you felt downhearted?</td>
<td></td>
</tr>
<tr>
<td>9. Did you feel depressed during the past month?</td>
<td></td>
</tr>
<tr>
<td>38. During the past depressed, have you been under or felt you were under any strain, stress or pressure?</td>
<td></td>
</tr>
</tbody>
</table>
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**Factor 3 – Loss of Behavioural/Emotional Control**

14. During the past month, have you been in firm control of your behaviour, thoughts, emotions, feelings?
8. During the past month, have you had any reason to wonder if you were losing your mind, or losing your memory?
18. How much of the time, during the past month, have you felt emotionally stable?
28. During the past month, did you ever think of taking your own life?
24. How often, during the past month, did you feel that nothing turned out the way you wanted it to?
20. How often have you felt like crying, during the past month?
21. During the past month, how often did you feel that others would be better off if you were dead?
27. How often, during the past month, have you felt so low that nothing could cheer you up?
28. During the past month, did you ever think of taking your own life?
16. During the past month, how often did you feel that you had nothing to look forward to?

**Factor 4 – General Positive Affect**

34. During the past month, how much of the time were you a happy person?
1. How happy, satisfied, or pleased have you been with your personal life during the past month?
5. How much of the time, during the past month, has your daily life been full of things that were interesting to you?
17. How much of the time, during the past month, have you felt calm and peaceful?
31. How much of the time, during the past month, have you felt cheerful, light hearted?
7. During the past month, how much of the time have you enjoyed the things you usually do?
6. How much of the time, during the past month, did you feel relaxed and free of tension?
26. During the past month, how much of the time has living been a wonderful adventure for you?
12. When you got up in the morning, this past month, about how often did you expect to have an interesting day?
37. How often, during the past month, have you been getting up feeling fresh and rested?
4. During the past month, how much of the time have you felt that the future looks hopeful and promising?

**Factor 5 – Emotional Ties**

10. During the past month, how much of the time have you felt loved and wanted?
23. During the past month, how much of the time did you feel that your love relationships, loving and being loved, were full and complete?
2. How much of the time have you felt lonely during the past month?
5.4.1.4 Inter-correlations of the Mental Health Index sub-scales

Pearson’s product-moment correlations of the five sub-scales were carried out in order to see how the two higher order factors correlated with each other as well as with the lower order factors found for this sample. This was done in order to see whether these dimensions were correlated or independent.

It can be seen in Table 5.5 that the inter-correlations between the two higher order factors were substantial, correlations between the Mental Health Index and the two higher order factors being inflated because of overlapping definitions.

As hypothesised (hypothesis II), there were high inter-correlations between three negative factors (Anxiety, Depression and Loss of Behavioural and Emotional Control) and psychological distress.

There were high inter-correlation between the two positive factors (General Positive Affect and Emotional Ties) and psychological wellbeing.

Table 5.5 Inter-correlations between the higher order factor and the lower order factors of the Mental Health Index

<table>
<thead>
<tr>
<th>Scale</th>
<th>(A)</th>
<th>(D)</th>
<th>(B)</th>
<th>(G)</th>
<th>(E)</th>
<th>Distress</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety (A)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (D)</td>
<td>.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural/Emotional</td>
<td>.72</td>
<td>.78</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>control (B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Pos. Affect (G)</td>
<td>-.57</td>
<td>-.71</td>
<td>-.69</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Ties</td>
<td>-.53</td>
<td>-.62</td>
<td>-.69</td>
<td>.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress</td>
<td>.88</td>
<td>.91</td>
<td>.82</td>
<td>-.65</td>
<td>-.63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well being</td>
<td>-.59</td>
<td>-.73</td>
<td>-.72</td>
<td>.95</td>
<td>.74</td>
<td>-.67</td>
<td></td>
</tr>
<tr>
<td>MHI Index</td>
<td>-.84°</td>
<td>-.89°</td>
<td>-.91°</td>
<td>-.87°</td>
<td>.77°</td>
<td>-.90°</td>
<td>.89°</td>
</tr>
</tbody>
</table>

*Correlations inflated due to overlapping definitions.
5.4.1.5 Alpha reliabilities for the Mental Health Index and sub-scales for the three samples.

Internal-consistency reliability was estimated using Cronbach’s alpha. The Mental Health Index and all scales of the MHI were found to have high levels of internal consistency for each of the three samples, ranging from .75 to .97 (see Table 5.6)

5.4.1.6 Differences in the scores of the Mental Health Index and sub-scales of the Mental Health Inventory

To investigate differences between the three sub-samples i.e. British Pakistanis, Britons and Pakistanis, by culture, sex and age, religion, and income separately, analyses of variance was performed on:
- the total score of the MHI items i.e. the Mental Health Index;
- the higher order factors of psychological distress and psychological wellbeing;
- the five lower-order factors. (Table 5.6)
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Table 5.6 Mean, sds, and reliabilities for all scales of the MHI for the three groups (n=229)

<table>
<thead>
<tr>
<th>Sub-scales</th>
<th>No of items</th>
<th>Cultural Groups</th>
<th>F values</th>
<th>Means</th>
<th>Sds</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>11</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=3.18*</td>
<td>30.94</td>
<td>6.28</td>
<td>.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>29.54</td>
<td>6.07</td>
<td>.87</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>31.97</td>
<td>6.73</td>
<td>.88</td>
</tr>
<tr>
<td>Depression</td>
<td>12</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=3.09*</td>
<td>19.00</td>
<td>4.40</td>
<td>.84</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18.05</td>
<td>3.87</td>
<td>.84</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19.61</td>
<td>4.49</td>
<td>.87</td>
</tr>
<tr>
<td>Behavioural/Emotional Control</td>
<td>5</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=8.17***</td>
<td>26.73 a</td>
<td>5.76</td>
<td>.79</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>23.23 ab</td>
<td>5.97</td>
<td>.86</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>28.08 ac</td>
<td>7.19</td>
<td>.87</td>
</tr>
<tr>
<td>General Positive Affect</td>
<td>7</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=2.92</td>
<td>56.11</td>
<td>10.52</td>
<td>.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>58.40</td>
<td>9.85</td>
<td>.90</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>54.71</td>
<td>10.63</td>
<td>.92</td>
</tr>
<tr>
<td>Emotional Ties</td>
<td>3</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=2.34</td>
<td>14.25</td>
<td>3.00</td>
<td>.64</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>14.66</td>
<td>3.26</td>
<td>.74</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13.60</td>
<td>3.56</td>
<td>.82</td>
</tr>
<tr>
<td>Psychological Distress</td>
<td>24</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=4.78**</td>
<td>86.57 a</td>
<td>11.60</td>
<td>.82</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>82.32 ab</td>
<td>10.30</td>
<td>.83</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>87.40 ac</td>
<td>12.63</td>
<td>.87</td>
</tr>
<tr>
<td>Psychological Wellbeing</td>
<td>14</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=2.78*</td>
<td>65.70</td>
<td>12.15</td>
<td>.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>68.21</td>
<td>11.57</td>
<td>.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>64.01</td>
<td>12.40</td>
<td>.93</td>
</tr>
<tr>
<td>Mental Health Index</td>
<td>38</td>
<td>British Pakistanis, Britons, Pakistanis</td>
<td>F(2,227)=4.98**</td>
<td>171.57 a</td>
<td>23.33</td>
<td>.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>178.21 ab</td>
<td>22.90</td>
<td>.95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>166.44 ac</td>
<td>26.18</td>
<td>.97</td>
</tr>
</tbody>
</table>

***p<.001 **p<.01 *p<.05 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
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5.4.1.6.1 Effect of Culture on the Mental Health Index

An analysis of variance were performed on the total score of the MHI items i.e. the Mental Health Index, for the three sub-samples i.e. British Pakistanis, Britons and Pakistanis, by culture. There was a significant main effect for culture $F(2,227)=4.98, p<.01$. Contrary to prediction, (hypothesis III), means indicated that British Pakistanis had a higher score on the Mental Health Index than Pakistanis. However, as predicted, British Pakistanis had a lower score on the Mental Health Index than Britons (Table 5.6 for means). As predicted (hypothesis IV), there was an effect of age $F(5,227)=2.94, p<.01$ and an effect of religion $F(2,227)=4.29, p<.01$. With age co-varied out, culture was significant at $F(2,227)=6.77, p<.001$ and with religion co-varied out, culture was significant at $F(2,227)=4.03, p<.01$. Against prediction, there was no effect of sex $F(1,227)=.36$ or for income $F(4,227)=1.05$.

5.4.1.6.2 Effect of Culture on higher order factors of the MHI

Anovas were performed on the higher order factors of mental health i.e. the sub-scales of psychological distress and psychological wellbeing, for the three groups by culture. There were significant main effects for culture for psychological distress $F(2,227)=4.78, p<.01$ Against prediction, (hypothesis III), means indicated that British Pakistanis had a lower score for psychological distress than Pakistanis. However, as predicted, British Pakistanis had a higher score for psychological distress than Britons (Table 5.6 for means). As predicted, (hypothesis IV), there was an effect of age $F(5,227)=3.29, p<.001$. With age co-varied out, culture was significant $F(2,227)=8.35, p<.001$. As predicted (hypothesis IV), there was an effect of religion $F(2,227)=5.45, p<.01$. With religion co-varied, culture was still significant $F(2,227)=3.86, p<.01$. Against prediction, there was no effect of income $F(4,227)=1.36$ or for sex $F(1,227)=.091$.

Against prediction (hypothesis III), the effect for culture was short of significance for psychological wellbeing $F(2,227)=2.77> .05$. As predicted, (hypothesis IV), there was an
effect of age $F(5,227)=1.99 \ p<.05$. Against prediction, there was no effect of sex $F(1,227)=1.10$ or religion $F(2,227)=2.67$.

5.4.1.6.3 Effect of culture on lower order factors of mental health

Anovas performed on the five lower order sub-scales of the MHI for the three cultural groups, British Pakistanis, Britons and Pakistanis, by culture showed significant main effects for culture for three factors: Anxiety $F(2,227)=3.18 \ p<.05$, Depression $F(2,227)=3.09 \ p<.05$ and Behavioural and emotional control $F(2,227)=8.17, \ p<.001$. The effect of culture was short of significance for General Positive Affect $F(2,227)=2.91$ or Emotional ties $F(2,227)=2.34$ (Table 5.6 for means and sds).

In order to investigate the effect of age and income, Anovas were performed on the lower order factors. Age was significant at $p<.01$ level only for Depression, $F(5,227)=3.04$ (mean, over 35 years: 17.65 sd 3.79; under 35 years: 19.81 sd 4.54) and for Loss of Behavioural and emotional control, $F(2,230)=3.85, \ p<.001$ (mean, over 35 years: 24.71 sd 5.67; under 35 years: 27.95 sd 7.41). Income was not significant for any of the lower order factors. There were no significant interactions.

Anovas were performed for religion on the lower order factors. There was a significant main effect for religion for Anxiety $F(2,227)=3.15, \ p<.05$, Depression $F(2,227)=3.35, \ p<.05$ and for Loss of Behavioural and emotional control $F(2,227)=7.19, \ p<.001$ (Table 5.7 for means for psychological distress and Loss of Behavioural and Emotional Control).
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Table 5.7 Effect of religion on the Mental Health Index, Psychological Distress and Loss of Behavioural and Emotional Control

<table>
<thead>
<tr>
<th>Scales of the MHI</th>
<th>F values</th>
<th>Religion Means and sds</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Muslim</td>
<td>Christian</td>
</tr>
<tr>
<td>Loss of Behavioural Emotional Control</td>
<td>$F(2,230)=7.19^{**}$</td>
<td>27.63 (6.58) a</td>
</tr>
<tr>
<td>Psychological distress</td>
<td>$F(2,230)=5.45^{**}$</td>
<td>87.26 (12.22) a</td>
</tr>
<tr>
<td>Mental Health Index</td>
<td>$F(2,230)=4.29^{**}$</td>
<td>162.44 (20.11) a</td>
</tr>
</tbody>
</table>

$^{**}p<.01$ Post hoc Scheffe test (mean difference significant at the $p<.01$ level of significance)

5.4.1.6.4 Effect of place of birth, length of stay and income in British Pakistani sample

In order to test the hypothesis (hypothesis V) that there would be an effect on all the MHI factor scores of place of birth and length of stay in the British Pakistani sample, analysis of variance was carried out on these variables separately. As predicted, there was a main effect of place of birth. Contrary to prediction, second generation Pakistanis' scores were higher for scales of the MHI than the first generation: for the Mental Health Index, $F(1,52)=5.44$, $<.001$ (first generation mean: 176.69; second generation mean: 160.67), for psychological distress $F(1,52)=5.49$, $<.001$ (first generation mean: 83.48; second generation mean: 92.13), for Depression $F(1,52)=5.55$, $<.001$ (first generation mean: 17.97; second generation mean: 21.40) as well as for Behavioural/Emotional Control $F(1,52)=5.00$, $<.001$ (first generation mean: 25.65; second generation mean: 29.07). As predicted, there was an effect of length of stay for the Mental Health Index only $F(1,52)=5.07$, $<.01$ (less than 15 years stay in the UK: 165.10; more than 15 years stay: 181.44).

As predicted (hypothesis VI), there was a main effect of income in the British Pakistani sample for psychological distress $F(5,66)=3.24$, $p<.025$, (lower income: 93.36; higher income: 84.27) and for Anxiety $F(1,66)=3.25$, $<.025$ (lower income: 34.90; higher income: 29.84). There were no significant interactions.
5.4.2 The association between levels of mental distress and causal beliefs about mental distress

It had been hypothesised that there would be a relationship between mental distress levels and the causal attributions made about mental distress/illness between the three cultural groups. Therefore, the first step in this analysis examined the differences of causal beliefs between cultural groups. The second step examined the significant inter-correlations between the Mental Health Index and the four categories of causal beliefs.

5.4.2.1 Effect of culture on causal attributions of mental distress

A multivariate Analysis of Variance was performed on the four causative categories in the MDEMQ in order to investigate differences in scores across the three cultural groups. To further investigate main effects, a series of univariate F tests were performed on the separate category scores. Where appropriate, the significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made.

The results of the multivariate analysis of variance and univariate F tests, means and sds are presented in table 5.8

Table 5.8 Effect of culture on categories of the MDEMQ (n=229)

<table>
<thead>
<tr>
<th>Culture</th>
<th>Stress</th>
<th>Western physiology</th>
<th>Supernatural</th>
<th>Non-western physiology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(2,227)=1.09</td>
<td>F(2,227)=3.79*</td>
<td>F(2,227)=9.95***</td>
<td>F(2,227)=5.90**</td>
</tr>
<tr>
<td>British Pakistanis</td>
<td>55.29 (6.44)</td>
<td>36.00 (6.11)</td>
<td>54.40 (17.29) a</td>
<td>17.76 (5.75) a</td>
</tr>
<tr>
<td>Britons</td>
<td>54.55 (9.11)</td>
<td>36.62 (5.70)</td>
<td>43.98 (18.80) b</td>
<td>15.78 (5.25) b</td>
</tr>
<tr>
<td>Pakistanis</td>
<td>56.45 (8.42)</td>
<td>38.54 (6.69)</td>
<td>56.40 (19.60) a</td>
<td>18.40 (4.96) a</td>
</tr>
</tbody>
</table>

***p<.001 **p<.01* p<.05 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)
There were significant differences between the two Asian groups on the one hand, and the Britons on the other, for three of the causal categories of the MDEMQ. There was an effect of culture for western physiological causes $F(2,227)=3.79$, $p<.05$, for supernatural causes $F(2,227)=9.95$, $p<.001$ and for non-western physiological causes $F(2,227)=5.90$, $p<.01$ (Table 5.8 for means). There was no effect of culture for the causal attributions of stress $F(2,227)=1.09$.

As opposed to the results of the first study (detailed in Chapter 4), British Pakistanis and Pakistanis did not differ significantly in their causal attributions of mental distress/illness in their traditional concepts, i.e. supernatural or non-western physiological causes. Both groups differed significantly from the British group in these two categories.

A Manova done to see the effect of religion showed that there was an effect on supernatural causes only $F(4,227)=4.13$, $p<.001$ (Means: Muslims 55.45; Christians 47.52; No religious affiliation 45.52). In order to see whether religion alone accounted for differences between cultural groups, religion was co-varied out. Differences in supernatural beliefs between cultural groups remained significant $F(2,227)=6.77$, $p<.001$.

5.4.2.2 The association between the Mental Health Index and causal beliefs of mental distress/illness.

In the second step of this analysis, one-tailed Pearson's product-moment correlations between the Mental Health Index and the four categories of causal beliefs were computed for British Pakistanis, Britons and Pakistanis separately. This was done to test the prediction that there would be an association between mental health and causal attributions.

Against prediction, (hypothesis VII), causal beliefs of mental distress and mental distress levels, as measured the Mental Health Index were not significantly correlated for the British Pakistani sample. However, as predicted, there were significant and negative correlations between the Mental Health Index and the stress category ($r=-.40$, $p<.01$) of causal beliefs for the British sample. There was also a significant and negative correlation between the Mental
Health Index and the stress category ($r=-.21$, $p<.05$) for the Pakistani sample.

These results were confirmed by multiple regression of the Mental Health Index on the four causal belief categories for the three groups separately. The mental health of Britons predicted beliefs in stress causes only, accounting for 12% of the variance ($r$ squared=.12; $F(1,79)=10.27$, $p<.001$). The mental health of Pakistanis also predicted beliefs in stress causes, accounting for only 5% of the variance ($r$ squared=.05; $F(1,70)=4.38$, $p<.05$).

The mental health of the British Pakistani sample was not a significant predictor for any category of causal beliefs.

Table 5.9 shows the beta values for the regression analysis of the Mental Health Index on the stress causal attributions only, for the three samples.

**Table 5.9 The Mental Health Index as predictor of the causal attributions of stress.**

<table>
<thead>
<tr>
<th>British Pakistanis</th>
<th>Britons</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta, $\beta$, $t$</td>
<td>Beta, $\beta$, $t$</td>
<td>Beta, $\beta$, $t$</td>
</tr>
<tr>
<td>-.009, -.025, -1.165</td>
<td>-.0129, -.339, -3.205***</td>
<td>-.0073, -.227, -2.138*</td>
</tr>
</tbody>
</table>

| $R=.03$ | $R=.12$ | $R=.23$ |
| $R^2=.01$ | $R^2=.12$ | $R^2=.05$ |
| $F(1,45)=.027$ | $F(1,79)=10.27***$ | $F(1,84)=4.57*$ |

**$p<.001$, ***$p<.05$**
5.4.3 Differences in cultural groups on attitudes to help-seeking pathways for mental distress.

In order to test the hypotheses that there would be significant differences between the cultural samples in attitudes towards pathways that would be considered appropriate for seeking help for mental distress/illness, Anovas were done between the three cultural groups for each of the pathways. These included self-reliance and acceptance in preference to seeking help, saying prayers, talking to family member/s, talking to mullah/priest/pir, consulting a hakim/vaid/alternative healer, consulting a doctor/GP, taking medication, consulting a psychologist, consulting a psychotherapist and consulting a psychiatrist.

As hypothesised (hypotheses VIII and IX), there were significant differences between the three cultural groups for self-reliance and acceptance in preference to seeking help $F(2,227)=12.86$ $p<.001$, saying prayers $F(2,227)=22.25$ $p<.0001$, and talking to family member/s $F(2,227)=16.26$ $p<.001$. British Pakistanis and Pakistanis had higher scores for self-reliance and acceptance in preference to seeking help, saying prayers, and talking to family member/s compared to Britons.

As hypothesised (hypothesis XI), there were significant differences between the three cultural groups for consulting a doctor/GP $F(2,227)=7.26p<.01$ and consulting a hakim/alternative healer $F(2,227)=13.26p<.001$. As predicted, British Pakistanis and Britons had higher scores for doctor/GP compared to Pakistanis. However, against prediction (hypothesis X), it was British Pakistanis and Britons who considered consulting a hakim/vaid/alternative healer for seeking help for mental distress as more appropriate than the Pakistanis. (Table 5.10 for F values and means).

Against prediction, (hypothesis XI and XII), no significant differences were found between British Pakistanis, Britons and Pakistanis for taking medication or for consulting a psychologist, psychotherapist or psychiatrist.

As predicted, (hypothesis XIII), no significant differences were found, in the choice of any pathway, between sub-groups in the British Pakistani sample by place of birth or length of stay.
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Table 5.10 F values and means between British Asians, Westerners and Pakistanis in pathways to seeking help for mental distress

<table>
<thead>
<tr>
<th>Pathways to Seeking Help</th>
<th>F values $F(2,227)= $</th>
<th>Means and sd</th>
<th>British Pakistanis</th>
<th>Britons</th>
<th>Pakistanis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reliance</td>
<td>12.86***</td>
<td>4.47 (1.88) a</td>
<td>3.52 (1.79) b</td>
<td>4.90 (1.88) a</td>
<td></td>
</tr>
<tr>
<td>Saying Prayers</td>
<td>22.25***</td>
<td>4.65 (2.11) a</td>
<td>2.98 (1.88) b</td>
<td>4.49 (1.71) a</td>
<td></td>
</tr>
<tr>
<td>Family Members</td>
<td>16.26***</td>
<td>2.94 (1.54) a</td>
<td>1.70 (1.80) b</td>
<td>2.79 (1.84) a</td>
<td></td>
</tr>
<tr>
<td>Mullah/priest</td>
<td>1.37</td>
<td>3.87 (1.56)</td>
<td>3.42 (1.48)</td>
<td>3.49 (1.87)</td>
<td></td>
</tr>
<tr>
<td>Hakim/vaid/alternative healer</td>
<td>13.26***</td>
<td>3.14 (1.62) a</td>
<td>2.67 (1.39) a</td>
<td>1.99 (1.27) b</td>
<td></td>
</tr>
<tr>
<td>Doctor/General Practitioner</td>
<td>7.26**</td>
<td>4.70 (1.45) a</td>
<td>4.87 (1.50) a</td>
<td>3.97 (1.78) b</td>
<td></td>
</tr>
<tr>
<td>Taking Medication</td>
<td>1.40</td>
<td>4.32 (1.24)</td>
<td>4.37 (1.68)</td>
<td>4.70 (1.67)</td>
<td></td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>.57</td>
<td>5.26 (1.22)</td>
<td>4.98 (1.85)</td>
<td>5.20 (1.84)</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>1.05</td>
<td>5.20 (1.50)</td>
<td>5.54 (1.19)</td>
<td>5.48 (1.51)</td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>.23</td>
<td>2.69 (1.30)</td>
<td>2.76 (1.49)</td>
<td>2.61 (1.68)</td>
<td></td>
</tr>
</tbody>
</table>

***p<.0001 **p<.01 *p<.05 Post hoc Scheffe test (mean difference significant at the p<.01 level of significance)

In order to distinguish the most discriminating variables between the three cultural groups in pathways considered appropriate for seeking help for mental distress, a step-wise discriminant analysis was next carried out.

5.4.3.1. Results of the Discriminant Analysis using the Step-Wise Procedure

This step-wise procedure enters variables into the analysis independently on the basis of their discriminating power. The 'next best' discriminator is selected at each step, until the addition of further variables fails to improve discrimination between groups. The canonical correlation is reported in Table 5.11, the square of which refers to the percentage of variance due to the independent variables in question. The chi-square test indicates how significantly the function discriminates between the groups.
Table 5.11 Discriminant Analysis using the Step-Wise Procedure

<table>
<thead>
<tr>
<th>Discriminant Function</th>
<th>Eigenvalue</th>
<th>Percentage of Variance</th>
<th>Canonical Correlations</th>
<th>Wilks' Lambda</th>
<th>Chi-Square</th>
<th>DF</th>
<th>Signif Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.61</td>
<td>82.3</td>
<td>.61</td>
<td>.55</td>
<td>127.700</td>
<td>10</td>
<td>.0001</td>
</tr>
<tr>
<td>2</td>
<td>.13</td>
<td>17.7</td>
<td>.34</td>
<td>.88</td>
<td>26.279</td>
<td>4</td>
<td>.0001</td>
</tr>
</tbody>
</table>

Table 5.12 The structure matrix for the step-wise discriminant analysis

<table>
<thead>
<tr>
<th>Pathways</th>
<th>Function 1</th>
<th>Function 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self reliance</td>
<td>.42*</td>
<td>.14</td>
</tr>
<tr>
<td>Doctor/GP</td>
<td>-.34*</td>
<td>.25</td>
</tr>
<tr>
<td>Hakim/vaid/alternative healer</td>
<td>-.29</td>
<td>.78*</td>
</tr>
<tr>
<td>Saying Prayers</td>
<td>.47</td>
<td>.58*</td>
</tr>
<tr>
<td>Family member/s</td>
<td>.41</td>
<td>.50*</td>
</tr>
<tr>
<td>Psychologist</td>
<td>-.07</td>
<td>-.32*</td>
</tr>
<tr>
<td>Mullah/priest</td>
<td>.03</td>
<td>.30*</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>.08</td>
<td>.29*</td>
</tr>
<tr>
<td>Taking Medicine</td>
<td>-.03</td>
<td>-.11*</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>-.05</td>
<td>-.09</td>
</tr>
</tbody>
</table>

* denotes largest absolute correlation between each variable and any discriminant function.

From Table 5.12, it is clear that the first function is based on self reliance and acceptance in preference of seeking help and consulting a doctor/GP, while the second function is based on consulting a hakim/vaid/alternative healer, saying prayers, talking to family member/s, consulting a psychologist, consulting a mullah/pir/priest, consulting a psychiatrist, taking medication and consulting a psychotherapist.

As shown in Table 5.13, five of the pathways, (self reliance, doctor/GP, hakim/vaid/alternative healer, saying prayers, and talking to family members) discriminated according to the step-wise procedure.
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Table 5.13 Step-Wise Procedure

<table>
<thead>
<tr>
<th>Item</th>
<th>Means</th>
<th>F</th>
<th>Wilke's Lambda</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Britons</td>
<td>4.65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistanis</td>
<td>2.98</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistanis</td>
<td>4.49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saving Prayers</td>
<td>19.43</td>
<td></td>
<td>0.92</td>
<td>.0001</td>
</tr>
<tr>
<td>Hakim/vaid/alternat.healer</td>
<td>18.86</td>
<td></td>
<td>0.91</td>
<td>.0001</td>
</tr>
<tr>
<td>Family member</td>
<td>18.08</td>
<td></td>
<td>0.88</td>
<td>.0001</td>
</tr>
<tr>
<td>Doctor/GP</td>
<td>16.52</td>
<td></td>
<td>0.88</td>
<td>.0001</td>
</tr>
<tr>
<td>Self reliance</td>
<td>14.74</td>
<td></td>
<td>0.85</td>
<td>.0001</td>
</tr>
</tbody>
</table>

Table 5.14 Predicted group membership of the discriminant analysis

<table>
<thead>
<tr>
<th>Actual Groups</th>
<th>Number of cases</th>
<th>Predicted group membership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Brit. Pakistanis</td>
<td>45</td>
<td>24 (53.3%)</td>
</tr>
<tr>
<td>Britons</td>
<td>88</td>
<td>15 (17.0%)</td>
</tr>
<tr>
<td>Pakistanis</td>
<td>88</td>
<td>18 (20.5%)</td>
</tr>
</tbody>
</table>

Table 5.14 provides an indication of the success rate for predictions of membership of the grouping variable's categories using discriminant functions developed in the analysis. The percentage of "grouped" cases correctly classified was 64.7%. 70.5% of the Britons were correctly classified, 64.8% of the Pakistanis and 53.3% of British Pakistanis. British Pakistanis were marginally more likely to be classified as Britons than Pakistanis.

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5.4.4 Integration of the observed relations

To obtain a clearer picture of the interrelations among these variables, it was necessary to conceptualise models suggesting causal paths between the different variables. This was done in order to investigate the interrelations between the proposed predictive variables and attitudes towards pathways considered appropriate for help-seeking. The models were constructed for those pathways that showed a significant difference between the cultural groups i.e. self-reliance and acceptance, saying prayer, talking to family members, consulting a hakim/vaid/alternative healer and consulting a GP/doctor. A pathway was also constructed for taking medication. Although this pathway did not show a significant difference in the scores between the groups, this causal path model was constructed in order to investigate the association between causal beliefs of mental distress/illness and general attitudes towards biomedical therapies.

The variables in the model were:
- socio-demographic variables of culture, religiosity, age, sex, income and education. (In this study, religion was replaced by ‘religiosity’ because of the high inter-correlation between culture and religion. The issue of multi-collinearity between variables is explained in detail below).
- the factor of psychological distress as measured by the Mental Health Inventory\textsuperscript{19};
- the four categories of the beliefs of mental distress of stress, supernatural, western physiology and non-western physiology causes;
- Each of the pathways of help-seeking separately i.e. self-reliance and acceptance, saying prayer, talking to family members, consulting a hakim/vaid/alternative healer, consulting a doctor/GP and taking medication.

The principal form of analysis was path analysis. Path analysis, which is a form of causal

\textsuperscript{19} Psychological distress was considered more appropriate as a measure of the mental health than the Mental Health Index, when measuring attitudes towards help-seeking for mental distress.
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modeling, was computed using hierarchical regression analysis. The variables entered into the path analytic models were chosen on the grounds of both theoretical importance as well as the findings of the current study. Variables were entered into the hierarchical regression analysis in a pre-determined order, based on a logical causal sequence whereby those variables thought to cause subsequent variables were entered first (Cohen and Cohen, 1983). The method of regression used was hierarchical, and was chosen because it deals with the problem of multi-collinearity (Cohen & Cohen, 1983). Multi collinearity arises when two or more independent variables correlate highly with one another. The coefficients tested in regression are partial coefficients. That means that if a given independent variable emerges as a significant predictor of the dependent variable when another independent variable is also entered into the regression equation, then that IV uniquely accounts for variance in the dependent variable. That variance is unique to itself and is not shared between it and the other independent variable. If two independent variables are highly correlated, neither may emerge as significant predictors of the dependent variable, as the variance unique to each may be greatly reduced as a result of their being inter-correlated.

Culture, sex and age were entered in Step 1. Two of these variables, i.e. culture and sex, were dummy variables. Education, income and religiosity were entered in Step 2 (pathways between the first group of variables and the second were not shown, for the sake of clarity). The score for psychological distress was entered in Step 3. The four categories of causal beliefs of mental distress were entered in Step 4. The dependent variable was each of the pathways of help-seeking separately i.e. self-reliance and acceptance, saying prayers, talking to family members, consulting hakim/vaid/alternative healer, consulting a GP/doctor and taking medication.

Entering variables in this hierarchical format means that those on the left side of the diagrams are given priority in the analysis. Hence, entering culture, sex, age, education, income and religiosity in the first two steps means that those variables entered later have to account for significant variance over and above that already accounted for by these variables. This order of entry ensures that for psychological distress or causal beliefs of mental distress
to be significant predictors of each of the pathway considered appropriate for seeking help, they must account for variance that has not been accounted for by the variables preceding them in the path model. The key difference between entering all the variables together and entering them hierarchically is that the latter attributes the variables entered in earlier stages both unique variance and also any overlapping variance that exists between them and variables entered later, since they are given priority in the analysis.

The causal path models are shown in stages for ease of explication. The first stage of the analysis shows a ‘partial’ causal path model (Figure 5.2) illustrating a causal path with socio-demographic variables (culture, age, sex, religiosity, income and education) as predictor variables and the four causal belief categories of mental distress as the dependent variables.

The second stage shows a ‘partial’ causal path model (Figure 5.3) illustrating a causal path with the socio-demographic variables and psychological distress as predictor variables and the four causal belief categories of mental distress as the dependent variable.

The full causal path models (shown in Figures 5.4, 5.5, 5.6, 5.7, 5.8 and 5.9) illustrate a causal path with six socio-demographic variables, psychological distress and the four causal belief categories of mental distress as independent variables. The six separate help-seeking pathways (self-reliance, prayers, family member/s, hakim/vaid/alternative healer, doctor/GP, taking medication) were the dependent variable, analysed separately in each model.

The β coefficients are shown in the path models rather than the bs. This is done because while two variables are dummy variables (sex, and culture), four variables are continuous variables (age, religiosity, income and education). Since the β reflects the strength of the relationship between two variables but one which has been standardized, in comparison to the b coefficient which uses the original units of the scales employed, it is considered that the βs are more useful in this study. Because it could be argued that the original units are, to some extent, arbitrary because they reflect questionnaire scales, only βs will be printed on the models for the sake of clarity.
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Figure 5.2 Socio-demographic variables as predictors of causal attributions of mental distress

- Britons
- Pakistanis
- Sex
- Age
- Religiosity
- Income
- Education

β.23
β.51
β-.26

Stress causes
Western Physiological causes
Supernatural causes
Non-western Physiological causes

Key:
- Britons=1
- Non-Britons=0
- Pakistanis=1
- Non-Pakistanis=0
- Males=1 Females=0

p<.05
p<.001
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Figure 5.3 Socio-demographic variables and psychological distress as predictors of causal attributions of mental distress

Britons $\beta = .38$

Pakistanis $\beta = .51$

Sex $\beta = .23$

Age $\beta = .25$

Religiosity

Income $\beta = .26$

Education

Psychological distress

Stress causes

Western physiological causes

Supernatural causes

Non-western physiological causes

Key:

Britons = 1  
Non-Britons = 0  
Pakistanis = 1  
Non-Pakistanis = 0  
Males = 1, Females = 0  

p < .05  
p < .001
5.4.4.1 Socio-demographic variables as predictors of causal attributions of mental distress

Socio-demographic variables, over-all, were significant predictors of beliefs in supernatural causes (R=.56, R^2=.31, F(7,78)=5.10, p<.001). As predicted, culture emerged a significant predictor of supernatural causal beliefs of mental distress/illness, such that being Pakistani predicted more supernatural causal beliefs compared to the reference group of British Pakistanis (β=.51, t=3.02, p<.001). Income significantly predicted supernatural causal beliefs, lower income predicting more supernatural causal beliefs (β= -.26, t= -2.24, p<.05). Sex also predicted beliefs in supernatural causes, with being male predicting beliefs in supernatural causes of mental distress (β=.23, t=2.41, p<.025).

Socio-demographic variables, over-all, were not significant predictors of beliefs in non-western physiological causes (R=.32, R^2=.10, F(7,78)=1.25ns).

No socio-demographic variables significantly predicted causal attributions of stress (R=.34,R^2=.11, F=(7,78)1.48ns) or western physiology (R=.25, R^2=.06 F=(7,78).76ns) for mental distress/illness.

5.4.4.2 Socio-demographic variables and psychological distress as predictors of causal attributions of mental distress

A regression analysis done with psychological distress as the dependent variable and culture, age, sex, religiosity, education and income as the predictor variables showed no over-all significance (R=.36, R^2=.17 F(7,78)=1.69ns). However, culture emerged as a significant predictor of psychological distress, such that being Briton predicted lower levels of psychological distress compared to the reference group of British Pakistanis (β= -.38,t=-2.28, p<.05).

With the addition of psychological distress into the model, the variance for stress causes became R=.36,R^2=.13, F(8,76)=1.33ns, for western physiological causes R=.27, R^2=.07 F(8,76)=.75ns, for supernatural causes R=.56, R^2=.31, F(8,78)=4.40, p<.001 and for the non-
western physiological causes $R=.33$, $R^2=.11$ $F=(8,78)1.21ns$. Findings indicate that, with the addition of psychological distress into the path model, the causal path model remained the same for all causal attributional categories. Therefore, the addition of psychological distress to the causal path model did not improve the model, as the variance remained virtually unchanged with the addition of psychological distress, as the $R$, $R^2$ and $F$ values of these categories show.

Results indicated that, against expectation, psychological distress did not significantly moderate the relationship between culture, age, sex, religiosity, education and income and the four categories of causal beliefs.
5.4.4.3 Predictors of help-seeking pathways

Figures 5.4, 5.5, 5.6, 5.7, 5.8 and 5.9 give the full causal path models with socio-demographic variables, psychological distress and the four causal belief categories of mental distress as predictor variables, and each help-seeking pathway (self-reliance, prayer, family member/s, alternative healers/hakim, doctors/GP, and taking medication) as the dependent variable. Solid lines in the models show the direct path to the help-seeking choice. Dotted lines show all other earlier paths in the model (shown in Figures 5.2 and 5.3).

The t values of regression done on each of these pathways separately are given in Table 5.15.
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Figure 5.4 Causal path model of help-seeking pathways for mental distress: self reliance and acceptance
R = .57, R^2 = .33, F(12, 66) = 2.73, p < .01

Key:
- - - - - .p > .06
- - - - .p < .05
Britons=1
Non-Britons=0
Pakistanis=1
Non-Pakistanis=0
Males=1 Females=0
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Figure 5.5 Causal path model of help-seeking pathways for mental distress: saying prayers
\( R = .65, R^2 = .42, F(12, 66) = 4.01, p < .001 \)

<table>
<thead>
<tr>
<th>Key:</th>
<th>p &lt; .01</th>
<th>p &lt; .001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Britons=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Britons=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistanis=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Pakistanis=0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females=0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Britons

Pakistanis

Sex

Age

Psychological distress

Saying Prayers

Religiosity

\( \beta = .32 \)

\( \beta = .38 \)

Stress causes

Western Physiological causes

Supernatural causes

Non-western Physiological causes

Income

Education
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Figure 5.6 Causal path model of helpseeking for mental distress: talking to family member/s
R = .54, R² = .29, F(12, 66) = 1.75, p > .05

Key:
- Britons = 1
- Non-Britons = 0
- Pakistanis = 1
- Non-Pakistanis = 0
- Males = 1
- Females = 0

β = .45

Psychological distress

Stress causes

Western Physiological causes

Talking to family members

Supernatural causes

Non-western Physiological causes

Religiosity

Income

Education

Sex

Age
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Figure 5.7 Causal path model of help-seeking for mental distress: consulting a hakim/vaid/alternative healer

$R = .51, R^2 = .26, F(12,66) = 1.94, p < .05$

Key:
- Britons = 1
- Non-Britons = 0
- Pakistanis = 1
- Non-Pakistanis = 0
- Males = 1
- Females = 0
Figure 5.8 Causal path model of help-seeking for mental distress: consulting a doctor/GP

R= .59, R²=.35, F(12,66)=2.93, P<.01

Key:
- Britons = 1
- Non-Britons = 0
- Pakistanis = 1
- Non-Pakistanis = 0
- Males = 1
- Females = 2

p < .05
p < .01
p < .001
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Figure 5.9 Causal path model of helpseeking for mental distress: taking medication
\( (R=0.60, R^2=0.375, F(12,66)=3.19, p<0.001) \)

Britons

Pakistanis

Sex

Age

Psychological distress

Stress causes

Western physiological causes

Taking medication

\( \beta = 0.33 \)

\( \beta = 0.24 \)

Religiosity

Supernatural causes

Non-western physiological causes

Income

Education

\( p < 0.05 \)

\( p < 0.01 \)

\( p < 0.001 \)

Key:

Britons = 1
Non-Britons = 0
Pakistanis = 1
Non-Pakistanis = 0
Males = 1 Females = 0

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Table 5.15 T values of variables predicting choice of help-seeking pathways

<table>
<thead>
<tr>
<th>Predicting choice of pathways</th>
<th>Self Reliance</th>
<th>Saving Prayers</th>
<th>Family Members</th>
<th>Hakim/Alternative healer</th>
<th>GP/Doctor</th>
<th>Taking Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.881</td>
<td>-.241</td>
<td>-.296</td>
<td>-1.891</td>
<td>3.282**</td>
<td>.899</td>
</tr>
<tr>
<td>Sex (Males=1, Females=0)</td>
<td></td>
<td>3.025**</td>
<td>- .914</td>
<td>- .303</td>
<td>.707</td>
<td>- .561</td>
</tr>
<tr>
<td>Religiosity</td>
<td>2.082*</td>
<td>3.493***</td>
<td>-1.888</td>
<td>- .951</td>
<td>-1.280</td>
<td>-2.065*</td>
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<tr>
<td>Education</td>
<td>1.738</td>
<td>1.061</td>
<td>1.720</td>
<td>- .058</td>
<td>-1.888</td>
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<tr>
<td>Income</td>
<td>-.374</td>
<td>-.297</td>
<td>-1.077</td>
<td>-1.540</td>
<td>-2.910**</td>
<td>.012</td>
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<td>Culture (Pakistanis=1, Non-</td>
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<td>1.227</td>
<td>-.295</td>
<td>-1.718</td>
<td>- .523</td>
<td>- .212</td>
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<td>PK=0)</td>
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<td>Psychological Distress</td>
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<td>-.422</td>
<td>230</td>
<td>-.956</td>
<td>-.371</td>
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<tr>
<td>Step 2</td>
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<tr>
<td>Causal Attributions</td>
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</tr>
<tr>
<td>Stress causes</td>
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<td>.012</td>
<td>-.365</td>
<td>-1.081</td>
<td>1.442</td>
<td>2.605**</td>
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<td>Western physiology causes</td>
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<td>-.104</td>
<td>-1.008</td>
<td>- .937</td>
<td>2.165*</td>
<td>1.249</td>
</tr>
<tr>
<td>Supernatural causes</td>
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<td>.700</td>
<td>1.352</td>
<td>1.766+</td>
<td>-2.418**</td>
<td>-3.832***</td>
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<td>Non-western physiology causes</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p>.06**p<.05***p<.01<p<.001

5.4.4.4 Predicting help-seeking behaviour

As predicted, culture, sex, age, religiosity, education and income all were significant predictors of help-seeking behaviour, their significance as predictors differing according to the choice of help-seeking pathway. As also predicted, causal attributions of mental distress/illness predicted attitudes to help-seeking pathways for mental distress/illness.
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5.4.4.4.1 Predictors of Self-reliance and acceptance in preference to seeking help for mental distress

Culture was short of significance as a predictor of self-reliance (β=-.29, t=1.68, p>.06), although results indicated a negative relationship between being British and self-reliance and acceptance compared to the reference group, British Pakistanis. However, being Pakistani emerged as a significant predictor of supernatural causal beliefs compared to the reference group of British Pakistanis (β=.51, t=3.02, p<.001) while supernatural causal beliefs themselves were the only significant direct predictors of self-reliance and acceptance (β=.40, t=2.60, p<.025).

Psychological distress, as measured by the MHI, was a significant predictor (β = -.23, t = -2.08, p<.05) and had an inverse relationship with self-reliance and acceptance as help-seeking behaviour. Education was short of significance as predictor of self-reliance (β=.19, t=1.74, p>.06) (Figure 5.4).

5.4.4.4.2 Predictors of Saying Prayers as a help-seeking pathway for mental distress

Religiosity was the most significant predictor of saying prayers as help-seeking behaviour (β=.38, t=3.49, p<.001) Sex also significantly predicted prayers (β=.32, t=3.035, p<.01), indicating that men considered prayers as an appropriate help seeking pathway more than women. Culture was not a significant predictor of saying prayers (Figure 5.5)

5.4.4.4.3 Predictors of Talking to family member/s as a help-seeking pathway for mental distress.

Culture was the only significant predictor of talking to family members (β= -.45, t= -2.48, p<.025, results indicating an inverse relationship between being British and talking to family members as a help-seeking pathway, compared to the British Pakistanis (Figure 5.6).
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5.4.4.4 Predictors of Consulting an alternative healer/hakim as a help-seeking pathway for mental distress.

Supernatural causal beliefs were just short of being significant as predictors of consulting a hakim or alternative healer ($\beta=.29$, $t=1.77$, $p>.06$). Age was also short of being a significant predictor of consulting a hakim/vaid/alternative healer ($\beta=-.24$, $t=-1.89$, $p>.06$), with younger people expressing a preference for this pathway than older people. Culture was not a significant predictor of consulting a hakim/vaid/alternative healer (Figure 5.7).

5.4.4.5 Predictors of Consulting a doctor/GP as a help-seeking pathway for mental distress.

Age was the most significant predictor of consulting a doctor/GP as an appropriate way of seeking help for mental distress ($\beta=.40$, $t=3.28$, $p<.01$), older people expressing a preference for this pathway more than younger people. Income significantly predicted consulting a GP/doctor ($\beta=-.37$, $t=-2.91$, $p<.01$), with those of lower income expressing preference for consulting a GP more than those of higher income. Beliefs in western physiology causes of mental distress significantly predicted consulting a GP ($\beta=.25$, $t=2.17$, $p<.05$) while supernatural causal beliefs significantly and negatively predicted consulting a doctor/GP for mental distress ($\beta=-.33$, $t=-2.42$, $p<.025$). Culture was not a significant predictor of consulting a doctor/GP (Figure 5.8).

5.4.4.6 Predictors of Taking medication as a help-seeking pathway for mental distress.

Beliefs in supernatural causes emerged as the most significant predictor, with an inverse relationship with taking medication ($\beta=-.58$, $t=-3.83$, $p<.001$). Beliefs in stress causes significantly predicted taking medication ($\beta=.33$, $t=2.61$, $p<.01$). Being religious was a significant and negative predictor of taking medication ($-24,t=-2.063$, $p<.05$). Culture was not a significant predictor of taking medication (Figure 5.9).

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5.5 Discussion

As hypothesised, the factor analysis of the MHI showed that the mental health, in this lay population, was a multi-dimensional construct. Although the variance explained was over 40.0% when mental health was measured as a unidimensional measure by the Mental Health Index, the five-factor model of the MHI accounted for a much greater portion of the variance. The two-factor solution replicated the original findings by Veit & Ware (1983). Items of the MHI grouped into two distinct constructs - one denoting negative mental states, or psychological distress, and the other denoting positive mental states, or psychological wellbeing. This result also supports the practice of other studies that have scored psychological distress and psychological wellbeing separately (Goldberg, 1978; Ware et al, 1979). This point may be of particular importance in measuring mental health in lay populations, since it seems to increase the precision of measurement instruments where it is assumed that psychological distress is undifferentiated.

As predicted, the hierarchical structure of higher-order factors comprising of lower-order factors was also found for this sample. With a few exceptions, negative items loaded on the three negative lower-order factors and positive items loaded on the two positive factors. As had been expected, the five factors of the MHI postulated by Veit & Ware (1983) were not replicated. This is not surprising since the sample used in this study was very different from the samples used for validation of the MHI in the original study. As there was high internal reliability for all the original sub-scales of the MHI for this sample, these measures of the MHI seem to provide a reliable basis for providing a more comprehensive understanding and interpretation of mental health.

Inter-correlations between the Mental Health Index and the higher order sub-scales, psychological distress and psychological well being, were high for this sample. Intercorrelations were also high between the higher order sub-scales and their respective lower order sub-scales. Since the reliability co-efficients for the sub-scales are, over-all, higher than the inter-correlations between the sub-scales of the MHI, it seems reasonable to
assume that the sub-scales are measuring unique and reliable variance.

There were significant differences, at the .01 level of significance, between the cultural groups, for the Mental Health Index, the higher order factor of psychological distress and the lower order factor of Loss of Behavioural and Emotional control. Means indicated that there were significant differences between the Pakistani and the British group, with the highest scores for the Pakistani group on all three scales.

It had been predicted, as earlier findings had shown, that the migrant British Pakistani group, would have higher levels of psychological symptomatology compared to the indigenous population in this country, as well as to Pakistanis who had not migrated. However, while British Pakistanis group had lower scores for the Mental Health Index than the British group, indicating a poorer state of psychological health, differences were not significant at the <.01 level. British Pakistanis also had higher scores on the Mental Health Index compared to Pakistanis, indicating better psychological health for the migrants than those who still lived in their country of birth, although these were also not significantly different at the <.01 level.

There were no significant differences, at the .01 level of significance, between the three cultural groups on psychological wellbeing and the lower order sub-scales of Anxiety, Depression, General Positive Affect and Emotional Ties.

In a comparison between the migrant group and the host population, results indicated British Pakistanis to be in poorer mental health. These results confirm the findings of earlier research (Beliappa, 1991; Raleigh 1991; Modood, Berthoud, Lakey, Nazroo, Smith, Virdee, & Beishon, 1997) that have indicated a poorer state of mental health in the migrant community than had first been assumed (Inechein, 1990). In comparing British Pakistanis to the Pakistanis living in Pakistan, it is clear, from the results of this study, that migration itself does not necessarily contribute to poorer mental health. The Pakistanis who still live in their country of origin had the highest levels of distress and lowest levels of wellbeing. These findings may be explained by the fact that the Pakistani sample in this study resides in Karachi, a city that has been in the grip of ethnic and sectarian violence during the last twelve year.
One of the more surprising findings showed that religion, at the .01 level of significance, had a significant effect on the Mental Health Index. There was also a significant effect for religion, at the .01 level, for psychological distress and Loss of Behavioural and Emotional Control, with Muslims scoring lowest on the Mental Health Index and highest on psychological distress and Loss of Behavioural and Emotional Control. These results seem to confirm those found by earlier research, showing Muslims as having the poorest physical and mental health compared to other British Asian sub-groups (Nazroo 1997a). Nazroo goes on to explain these differences in structural, rather than cultural, terms. He points out that Pakistanis in the UK comprise the majority of the Muslims in the UK and are often the most socio-economically disadvantaged groups of migrants in the country. Research has shown that low income in all groups is associated with poor health (Smaje, 1995; Nazroo, 1997b). In this study, however, income did not have a significant effect on mental health as measured by the Mental Health Index for the entire sample. One of the reasons that could account for this result could be that even those with low income came from middle class backgrounds, and therefore, did not suffer any real economic disadvantage or deprivation. However lower income, when the British Pakistani sample was analysed separately, had an effect on psychological distress and the sub-scale of Anxiety. This latter finding shows that, as far as the migrant group is concerned, the psychological effect on a member of a visible ethnic minority group can arise from negative aspects arising out of a lower socio-economic status. As Smaje (1996) has pointed out, those that are socially disadvantaged are perhaps most at risk to feel the negative effects of prejudice, discrimination and racism.

Significant differences were also found between first and secondgeneration British Pakistanis for psychological distress and the lower order factors of psychological distress, with results indicating a higher level of psychological distress for second generation migrants compared to the first generation. These findings confirm those of the Fourth National Survey which investigated levels of mental health of the Asian migrant population and found that those who had migrated here after the age of 11 had better mental health (Nazroo, 1997). Results obtained from analysis of the sub-scales of the MHI demonstrate that it is a useful
measurement tool to investigate the multi-dimensional nature of mental health and to illustrate differences and similarities, in the mental health of groups in a lay population, the different dimensions of mental health. However, more validation studies are needed on larger samples in cross-cultural research before its validity can be assumed for use in research across cultural groups.

As predicted, there were differences in the causal attributions of mental distress in three of the four categories of causal beliefs. However, the two non-western causal categories only (supernatural and non-western physiological causes) were significant at the .01 level of significance. Both Asian groups had higher beliefs in supernatural and non-western physiological causes of mental distress than the Britons in this study. These results confirm the distinctions made, along western and non-western lines, by Eisenbruch (1990). This finding also directly contradicts the results of the first study, where distinctions were not found between the two non-western groups and the western group. Thus, while results of the second study might be considered evidence for the significance and durability of ethno-geographic health beliefs of the Asian culture, the contrast in the findings of the two studies suggest that these beliefs are also changeable.

While the differences found in non-western explanations, in this study, could be understood as illustrating causal attributions made for 'mental distress/illness' (as opposed to just 'mental distress', as in the first study), the differences in western explanations of mental illness did not confirm Eisenbruch's distinctions. There were no significant differences, at the .01 level, between British Pakistanis, Britons and Pakistanis either in the western physiology causal category or in the stress category. These two rather contradictory results (in terms of western and non-western explanations) are in line with Weiss' findings (1997) who reported, in studying traditional beliefs in India, that there is both 'continuity and change' in people's concepts of disease and illness.

As predicted, causal path modelling showed culture to be a significant predictor of supernatural causes, such that Pakistanis were significantly and positively associated with this category of causal attributions compared to the reference group of British Pakistanis.
Against prediction, mental health was not a predictor of the causal beliefs of mental distress, in the two Asian samples, with one exception. The Mental Health Index of Pakistanis predicted beliefs in stress causes only, although the link was weak (with 5% variance explained). There was a stronger association between the Mental Health Index and stress causal attributions for the British sample, indicating that Britons' mental health significantly predicts causal beliefs of stress (12% of the variance). No other association was found between mental health and any category of causal attribution. These results seem to suggest that the mental health of an Asian population did not substantially modify causal beliefs about mental distress. It appears, therefore that, in the two Asian groups, mental distress beliefs are part of a wider understanding of health and illness and are not predisposed to change with their mental health. This is in contrast to the finding for the British group that showed a relationship between beliefs about the causal attributions of stress and mental health.

Causal path modelling, done for the whole sample, showed that psychological distress did not significantly predict any category of causal attribution of mental distress and mediated only in the choice of one help-seeking pathway. The causal path model indicated an inverse relationship between psychological distress and self reliance and acceptance in preference to seeking help for mental distress.

A step-wise discriminant analysis done to distinguish between groups indicated that British Pakistanis were marginally more likely to be classed as British than Pakistanis. However, more detailed analysis of differences in cultural attitudes towards seeking help also showed some aspects which have been associated with the Asian culture. As predicted, findings demonstrated that both groups of Asians considered self-reliance and acceptance in preference to seeking help for mental distress, saying prayers and talking to family member/s as more appropriate ways of dealing with mental distress than the British group. These results demonstrate that the explanatory models of Asians can be far removed from western constructions, even for those Asians who have lived in a western society for many decades. Although, in the causal path model, culture did not emerge as a direct significant predictor
of self-reliance, being Pakistani significantly predicted supernatural causal beliefs, which emerged as the only significant predictors of self-reliance and acceptance.

Culture was again not a direct significant predictor of saying prayers as a help-seeking pathway. Not surprisingly, religiosity most significantly predicted saying prayers. As almost 32% of the British sample were of no religious affiliation, compared to 0% in the British Pakistani or the Pakistani sample, it is undoubtedly the religiosity of the two Asian samples that predict saying prayers. This result confirms earlier findings that have shown the importance of religion as a way of coping with mental distress and illness in the Indo-subcontinent (Kohli & Dalai, 1998).

Rather more surprisingly, sex was a significant predictor, such that men considered saying prayers as an appropriate help-seeking pathway compared to women. Although this result goes against expectation, because of an assumed reluctance on the part of Asian women particularly, it was in line with research, in the West, that has shown that it is women who are more amenable to looking for help than men (Price & McNeill, 1992). This result further confirms the findings of the first study that demonstrated that men, as compared to women, had a less favourable attitude to seeking help.

The findings of this study also shed light on another assumption associated with cultural attitudes of Asians, i.e. talking to family members as an appropriate way of seeking help. Culture was a significant predictor on talking to family members as a way of seeking help for mental distress. Causal path modelling showed that being British negatively predicted talking to family members as a help-seeking pathway for mental distress compared to the British Pakistani group. This result could be taken as confirming assumptions that people from the Indo-subcontinent consider psychological problems the province of helpful relatives as well as confirming the conclusions that the family, amongst British Asians, is perceived largely as a supportive structure (Rack, 1982; Stopes-Roe & Cochrane, 1990).

While the results of causal analysis of these three pathways might confirm assumptions about Asians’ inhibitions to seek help, there were no differences between the three groups in their attitudes towards consulting a psychologist, a psychotherapist or a psychiatrist. Against
expectation, the British Pakistanis and the Pakistanis did not have a more negative attitude to mental health professionals, such as a psychologist, a psychotherapist or a psychiatrist than the Britons. All three groups considered a psychotherapist and a psychologist as being the most appropriate pathway for seeking help for mental distress, (with the highest mean) indicating the much more open attitude to psychological therapies both in the West and elsewhere. However, again as the means show, all three groups have a less positive attitude to consulting a psychiatrist compared to either a psychotherapist or psychologist, for mental distress/illness. This result might be against expectation but is in line with the zeitgeist of the times, that all cultures have a more negative attitude towards what are perceived as biomedical treatments that do not take into account the holistic nature of the ill person.

Again, somewhat in contradiction to the findings discussed earlier, there were no significant differences between the three cultural groups on their attitude to taking medicine. This result confirms the findings of earlier studies that have shown that Asians use of western medication is widespread and that it forms an accepted part of ‘traditional’ remedies and treatments (Johnson-Cross & Cardew, 1983; Bhopal, 1986; Christakis et al, 1994). Causal path analysis showed that causal attributions were the main predictors of the pathway of taking medication for mental distress/illness. As might be expected, while beliefs in stress causes significantly predicted taking medication as an appropriate pathway for help-seeking, supernatural causes significantly and negatively predicted taking medication. Religiosity was the only other significant, though negative predictor of taking medication.

Although supernatural causes were also the most significant predictor of consulting a hakim/vaid/alternative healer, British Pakistanis and Pakistanis did not have similar views on going to hakims or alternative healers. The migrant group had a more favourable attitude to this complementary pathway for treatment for mental distress compared to the Pakistanis living in Pakistan. Hatfield and colleagues (1996) had also found British Asian male respondents to favour alternative therapies, such as ‘hikmet’. Since there were no differences for this pathway between British Pakistanis and Britons, this result might again be explained in the context of the resurgence of alternative healing in the West (even for life-threatening
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diseases, such as cancer). These findings seem to suggest that while the increase of holistic ways of treatment is a modern phenomenon in western societies, holistic therapies that have been part of the medical pluralism available in the Indo-subcontinent, may be losing ground to the more bio-medical therapies, as found by Weiss et al (1986).

Age was just short of significance for this pathway, with results indicating that the younger the person, the more favourably inclined towards hakim/vaid/alternative healer. These results are in line with findings of a study carried out by Campion and Bhugra (1997) in South India. They found that a significantly higher number of patients who visited traditional, religious healers were under the age of 17 years compared with older age groups. Campion and Bhugra had also found that visiting healers was significantly linked with low income. This was also confirmed by the findings of the present study, with income significantly predicting supernatural causes, which were just short of being a significant predictor of consulting a hakim/alternative healer.

Some of these results might point to Pakistanis generally regarding bio-medical therapies highly, as Christakis and colleagues (1994) have argued is the case in many developing countries. However, it was British Pakistanis and Britons who considered the doctor or GP as a more appropriate way of seeking help than the Pakistanis. This result was predicted, in view of the fact that this pathway was readily available in the UK and, as Weiss has pointed out, help-seeking involves not only ideological but practical issues as well. Therefore, this finding can, perhaps, most easily be understood in the context of the different state health systems of the UK and the countries of the Indo-subcontinent.

Indeed, causal path analysis showed that more structural factors, rather than culture, were significant predictors of consulting a GP or doctor. As has been found in earlier research, (Modood, Berthoud, Lakey, Nazroo, Smith, Virdee, & Beishon, 1997), both age and income predicted consulting a doctor/GP for seeking help for mental distress. While it was again those of low income that considered this pathway appropriate for seeking help, it was the older, rather than younger, age group that predicted consulting a doctor/GP for mental distress. Although culture, as mentioned earlier, was not directly a significant predictor,
causal attributions of mental distress directly predicted this pathway. As would be expected, while beliefs in western physiological causes of mental distress/illness predicted consulting a doctor/GP, supernatural causal attributions significantly and negatively predicted consulting a doctor/GP.

Although these results have illustrated some aspects of differences, between cultural groups, in pathways that are considered suitable for seeking help for mental distress, it must be remembered that choices, in an Asian population, may not be made between therapies but can include multiple paths. Finally, it must be emphasised that while these findings may have illustrated the relationship between causal attributions of mental distress of groups, the mental health of groups and associated attitudes to different ways of seeking help, the link between attribution, expressed attitudes and actual illness behaviour may be tenuous. As mentioned in earlier discussions in the first study, and as research in attributions has shown (Ajzen & Madden, 1986), the pathway from expressed attitude to actual behaviour is weak.

Earlier research has shown that attitudes towards help-seeking change with motivation, personal relevance, availability of choices, perceived efficacy as well as with severity of distress (Christakis, et al, 1994).

In trying to understand the relationship between causal attributions of mental distress and help-seeking, it seemed advisable to investigate an actual choice of pathway made by a lay population. Therefore, the next study investigated one choice of pathway i.e. consulting a GP. Although the participants in the next study did not make this choice specifically as a help-seeking pathway for mental distress, this pathway is considered to be particularly relevant because it is implicated in issues that are specific to Asians and their mental health.

5.6 Summary

Following the findings of the first study, this study examined the association between levels of mental distress, causal attributions and attitudes towards help-seeking pathways considered appropriate for help-seeking for mental distress, in the three cultural groups.
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Hypothesis I: As predicted, the mental health in this lay population was multi-dimensional i.e. the dimension of psychological distress was separate from psychological wellbeing. The two factor solution for the MHI was replicated for this sample.

Hypothesis II: As predicted, there was a hierarchical order of mental health dimensions, as proposed by Veit & Ware (1983). As predicted, higher order factors were correlated with their lower order factors. As expected, however, their exact lower order factors were not replicated for this sample.

Hypothesis III: Contrary to prediction, British Pakistanis’ scores were not different, on the scales of the MHI, from Pakistani or British groups at <.01 level of significance, while there were significant differences at <.01 level between the British and the Pakistani sample.

Hypothesis IV: As predicted, there was an effect of religion and age. Muslims had higher scores on measures of psychological distress, at <.01 level of significance, than other sub-groups and younger people had higher scores than older people. Against prediction, there was no main effect of sex or income on the scores of the scales of the Mental Health Inventory.

Hypothesis V: As predicted, there were significant differences, at <.01 level of significance, between first and second generation British Pakistanis for the MHI Index as well as for several sub-scales. Contrary to prediction, it was the second generation that had higher scores of psychological distress than the first generation. As predicted, there was also a main effect of length of stay in the UK in the British Pakistani sample. Those having been in the UK longer had higher scores on psychological distress than those with shorter stay.

Hypothesis VI: As predicted, there was an effect of income in the British Pakistani sample. Those with lower income had higher scores on psychological distress than those with higher income.

Hypothesis VII: Against prediction, the mental health (as measured by the MHI) of only the British sample was significantly associated with causal attributions of mental distress, specifically stress attributions.

Hypothesis VIII and IX: As predicted, the two Asian groups, compared to the British group,
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considered it more appropriate to be self-reliant and accepting in preference to seeking help for mental distress. As predicted, the two Asian groups also considered it more appropriate to say prayers or talk to a family member/s as a way of seeking help for mental distress than Britons.

*Hypothesis X*: Contrary to prediction, the British Pakistanis and the Britons had a more positive attitude to consulting an alternative healer/hakim than Pakistanis.

*Hypothesis XI*: As predicted, the British Pakistani and the British groups had a more positive attitude towards consulting a GP or a doctor for mental distress than the Pakistani group.

Against prediction, there were no significant differences, between the three cultural groups, on taking medication.

*Hypothesis XII*: Against prediction, there were no significant differences, between the three cultural groups, on taking medication or consulting professional help (psychologist, a psychotherapist or a psychiatrist) for mental distress.

*Hypothesis XIII*: As predicted, no significant differences were found, in the choice of any pathway, between sub-groups in the British Pakistani sample by place of birth or length of stay.

*Hypothesis IV*: As predicted, causal path models constructed to examine predictors of the pathways for seeking help for mental distress showed that culture, causal attributions of mental distress, and socio-demographic variables such as age and income, were significant predictors in attitudes towards pathways considered appropriate for help-seeking for mental distress.
CHAPTER 6

Study three

Factors in the choice of one pathway of help-seeking for mental distress: GP consultation
Chapter 6

Study 3: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation

6.1. Introduction

While the under-utilisation of mental health services by ethnic minority groups has led to concerns that the health services may be failing them (Fenton & Sadiq, 1993; Bowes & Domokos, 1993), research has shown that British Asians have relatively high rates of GP consultation compared to their use of psychiatric services (Balajaran, Yuen & Raleigh (1989). This particular choice of help seeking – consulting a general practitioner - has held great interest for researchers. Firstly, the GP is the first contact that patients make when faced with mental distress. Consultation rates, therefore, may well be an indication of morbidity rates of mental distress. Regier, Goldberg & Taube, (1978) have found that primary care is the main avenue for the delivery of care to persons with psychiatric disorders. In the UK, Goldberg and Bridges (1985) found that 33% of patients attending general practitioners met DSM-III criteria for a psychiatric disorder. Secondly, although this is help-seeking at primary care level, GP consultations have particular relevance to attitudes to mental distress because of several different issues. The attributional beliefs that patients have about their illness, levels of mental distress and the presentation or symptoms of their distress, as well as other factors, determine the choice of consulting a GP.

Research specifically about the rates of GP consultation within the ethnic minority groups, such as the British Asian community, have been somewhat inconclusive. Although Bhopal (1986) found the persistence of traditional beliefs and therapies within the British Asian community in the UK, he concluded that it was not at the cost of western medicine. Other research, too, has demonstrated that Asian patients are not opposed to it. Brewin (1980) found similar rates of GP consultation among matched samples of patients of Asian and Western origin. However, Gillam, Jarman, White & Law, (1989) found that while British Asians’ patients consulting rates were similar to other ethnic groups, those who did consult, did so more frequently. Other research has also shown an above average rate of general practitioner consultation (Donaldson, 1986). Balajaran and colleagues (1989) found that after adjusting for age and socio-economic group, consultation rates among men and women of Pakistani origin were almost three
times and double compared to the indigenous men and women respectively. However, a later study found that when Asian patients were matched with non-Asian patients by age, gender and address (Heatley & Yip, 1991), there were no significant differences between the two groups.

Gillam et al (1989) found that, while general statements could not be made about GP consultations rates amongst British Asians (which often depended on type of disease), these rates were particularly reduced for mental disorders, specifically anxiety and depression. As levels of distress have been shown to be the single most important predictor of help-seeking in most cultures (Mechanic, 1978), low levels of psychological distress amongst British Asians were initially held accountable for low levels of health service contact in this community for mental distress. However, more recent studies have shown higher levels of psychological distress in British Asians than first supposed (Beliappa, 1991; Hatfield, Mohamad, Rahim, & Tanweer, 1996; MacCarthy & Wilson, 1994). It is clear that there are other factors that are implicated in this particular choice of help-seeking.

Christakis, Ware and Kleinman (1994) found that one of the main reasons behind the choice of a help-seeking pathway is the perceived efficacy of the healer. One piece of evidence that this might be the case for British Asians’ reluctance to consult GPs specifically for mental or emotional distress (as some studies have found), comes from a report of interviews carried out in Haringey (Beliappa, 1991). British Asians expressed psychological distress but expressed reluctance to go to the GP with emotional problems as they saw the GP as able to treat only physical problems. This perceived lack of efficacy for help for mental distress is not unfounded, as there is evidence that general practitioners are consistently less likely to identify psychiatric morbidity in Asian patients than white patients (Wilson & MacCarthy, 1994; Odell, Surtees, Wainwright, Commander & Sashidharan, 1997).

However, Smaje (1995) points to the difficulty of disentangling attitudes from need. He reports that a deeper analysis of GP consultation reveals that, where there is an excess use of this primary care service, it seems to be associated to need. Considering the fact that large parts of this community lives in poorer socio-economic circumstances compared
to the population, with a concomitant negative effect on physical and mental health, greater use of GPs would be expected (Nazroo, 1997a). It is clear, therefore, that the factors that contribute both to the attitudes towards the GP, as well as frequency of GP consultation, need further analysis.

One of the main factors held responsible for high GP consultation is the presentation of somatic symptoms to express emotional or mental distress. As Bridges & Goldberg (1985) have found, the presentation of somatic manifestations of a psychiatric illness can be the cause of hidden psychiatric morbidity in primary care settings. Other research has shown that somatization can cause an unnecessary use of non-psychiatric health care services (Katon, Kleinman, & Rosen, 1982b; Kawanishi, 1992; Smith, & Prior, 1997). These issues have resulted in somatization being one of the most important issues in Asian mental health research and related behaviour (Leong, 1986).

Somatization is defined as “a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to physical illness, and to seek medical help for them” (Lipowski, 1988). This somatic presentation of distress commonly seen in primary care is not equivalent to the somatoform disorders identified by DSM-IV (Kirmayer & Robbins, 1994) but is essentially seen to be fundamentally emotional or social in origin (Lipowski, 1988).

There is much evidence to support this assumption. Bridges, Goldberg, Evans, and Sharpe, (1991) reported that, compared to ‘psychologizers’ (those who express their distress in psychological terms), ‘somatisizers’ were found to be less depressed and had lower trait anxiety but reported high levels of stress and dissatisfaction in their social circumstance. Mumford et al (1991a) also found high correlations between levels of somatic presentation and psychosocial stress and Bhatt, Tomenson, & Benjamin, (1989) found somatisers attributing their distress to psychosocial causes.

Craig, Drake, Mills, and Boardman’s (1994) conclusions also implicate social and personal factors that differentially affect somatic and emotional styles of expressing distress. Verhaak and Tijhuis (1994) demonstrated that somatizing patients placed less emphasis on the underlying mental health problems compared to psychologizing patients. This reason may lie behind the finding, by Bridges et al (1991), that somatizers were less
likely to discuss emotional problems with a doctor or to consult their general practitioner for depressive symptoms.

Although patients from all ethnic groups have been found to present with somatic presentation, there is much evidence that non-western cultures, such as the Indian, African and the Chinese culture typically present somatically (Tseng 1975; Janakiramaiah & Subbakrishna, 1980; Katon et al, 1984). Theorists have explained this in various ways. It has been asserted that individuals from non-western cultures present with somatic symptoms because there is no clear distinction between the psyche and soma (Helman, 1980). Other researchers have attributed this form of presentation to the limited range of expressions of psychological distress in some languages (Leff 1977; 1988). Angel and Thoits (1987) asserted that the ‘more traditional the culture, the less differentiation there will be between physical illness and psychological disturbance’ (p.484).

The explanation by Kleinman (1980), of somatic presentation as culturally appropriate symptoms that have symbolic meaning within a given cultural context, opened the way for understanding the social and cultural context of somatization. However, confounding issues cloud the understanding of this concept. On the one hand, from the point of view of Western science, it was a ‘useful heuristic concept’ Kirmayer (1984); on the other, the concept revealed the underlying problem of adopting (western) ‘implicit norms of emotional expression’ in pathologising the cultural language of suffering (Kirmayer, 1989).

As mentioned in earlier discussions, Weiss and colleagues (1986) have argued that to consider somatization as secondary to depression in non-western cultures, such as that of India, (as is done by Western research), is to make an ethnocentric assumption. Somatisation, as Mirdal (1985) has pointed out, is not an alternative to expressions of emotional distress but an accompaniment. The absence of the Cartesian mind/body distinction in the non-western cultures means that “the opposition between somatic and emotional/social idioms is not intrinsic to many cultures’ language of distress”(pp. 287). Mumford, Devereaux, Maddy, & Johnston, (1991a) also refuted the idea that somatisers convert their psychological distress into somatic symptoms. They found a similar number of somatic symptoms between those with prominent psychological distress and those who
presented with physical symptoms without an organic basis. In a recent study, Kisely, Goldberg and Simon (1997), in examining the relationship between psychological distress and somatic symptoms found that somatic symptoms, irrespective of aetiology (i.e. either with a clear organic cause or which had no organic cause), were associated with increased social and psychiatric morbidity.

There is much evidence from research carried out in India that somatic symptoms are common in the expression of emotional or mental distress. Nichter (1981) found somatic complaints such as digestive disorders, poor appetite, weakness and body pain, menstrual complaints and burning sensations in body extremities as a form of expression of distress among Brahmin women of India. Chakraborty and Sandel (1983) also noted the symptoms of bodily heat or burning as had been noted by Janakiramaiah and Subbakrishna (1980) in Muslim women patients as well as in Hindu women by Janakiramaiah (1983). Mumford, Bavington, Bhatnagar, Hussain, Mirza and Naraghi (1991) also found that the repertoire of somatic symptoms is common between many of different groups across the Indo-subcontinent. However, demographic variables, such as educational differences and urban and rural populations, have been found to influence the presentation of somatic symptoms within the Indian culture (Chaturvedi and Michael, 1993).

In Britain, Bal (1987) found a higher proportion of psychosomatic presentation than psychological presentation among British Asians compared to a comparable Caucasian group of patients attending GP clinics. Although Bhatt, Tomenson, and Benjamin (1989), found no major differences in the reporting of somatic symptoms in a comparison between British Asians and indigenous patients in Manchester, a comparison of non-clinical populations in Britain and Pakistan, revealed differences in the frequency of particular symptoms between the groups (Mumford, 1989).

Later studies at general practices suggest that the cluster of BSI symptoms that identifies mood disorders in indigenous British patients is similar to that in Pakistanis (Mumford, Devereux, Maddy, & Johnstone 1991a). Indeed, some further research of primary care use in the West has indicated that somatization may be equally common in Britain and North America (Goldberg & Bridges, 1988; Schulberg & Byrns, 1988) as in the more
However, much evidence has been presented for cultural variation in the concepts of the illness and the experience of the distress which shape the expression and communication of the distress. Mumford (1993) has summarised these ideas and put forward a model in which culture shapes somatic symptoms at three levels. Firstly, language and idiom without which the distress cannot be expressed; secondly, concepts of health and disease without which the symptoms that are expressed cannot be interpreted and finally, culturally sanctioned illness behaviour without which the illness cannot be presented to obtain treatment.

Therefore, the somatic expression of distress can be understood, on the one hand, as an interaction between culturally sanctioned behaviour and the social context, as described by Kleinman and Kleinman (1986), in their account of somatization in China after the Cultural Revolution. As they explain it, somatization can be a culturally accepted reaction to powerful social burdens placed on the person’s resources, which help to express the suffering of the individual. This could very well apply to the Indian culture. On the other hand, it can also be understood as the interaction between culturally sanctioned behaviour and the cultural conventions that dictate social acceptance of behaviour within a culture. Therefore, it seems that presenting with somatic symptoms may have different functions. It may ensure validation of a sick role, or even more importantly, the denial of mental illness might mean the avoidance of stigmatisation (Johnson & Orrell, 1996). This might be the reason why even those British Asians who scored above the cut-off point for psychiatric morbidity were more likely to state that they were consulting their GP about a physical problem compared to attenders from the indigenous population (Mumford et al, 1991b; Wilson & MacCarthy, 1994).

Nevertheless, Mumford (1993) questions the supposedly high rate of somatic presentation of psychiatric disorders in non-western cultures as well as among the ethnic minority groups in the West. His suggestion, that the somatic presentation of distress merits deeper analysis, gives a valuable insight into somatization. He analyses the language of emotion and indicates three basic modes of express: somatic sensations, somatic metaphor and abstract psychological language. Thereby, he makes an important
differentiation between the actual somatic sensation and the reporting of somatic sensation by which use of somatic metaphors situates the distress in different parts of the body, determined by culture. Mumford compares the Urdu phrases of ‘dil main dard’, (which refers to the sensation of having pain in the heart), a somatic sensation, to ‘mera dil dukhta hai’ (which refers to an aching heart), a somatic metaphor. By separating the presentation of somatic symptoms from the experience of somatic symptoms, Mumford emphasises the significance of language and idiom, perhaps the most culture specific aspect of a culture, and its role in the expression and the communication of distress.

This point may have particular pertinence, not only to the issue of somatisation, but also to the GP/patient interaction. While few British-born doctors speak any Asian languages, the English language has not been seen to be a problem for most South British Asians (Rashid & Jagger, 1992). However, other researchers have identified language problems (Donaldson, 1986). This latter study found that only 2% of women and 37% of men reported an ability to speak English. Amongst those who spoke it, explaining a problem to a doctor was reported to be the most difficult of six suggested social problems. A related point is that Asians from the Indo-subcontinent who do not speak English generally have poorer levels of education, a factor that has been found to correlate with expressing distress in somatic terms (Mechanic, 1978).

The problem in communication may lie behind the fact that some sections of this ethnic minority community have particularly low levels of use of health services. Although women have been reported to have higher somatic symptoms both in the UK and in Pakistan compared to men (Mumford, 1989), British Asian women have been found to be particularly reluctant to consult GPs (Murray & Williams, 1986; Gillam, Jarman, White, and Law, 1989). More recently, Smaje (1995) also identified particularly low use of GP services by women of Pakistani origin. It is not surprising, in view of their inability to communicate (Donaldson, 1986), that Ahmad, Kernohan and Baker (1989) found that cultural and linguistic concordance between women patients and GP was more important than sex of GP.

Furthermore, it seems that Asians women’s understanding or ‘insight’ of the illness (Johnson and Orrell, 1995) – explanatory models, in Kleinman’s words - are at odds with
active help-seeking (Currer, 1986). On the other hand, Webb-Johnson (1981) pointed out that many requests for help were made from women when a telephone advice service was set up for ethnic minorities. Elsewhere, it has been reported that 39% of all the clients of the MIND branch in Newham were Asian (compared with an estimated Asian population in the borough of 13% (Gupta, 1991). This latter evidence may be testifying not only to an unmet need, but also to the fact that a negative attitude towards seeking help may be related as much, if not more, to structural barriers than to cultural attitudes.

This study set out to examine cultural and other factors that influence consulting a GP as help-seeking for mental distress (although this choice may not be a conscious one). It therefore examined the relationship between causal beliefs about one’s illness, levels of mental distress, expressed somatically and psychologically, and GP consultation.

6.2 Aims and Hypotheses

The study set out to investigate differences in factors that determine GP consultation between two cultural groups, a British Asian and a British sample. Differences were examined in distress levels as measured by the Bradford Somatic Inventory and the 28-item General Health Questionnaire. Differences were also examined between frequency of GP visits and attitudes to consulting the GP in times of mental distress. Patients were also asked to identify causal attributions of their particular illness by indicating their causal beliefs as identified by 42 causal items (Eisenbruch, 1990).

It was predicted, from the literature, that:

I. British Asians patients would have higher somatization levels, as measured by the Bradford Somatic Inventory than British patients.

II. There would be a main effect of sex on levels of somatization. There would be an interaction of culture and sex, with higher levels of somatic presentation of distress for British Asian women than Asian men or British women.

III. There would be a main effect of income and education on somatic presentation. It is hypothesised that people with lower incomes and lower levels of education would have higher levels of somatic presentation than those with higher incomes.
and higher levels of education. There would be a significant effect of age, with older people having more somatic symptoms than younger people. The effect of religion on somatic distress would also be investigated.

IV. There would be no significant differences in somatisation levels between the subgroups of the British Asian sample (Indians, Pakistanis, Bangladeshis and East Africans).

V. There would be a significant difference in levels of somatization between the first generation and the second generation in the British Asian sample. It is predicted that there would a higher level of somatic levels of distress in the first generation of migrants compared to the second generation. The effect of length of stay in the UK in this migrant group would also be investigated.

VI. Proficiency in English and would be associated with somatic distress. It is predicted that those in the British Asian sample not proficient in English would have high levels of somatic distress.

VII. There would be a difference, in the two cultural samples, in psychological distress levels. British Asians would have higher levels of psychological distress, as measured by the factors extracted for this sample of the 28-item GHQ.

VIII. There would be a main effect of religion, with Muslims having higher scores for the sub-scales of the GHQ as compared to other groups.

IX. There would be an effect of income, with those of lower income having higher scores for the GHQ sub-scales than those with higher income.

X. The effects of sex, age and education would also be investigated.

XI. There would be a significant difference in levels of psychological distress, as measured by the GHQ sub-scales between the first generation and the second generation in the British Asian sample. It is predicted that there would a higher level of somatic levels of distress in the first generation of migrants compared to the second generation.

XII. There would no significant differences between those proficient in English and those not proficient in English for the sub-scales of the GHQ.

XIII. There would be a higher association between the somatic expression of distress
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(measured by the BSI) and the expression of psychological distress (measured by the factors of the GHQ) for British Asians compared to the British sample.

XIV. There would be an association between the somatic symptoms, as measured by the BSI and the causal attributions made by individuals of their own illness. It was predicted that there would be a relationship between the BSItotal and supernatural and non-western physiological attributions for the British Asian sample and a relationship between the BSItotal and beliefs in stress and western physiological causes of illness for the British sample.

XV. There would be an association between levels of distress as measured by the BSI and the frequency of GP consultation. It is, therefore, hypothesised that British Asians would have a higher frequency of GP consultation compared to the British sample.

XVI. There would be a significant correlation between frequency of GP visits and attitudes towards consulting the GP for emotional or mental distress for both British Asian and British samples.

XVII. That stress and supernatural causal attributions would be significant predictors of somatic symptoms, which would be significant predictors of GP visits.

6.3 Method

6.3.1 Sample

The study sample consisted of patients who attended two general practice clinics – one in Woking and the other in Hounslow. The first practice has two Asian male partners. The second practice has three Asian partners, two female doctors and one male doctor. While the latter serves an area with a high concentration of British Asians, the former practice is in an neighbourhood with a mixture of British Asians and native Britons, although a couple of streets around the practice have lately become almost exclusively Asian. The Asian population in this community is mainly comprised of Muslims from Mirpur Khas, in Pakistan. Both areas are socially mixed (social classes 3 and 4), with
predominantly small terraced housing, which is largely owner-occupied.
Out of 150 patients approached, for the British Asian sample, there were 27 (18\%) refusals and 21 (14\%) incomplete questionnaires. Out of the 50 patients approached for the British sample, there were no refusals but there were 6 incomplete questionnaires. The entire sample comprised of 146 adults, between the ages of 18 and 75, who participated in this study. Of these, 102 were British Asians (69.9\%) (59 Indians, 36 Pakistanis, 3 East Africans, 4 Bangladeshis,) and 44 native Britons (30.1\%). 34.3 \% of the British Asians were born in the UK and Europe. The mean length of stay in the U. K., for the rest of the Asian sample, was 28.6 years. There were no significant differences between British Asians and Britons with regard to marital status, highest education obtained and income (Table 6.1).
## Table 6.1 Distribution of Subjects by sex, age, religion, marital status, education and income

<table>
<thead>
<tr>
<th></th>
<th>British Asians</th>
<th>% Total</th>
<th>British</th>
<th>%Total</th>
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<tr>
<td><strong>Sex</strong></td>
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</tr>
<tr>
<td>Men</td>
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</tr>
<tr>
<td>25,001 +</td>
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<td>13</td>
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6.3.2. Measures

6.3.2.1 The Bradford Somatic Inventory (BSI)

6.3.2.1.1 Construction of the Bradford Somatic Inventory (BSI)

The Bradford Somatic Inventory (appendix 6.1) was developed by Mumford (1989) to meet the need for a multicultural inventory of common somatic symptoms. It was developed in Urdu and English simultaneously and was compiled from symptoms reported by anxious or depressed individuals in Britain and the Indian sub-continent. A systematic search was made of hospital case notes of Pakistani patients in Peshawar and British patients in Yorkshire, diagnosed with anxiety, depression, hypochondriasis or conversion hysteria, which yielded the initial items. These were checked against case notes of similar patients in north and south India and Nepal; the BSI was revised and expanded to cover 90% of all the somatic symptoms recorded in psychiatric case notes at each of the five centres.

6.3.2.1.2 Validity and reliability of the BSI

In a validation study in Lahore (Mumford et al 1991b), 600 patients attending general medical clinics completed the BSI in Urdu while the physician’s diagnosis was recorded independently. Patients with mood disorders reported fourteen symptoms (out of the 44 BSI items), significantly more often compared to patients with an organic diagnosis. If only those symptoms were counted which were present on more than 15 days during the past month, the BSI symptoms increased to 21. A further 60 patients were recruited from the clinics and interviewed by a psychiatrist. Using a cut-off score of 13/14, the 21 item BSI identified patients with a DSM-III-R psychiatric diagnosis with sensitivity of 87% and specificity of 75%. Another study carried out at clinics in the UK found that selected BSI items correctly classified 80% of anxiety and depression groups (Mumford, 1994), as measured by the Hospital Anxiety and Depression Scale (HADS, Zigmond & Snaith,
1983). The BSI has been used in several cross-cultural studies, to measure differences in somatic symptoms (Mumford, 1989; Mumford et al, 1991a; Mumford et al, 1991c). This 44-item questionnaire asks participants to record changes in emotions during the past month. It has three choices for each item: absent, present on less than 15 days during the past month or present on more than 15 days during the past month. These score 0, 1 and 2 respectively.

6.3.2.2 The General Health Questionnaire

The General Health Questionnaire (GHQ) (appendix 6.3) is a relatively well established screening instrument that was developed by Goldberg in the 1960s and 1970s for the detection of psychiatric morbidity. The development of the GHQ was stimulated by a shift in psychiatric epidemiological research, from the secondary care level (hospitals) to the primary care level (the community). The GHQ (Goldberg, 1972) was designed as a self-administered screening instrument for the detection of minor psychiatric morbidity, especially anxiety and depressive neurosis. Although it was intended for use in general practice, it has been used in a variety of other settings as well, such as hospital, community and student samples. The GHQ has thus been used as an epidemiological tool and a screening instrument, as well as an index of psychiatric morbidity against which a number of other variables have been correlated.

The construction of the GHQ was based on symptoms observed by psychiatrists and clinical researchers. A large item pool was collated which, in conjunction with psychiatrists opinions, was used to generate four areas on which the subsequent search focused. These included items to do with depression and unhappiness, anxiety and felt psychological disturbance, objectively observable behaviour (social impairment and social inadequacy) and hypochondraisis i.e. superficially organic items. Using these four areas as a template, an extensive search was made for appropriate items from a range of
pre-existing instruments\textsuperscript{20}. The selected items were subjected to a calibration study, an item analysis and a principal component analysis. before the final 60-item version was drafted.

The original version of the GHQ consisted of sixty items, looking at psychological distress and change in established behaviour patterns; symptoms that are experienced ‘more than usual’ are considered a sign of pathology. The GHQ, therefore, focuses on breaks in normal functioning rather than lifelong traits. The GHQ-28 was developed by Goldberg and Hillier (1979) on the basis of a principal component analysis of the 60 item version. The GHQ-28 has become popular for research due to its ability to generate four distinct sub-scale measures of somatic, anxiety*, social dysfunction and depression symptoms. It thus has the capacity to identify distinct symptoms. In particular, it has been found by a number of studies to be a good measure of depressive neurosis (Rand, Badger, & Coggins, 1988; Shek, 1993; Clarke, Smith, & Hernan, 1993). Indeed, in several studies, it has been adopted as a measure of depression (McNabb, 1983; Clarke et al, 1991).

\textbf{6.3.2.2.1 Validity and reliability of the GHQ}

Over fifty validation studies have been conducted on the GHQ. Although not designed to be a cross-culturally sensitive instrument, it has been used in many different cultural settings, as well as (although to a lesser extent) in comparative studies investigating morbidity in cultural or minority groups. There is evidence that the GHQ translates well into other languages (Shek, 1993) and the GHQ has now been translated in approximately thirty-six languages in total. There is evidence from research carried out in many different cultural settings that the GHQ appears to be a potentially useful tool for detecting distress, at least at an undifferentiated level, across cultures (Lobo et al, 1986; Vazques-Barquero et al, 1986; Oduwole & Ogunyemi, 1989: Chan, 1993).

\textsuperscript{20} The Cornell Medical Index, the Minnesota Multiphasic Personality Inventory, Taylors Manifest Anxiety Scale and Eysenck’s Maudsley Personality Inventory, as well as Veroff et al’s (1962) study on the views of 342 non-hospitalised Americans about aspects of adjustment and ‘felt distress’.
Previous research using the GHQ in India has found it to be a valid screening instrument (Gautam, Nijhawan, & Kamal, 1987; Bandyopadhyay, Sinha, Sen, & Sen, 1988). In order to improve validation indices, however, these researchers recommended the use of higher cut-off scores for identifying cases in this setting. Although translation appeared to exert an effect on the GHQ at the item level in both Hindi and Chinese studies (Chan, 1985; Sriram, Chandrashekar, Isaac, & Shanmugham, 1989), these effects did not seem to have repercussions on validity levels. Mumford (1989) also administered the GHQ, along with the Bradford Somatic Inventory, to Pakistani medical students, to ascertain the relationship between somatic symptoms and psychological distress.

The GHQ has been used in British Asian migrants (Cochrane, Hashmi, & Stopes-Roe, 1977; Currer, 1986; Krause, Rosser, Khiani, & Lotay, 1990). Cochrane and colleagues, (1977) using a modified version of the GHQ on a British Asian sample concluded, on the basis of a criteria group method, that the GHQ was a valid measure of psychological distress. They found no significant differences in GHQ scores between British and Asian respondents. Krause et al (1990) compared the GHQ with a devised Punjabi Health Questionnaire (PHQ) in Bedford. They also found little significant difference in British and Punjabi responses. Jacob, Bhugra & Mann (1997) examined the validity of the 12-item version of the GHQ among ethnic Indians living in the UK. The results documented high sensitivity and specificity of the GHQ-12 among the ethnic Indians living in the UK.

6.3.2.3 Items of the MDEMQ

A list was compiled of all 42 items comprising the Mental Distress Explanatory Model Eisenbruch (1990) (appendix 6.5).

The participants were asked to tick those causes that they considered responsible for the reason that they were attending the GP clinic or for their illness.

6.3.2.4 Attitude towards the GP and Frequency of GP consultation

A measure (appendix 6.5) on which participants were asked to indicate:
Chapter 6: Study 3: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation

- the frequency of visits to the GP that year (Once=1, Two=2, Three or more times=3)
- whether they considered it appropriate to talk to the GP when they were anxious or sad (Definitely no=1, Probably no=2, Probably yes=3, Definitely Yes=4).
- how frequently they had talked to the GP when they were anxious or sad in the last year (Never=1, Rarely=2, Sometimes=3, Often=4).

6.3.2.5 The Urdu versions of the BSI, the GHQ and translations of the measure relating to GP visits.

The Urdu version of the GHQ and BSI were already available, (appendices 6.2 and appendix 6.4). The full version of the MDEMQ had already been translated for earlier studies (see Chapter 4, Section 4.3.1.4.). (appendix 4.2).

The measure relating to GP visits was translated into Urdu by a proficient English and Urdu speaker. The translated Urdu versions were then subjected to an independent back translation into English. No problems were encountered in the translation as the three questions asked were simple and related to frequency of GP visits and attitudes towards their GP (appendix 6.6). All these translated items were organised into measurement instruments for this study.

6.3.2.6 Procedure

The study population consisted of patients attending the practices during a period of six months, during which the researcher was allowed by the GPs to access them on predetermined days. As a consequence, the researcher spent several hours a week at the surgeries once a fortnight, on different days of the week, during a period of nine months. Patients attending the two clinics over this period were asked if they would like to take part in a research project. After explaining the aim of the research, each patient who consented to participate was asked to complete two sheets. The first contained three questions relating to their frequency of GP consultation and related attitudes and the other contained a listing the 42 items relating to causal beliefs of illness. They were then asked to self-administer the 44-item version of the Bradford Somatic Inventory and the 28-item
version of the GHQ. These two questionnaires were alternated in priority.  
22.2 % of the British Asian sample reported themselves as not being proficient in English. Although some of the participants could read the questionnaires, others could not read Urdu very well. All participants who were not proficient in English were administered the questionnaires in Urdu.

6.4 Results

As in earlier studies, results of somatic and psychological distress measures of the two groups are presented first, followed by results showing associations between causal attributions of patient’s illness and distress levels. Following these analyses, results present the relationship between distress levels, causal attributions and GP consultation. Total N was 146. For multivariate analysis, N was reduced to 145 with the deletion of 1 cases because of missing data. Outliers in the data were adjusted. Results of assumptions of normality and homogeneity of variance-covariances matrices were satisfactory.

6.4.1 Somatic levels of distress as measured by the Bradford Somatic Inventory

6.4.1.1 Alpha reliabilities for the total score of the Bradford Somatic Inventory (BSItotal) for the the British Asian and the British sample

The BSI total score (BSItotal) was found to have high levels of internal consistency for both the British Asian and the British samples. Internal consistency of the BSItotal for British Asians was .97 and .88 for the British sample.
6.4.1.2 Differences in the BSI total for culture, sex, age, religion, education and income

Analysis of variance was performed on the total score of the BSI items, to investigate differences between the two sub-samples i.e. British Asians and Britons across:

i) culture

ii) religion

iii) sex

iv) age

v) income

vi) education

Where appropriate, the significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made.

6.4.1.2.1 Effect of culture on the total score of the Bradford Somatic Inventory

As hypothesised (hypothesis I), there was a significant main effect of culture $F(1,144)=8.30, p<01$, with higher scores of the BSI for British Asians than for Britons. Against prediction (hypothesis II), there was no main effect for sex $F(1,144)=.53$ and no interactions. As predicted (hypothesis III), there was a significant effect of income $F(5,144)=8.56, p<.001$, with higher scores for those with lower income compared to those with higher income. Culture remained significant when income was co-varied $F(1,144)=6.138, p<025$ (Table 6.2. for F values and means).

As predicted (hypothesis III), there was an effect of age $F(8,144)=3.11p<01$ and education $F(3,144)=10.67, p<.001$. Culture had a greater significance level when age was co-varied $F(1,144)=16.66, p<001$. Culture remained significant, but not at the .01 level of significance, when education was co-varied $F(1,144)=4.18, p<05$. There was an interaction of age by culture $F(1,144)=2.64p<.05$. (Table 6.2. for F values and means).

As predicted (hypothesis III), there was an effect of religion $F(3,144)=5.04, p<.001$. Culture remained significant when religion was co-varied $F(1,144)=5.95, p<01$. 

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Table 6.2 Analysis of variance of main effects and interaction on the score of the BSI total

<table>
<thead>
<tr>
<th>F values</th>
<th>Mean and sds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culture</strong></td>
<td>British Asian</td>
</tr>
<tr>
<td>$F(1,144)=8.30^{**}$</td>
<td>27.92 (22.91)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>Under 35 years</td>
</tr>
<tr>
<td>$F(8,144)=3.11^{**}$</td>
<td>17.21 (14.12)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Male</td>
</tr>
<tr>
<td>$F(1,144)=53$</td>
<td>22.62 (21.14)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td>Muslim</td>
</tr>
<tr>
<td>$F(3,144)=5.04^{***}$</td>
<td>24.35 a (26.02)</td>
</tr>
<tr>
<td></td>
<td>Sikh</td>
</tr>
<tr>
<td></td>
<td>Christians</td>
</tr>
<tr>
<td></td>
<td>No religion</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td>Low Income</td>
</tr>
<tr>
<td>$F(5,144)=8.56^{***}$</td>
<td>33.27 (22.21)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>No/Primary education</td>
</tr>
<tr>
<td>$F(3,144)=10.67^{***}$</td>
<td>36.58 (16.98)</td>
</tr>
<tr>
<td><strong>Age by culture</strong></td>
<td>under 35 years</td>
</tr>
<tr>
<td>$F(1,144)=2.64^{*}$</td>
<td>British Asians : 17.47 (15.11)</td>
</tr>
<tr>
<td></td>
<td>Britons</td>
</tr>
</tbody>
</table>

Sig. level ***p<0.001 ** p<0.01 *p<0.05 Post hoc Scheffe test (mean difference significant at <.01 level)

6.4.1.3 Differences between sub-groups in the British Asian sample

An analysis of variance was performed on the BSI total for sub-groups in the British Asian sample (Indians, Pakistanis, Bangladeshis and East Africans).

6.4.1.3.1 Effect of culture on sub-groups of the British Asian sample

Against prediction (hypothesis IV), analysis of variance showed significant differences for the BSI total between Indians, Pakistanis, Bangladeshis and East Africans $F(3,98)=4.87p<.01$. (Indian mean: 21.11; Pakistani mean: 36.06; Bangladeshi mean: 33.75; East African mean: 25.23).

6.4.1.4 Effect of place of birth, length of stay and proficiency in English on the BSI total score in the British Asian sample.

Analysis of variance was performed on the total score of the BSI items, to investigate
effect of place of birth, length of stay and proficiency in English in the British Asian sample only.

As predicted (hypothesis V), there was a significant effect for place of birth \( F(1,98)=3.62, p<01 \). First generation British Asian had higher scores (mean: 34.40 sd 18.01) than second generation British Asians (mean: 15.60 sd 11.20). There was an effect of length of stay in the UK \( F(1,98)=2.85, p<.05 \). Those who had lived in the UK more than 15 years had higher scores (mean: 30.64 sd 22.49) than those who had lived in the UK less than 15 years (mean: 17.21 sd 14.12).

As predicted (hypothesis VI), there was an effect of proficiency in English \( F(1,98)=18.58, p<.001 \). Those who were not proficient in English were administered the questionnaires in Urdu and had higher scores (mean: 42.46 sd 22.90) than those who were proficient in English and had self-administered the questionnaires (mean: 17.61 sd 13.20).
6.4.1.5 The relationship between socio-demographic variables and the BSITotal

6.4.1.5.1 Inter-correlations between the BSITotal and demographic variables

In order to examine the relationship between socio-demographic variables and somatic presentation of distress, inter-correlations were carried out between the BSITotal and all socio-demographic variables. There were significant inter-correlations between BSITotal and culture (Spearman’s rho = -.23 p<.01), age (rho = .34 p<.001), religiosity (rho = .28 p<.001) and marital status (rho = .30 p<.001). There were significant negative correlations between BSITotal and education (rho = -.37 p<.001) and income (rho = -.47 p<.001). Sex and first language did not correlate significantly with the BSITotal.

6.4.1.6 Predictors of the BSITotal

A linear regression model was constructed using the BSITotal score as the dependent variable and five demographic variables (income, age, marital status, religiosity and culture) that correlated significantly with the BSITotal score as the predictor variables. Two of these variables, culture and marital status, were dummy variables. Three variables, culture, income and age were found in the final regression equation indicating that they contributed significantly to the Bradford Somatic Total (BSITotal) (Table 6.3).

<table>
<thead>
<tr>
<th>Causal beliefs</th>
<th>B</th>
<th>SE</th>
<th>B</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-3.602</td>
<td>.866</td>
<td>-.331</td>
<td>-4.162***</td>
</tr>
<tr>
<td>Age</td>
<td>1.876</td>
<td>.574</td>
<td>.260</td>
<td>3.267***</td>
</tr>
<tr>
<td>Culture*</td>
<td>-11.025</td>
<td>3.292</td>
<td>-.251</td>
<td>-3.349***</td>
</tr>
<tr>
<td>Constant</td>
<td>38.062</td>
<td>6.108</td>
<td></td>
<td>6.15***</td>
</tr>
</tbody>
</table>

F = 20.35***
Multiple R = .36
R² = .31
Adjusted R² = .29

Table 6.3 Multiple linear regression analysis of socio-demographic variables using the scores on the BSITotal as the dependent variable

Sig. level ***p<.001 **p<.01 *p<.05 *(British Asians=0, Britons=1)
6.4.2 The dimensions of psychological distress as measured by the General Health Questionnaire

The GHQ was chosen to measure the dimensions of mental distress present in a general practice sample. The GHQ was factor analysed to confirm the factor structure of the GHQ-28 (sub-scales of somatic symptoms, anxiety and insomnia, social dysfunction and severe depression).

The factors extracted for this sample were different from the GHQ-28 sub-scales (Appendix 6.7). Subsequent analysis was carried out on the original GHQ-28 sub-scales in order to ascertain differences between the two cultural groups and to investigate the association between the scores of the Bradford Somatic Inventory and the sub-scales of the GHQ-28 in this sample.

6.4.2.1 Internal consistency of sub-scales extracted from the GHQ for British Asian and the British samples.

Alpha coefficients of internal reliability were calculated for the two cultural groups, thereby testing the internal consistency of the four GHQ sub-scales (Table 6.4).

Reliabilities of all four sub-scales were high for the British Asian sample. Reliabilities were high for the British sample for all sub-scales other than that of Anxiety and Insomnia, which had moderate levels of reliability for this sub-sample.

Table 6.4 Alpha reliabilities of GHQ sub-scales for British Asian and British samples

<table>
<thead>
<tr>
<th></th>
<th>Somatic symptoms</th>
<th>Anxiety &amp; Insomnia</th>
<th>Social Dysfunction</th>
<th>Severe Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Asians</td>
<td>.89</td>
<td>.87</td>
<td>.91</td>
<td>.93</td>
</tr>
<tr>
<td>Britons</td>
<td>.75</td>
<td>.59</td>
<td>.85</td>
<td>.91</td>
</tr>
</tbody>
</table>
6.4.2.2 Difference in sub-scales of the GHQ across the two cultural groups

In order to test for the effect of culture on differences in scores of the scales of the GHQ, a multivariate analysis of variance was performed on the four sub-scales of the GHQ: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. Analysis was done for:

i) culture
ii) religion
iii) sex
iv) age
v) income
vi) education

To investigate further main effects, a series of univariate F tests were also performed on the separate category scores. Where appropriate the significance levels of the F tests was adjusted to 0.01 using post hoc Scheffe test, so that the observed significance level is adjusted for the fact that multiple comparisons are being made.

Prior to conducting statistical tests, normality of variance and homogeneity of variance test assumptions were verified. The results of the multivariate analysis of variance and Univariate F tests are presented in table 6.5.
**Chapter 6** *Factors in the choice of one pathway of help-seeking for mental distress: GP consultation*

**Table 6.5 Multivariate and Univariate Analysis of Variance of GHQ sub-scales by culture, religion and income* *(n=132)*

<table>
<thead>
<tr>
<th>Effect</th>
<th>Pillais</th>
<th>Somatic Symptoms</th>
<th>Anxiety and Insomnia</th>
<th>Social dysfunction</th>
<th>Severe Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Culture</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$F(1,131)=3.29^*$</td>
<td>$F(1,131)=11.25***$</td>
<td>$F(1,131)=5.19^*$</td>
<td>$F(1,131)=6.01^*$</td>
<td>$F(1,131)=11.19***$</td>
</tr>
<tr>
<td>Mean and sd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>British Asian</td>
<td>15.17 (5.46)</td>
<td>15.15 (4.68)</td>
<td>15.41 (5.36)</td>
<td>12.54 (6.00)</td>
<td></td>
</tr>
<tr>
<td>Western</td>
<td>12.23 (2.99)</td>
<td>13.45 (2.35)</td>
<td>13.18 (4.05)</td>
<td>9.29 (3.47)</td>
<td></td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$F(4,131)=2.14^*$</td>
<td>$F(4,131)=7.30***$</td>
<td>$F(4,131)=3.21^*$</td>
<td>$F(4,131)=2.83^*$</td>
<td>$F(4,131)=4.19**$</td>
</tr>
<tr>
<td>Mean and sd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslims</td>
<td>17.16 (5.89)</td>
<td>16.36 (5.58)</td>
<td>16.57 (5.57)</td>
<td>14.03 (6.49)</td>
<td></td>
</tr>
<tr>
<td>Hindus</td>
<td>11.94 (2.99)</td>
<td>13.75 (2.88)</td>
<td>13.21 (3.29)</td>
<td>10.05 (4.41)</td>
<td></td>
</tr>
<tr>
<td>Sikhs</td>
<td>14.40 (4.75)</td>
<td>14.52 (4.49)</td>
<td>15.25 (5.62)</td>
<td>12.03 (5.36)</td>
<td></td>
</tr>
<tr>
<td>Christians</td>
<td>12.54 (3.60)</td>
<td>13.34 (2.19)</td>
<td>13.02 (3.97)</td>
<td>9.48 (4.01)</td>
<td></td>
</tr>
<tr>
<td>No religion</td>
<td>12.00 (3.34)</td>
<td>14.18 (2.68)</td>
<td>14.36 (5.29)</td>
<td>10.09 (5.30)</td>
<td></td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$F(1,131)=1.87$</td>
<td>$F(1,131)=5.61***$</td>
<td>$F(1,131)=4.79***$</td>
<td>$F(1,131)=4.22***$</td>
<td>$F(1,131)=5.89***$</td>
</tr>
<tr>
<td>Low income</td>
<td>16.07 (5.31)</td>
<td>15.92 (4.75)</td>
<td>16.32 (5.72)</td>
<td>13.51 (6.18)</td>
<td></td>
</tr>
<tr>
<td>High Income</td>
<td>12.19 (3.63)</td>
<td>12.91 (2.55)</td>
<td>12.76 (3.33)</td>
<td>9.14 (3.28)</td>
<td></td>
</tr>
</tbody>
</table>

**Sig level*** $p<.001$ ** $p<.01$ * $p<.05$  Post Hoc Scheffe test mean difference adjusted to .01

6.4.2.2.1 Effect of culture on the sub-scales of the GHQ across the two groups

As hypothesised (hypothesis VII), there was a main effect of culture of the GHQ scales. The main effect of culture was due to a significant difference in means in British Asian and British respondents’ scores for the combined scales of the GHQ, $F(1,131)=3.29$, $p<.05$. There was also a significant difference in scores for all four GHQ scales: somatic symptoms $F(1,131)=11.25$ $p<.001$, anxiety and insomnia $F(1,131)=5.19$, $p<.05$, social dysfunction $F(1,131)=6.01$, $p<.01$ and severe depression $F(1,131)=11.19$, $p<.001$. Means indicated that the British Asian group had higher scores on all four sub-scales compared to the British group (Table 6.5 for means).

As hypothesised (hypothesis VIII), there was a main effect of religion for combined variables $F(2,131)=2.14p<.01$ and for somatic symptoms $F(2,131)=7.30p<.001$. Post hoc Scheffe test indicated that Muslims and Sikhs had higher scores for somatic symptoms than Hindus, Christians or those of no religious affiliation.

As hypothesised (hypothesis IX), there was a main effect of income at the .001 level of
significance for all four sub-scales, somatic symptoms $F(1,131)=5.61p<.001$, anxiety and insomnia $F(1,131)=4.79p<.001$, social dysfunction $F(1,131)=4.22p<.001$ and severe depression $F(1,131)=5.89p<.001$. Means indicated that those with lower income (less than £15,000 annually) had higher scores on all four sub-scales than those with higher income (Table 6.5 for means).

Against hypothesis (hypothesis X), there was no main effect for sex, at the .01 level of significance, for the combined variables $F(1,131)=2.87p<.05$ or for any sub-scale, for age $F(4,131)=.88$ or for education $F(3,131)=1.39$.

**6.4.2.2.1 Effect of place of birth and proficiency in English on GHQ scales in the British Asian sample**

As predicted (hypothesis XI), there was an effect of place of birth for the combined variables $F(8,98)=6.29$, <.001 as well as for somatic symptoms $F(1,98)=16.94$, <.001, anxiety and insomnia $F(1,98)=19.92$, <.001, social dysfunction $F(1,98)=12.05$, <.001 and severe depression $F(1,98)=19.09$, <.001. Means indicated higher scores on all four GHQ sub-scales for the first generation of British Asians compared to the second generation (Table 6.6).

Against prediction (hypothesis XII), there was an effect of proficiency in English for the combined variables $F(1,98)=4.25$, <.001 as well as for somatic symptoms $F(1,98)=22.05$, <.0001, anxiety and insomnia $F(1,98)=15.86$, <.0001, social dysfunction $F(1,98)=11.56$, <.001 and severe depression $F(1,98)=12.80$, <.001. Means indicated higher scores on all four GHQ sub-scales for those who were not proficient in English (and were administered the questionnaires) compared to those who were proficient in English and self-administered the questionnaires (Table 6.6). No significant effect was found for length of stay for the combined variables $F(7,98)=1.33$ or for the separate sub-scales.
Table 6.6 Multivariate and Univariate Analysis of Variance of GHQ sub-scales by place of birth and proficiency in English for the British Asian group (n=98)

<table>
<thead>
<tr>
<th>Pillai's F(1,98)=6.29***</th>
<th>Somatic symptoms</th>
<th>Anxiety &amp; Insomnia</th>
<th>Social Dysfunction</th>
<th>Severe Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First generation</td>
<td>16.07 (5.67)</td>
<td>16.60 (4.93)</td>
<td>16.62 (5.72)</td>
<td>14.00 (6.33)</td>
</tr>
<tr>
<td>Second generation</td>
<td>11.67 (3.04)</td>
<td>12.03 (1.93)</td>
<td>12.53 (3.13)</td>
<td>8.89 (3.30)</td>
</tr>
<tr>
<td>Proficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F(1,98)=4.25***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proficient</td>
<td>13.75 (4.56)</td>
<td>14.00 (4.01)</td>
<td>14.29 (4.76)</td>
<td>11.58 (5.51)</td>
</tr>
<tr>
<td>Not Proficient</td>
<td>21.15 (4.94)</td>
<td>19.60 (4.49)</td>
<td>20.22 (5.21)</td>
<td>16.78 (6.36)</td>
</tr>
</tbody>
</table>

Sig. level ***p<.001

6.4.2.3 Inter-Correlation between GHQ sub-scales and BSImtotal

Inter-correlations of the four GHQ scales and the BSImtotal scores were carried out separately for the two samples. Firstly, this was done in order to verify that the presentation of somatic distress did not exclude the experience of psychological distress. Secondly, this was done to see differences, between the two samples, in the inter-correlations between the BSImtotal and different aspects of psychological distress as measured by the four sub-scales of the GHQ (Table 6.7).
Chapter 6: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation

Table 6.7 Inter-correlations between the BSItotal and the four scales of the GHQ.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Somatic symptoms</th>
<th>Anxiety and Insomnia</th>
<th>Social dysfunction</th>
<th>Severe Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>.85***</td>
<td>.45**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social dysfunction</td>
<td>.82***</td>
<td>.41**</td>
<td>.83***</td>
<td>.56**</td>
</tr>
<tr>
<td>Depression</td>
<td>.82***</td>
<td>.35*</td>
<td>.75***</td>
<td>.49**</td>
</tr>
<tr>
<td>BSItotal</td>
<td>.84***</td>
<td>.49**</td>
<td>.74***</td>
<td>.46**</td>
</tr>
</tbody>
</table>

(1) British Asian (2) Britons Sig. level ***p<.001 ** p<.01 *p<.05

As can be seen in Table 6.7, there were high inter-correlations, as predicted (hypothesis XIII) between the BSItotal and the GHQ scales of somatic symptoms and anxiety and moderate correlations between the BSItotal and social dysfunction and severe depression for the British Asian sample.

For the British sample, there were low inter-correlations between the BSItotal and somatic symptoms, anxiety and social dysfunction. There was no inter-correlation between the BSItotal and severe depression.
6.4.3 Causal attributions made about one's own illness

6.4.3.1 Item analysis of causal beliefs

Item analysis, i.e. endorsement of a causal belief, was conducted of all the items of attributional beliefs for the whole sample, indicating the items that were considered as the causes of the illness or problems that had brought the person to consult the GP. The endorsement percentages are presented in Table 6.8.

Table 6.8. Endorsement percentages of causal belief items by the British Asians and Britons

<table>
<thead>
<tr>
<th>Causal beliefs</th>
<th>British Asians</th>
<th>Britons</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Western Physiological causes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad nerves in the body</td>
<td>20.6%</td>
<td>20.5%</td>
</tr>
<tr>
<td>The effects of old age</td>
<td>25.5%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Infection</td>
<td>46.1%</td>
<td>29.5%</td>
</tr>
<tr>
<td>Genetic or inherited defect</td>
<td>7.8%</td>
<td>0</td>
</tr>
<tr>
<td>Being born this way</td>
<td>3.9%</td>
<td>0</td>
</tr>
<tr>
<td>Physical illness</td>
<td>23.5%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Chemical imbalance in the brain</td>
<td>2.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Brain damage or head injury</td>
<td>1.0%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stress causes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad experiences during childhood</td>
<td>8.8%</td>
<td>0</td>
</tr>
<tr>
<td>Intentionally physically harmed by another person</td>
<td>2.9%</td>
<td>0</td>
</tr>
<tr>
<td>Exposure to a fright or shock</td>
<td>9.8%</td>
<td>0</td>
</tr>
<tr>
<td>Pace of modern life</td>
<td>9.8%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Having had an accident</td>
<td>10.8%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Death of a relation or close friend</td>
<td>9.8%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Migration to a new country</td>
<td>7.8%</td>
<td>0</td>
</tr>
<tr>
<td>Not having enough money</td>
<td>6.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Too much work or study</td>
<td>3.9%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Conflict or break-up of family relationships</td>
<td>11.8%</td>
<td>0</td>
</tr>
<tr>
<td>Unemployment</td>
<td>8.8%</td>
<td>0</td>
</tr>
</tbody>
</table>
### Study 3: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation

#### Non-western physiological causes

<table>
<thead>
<tr>
<th>Cause</th>
<th>British Asians</th>
<th>British Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being hot but not from climate or temperature</td>
<td>10.8%</td>
<td>0</td>
</tr>
<tr>
<td>Wind or gas or currents flowing through the body</td>
<td>10.8%</td>
<td>0</td>
</tr>
<tr>
<td>Eating food which is wrong for that person</td>
<td>7.8%</td>
<td>0</td>
</tr>
<tr>
<td>The person's body being out of balance</td>
<td>13.7%</td>
<td>13.6%</td>
</tr>
<tr>
<td>One or more of person's vital organs being disrupted</td>
<td>3.9%</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Supernatural causes

<table>
<thead>
<tr>
<th>Cause</th>
<th>British Asians</th>
<th>British Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with something or someone taboo</td>
<td>0.9%</td>
<td>0</td>
</tr>
<tr>
<td>The person had bad or ominous dream or sensation</td>
<td>2.9%</td>
<td>0</td>
</tr>
<tr>
<td>Bad luck or chance</td>
<td>13.5%</td>
<td>0</td>
</tr>
<tr>
<td>Doing the wrong thing during pregnancy</td>
<td>2.0%</td>
<td>0</td>
</tr>
<tr>
<td>Failure to properly observe rituals after giving birth</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Birth control against religion and culture</td>
<td>4.9%</td>
<td>0</td>
</tr>
<tr>
<td>Doing the wrong thing when menstruating</td>
<td>2.0%</td>
<td>0</td>
</tr>
<tr>
<td>Astrological destiny</td>
<td>2.0%</td>
<td>2.3%</td>
</tr>
<tr>
<td>The person's karma</td>
<td>2.9%</td>
<td>0</td>
</tr>
<tr>
<td>A dangerous unprovoked spirit</td>
<td>2.0%</td>
<td>0</td>
</tr>
<tr>
<td>Spirit angry because someone did something wrong</td>
<td>4.9%</td>
<td>0</td>
</tr>
<tr>
<td>Person's soul leaving the body and becoming scattered</td>
<td>3.3%</td>
<td>0</td>
</tr>
<tr>
<td>Contact with something / someone dangerous / unclean</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Doing something forbidden by social or cultural rules</td>
<td>4.9%</td>
<td>0</td>
</tr>
<tr>
<td>Someone unwittingly casting a spell</td>
<td>2.0%</td>
<td>0</td>
</tr>
<tr>
<td>Someone wanting to hurt person by casting spell</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>Someone engaging a witch/shaman to cast spell</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>The person seeing/hearing/feeling something ominous</td>
<td>4.9%</td>
<td>0</td>
</tr>
</tbody>
</table>

In comparing the responses of the two samples, British Asians’ attributions of the causes of their problems that have brought them to consult the GP were wider ranging compared to the British sample, which are mainly limited to either stress or western physiological causes’ (Eisenbruch, 1990). Although these endorsement percentages were low, almost all beliefs in supernatural agencies (e.g. Bad luck or chance) and non-western physiological causes (e.g. Wind or gas or currents flowing through the body) were endorsed by British Asians but not by the British sample. The notable exceptions were
two items - Body being out of balance and Astrological destiny - which were also endorsed by the British sample.

6.4.3.2 Inter-Correlation between the four categories of causal beliefs and BSI total

Inter-correlations of the total scores of each of the four categories of causal beliefs (western physiology, non-western physiology, stress and supernatural causes) about the patient’s own illness and the BSI total scores were carried out separately for the two samples. This was done in order to see whether, as predicted, there would be an association between supernatural causes and somatic symptoms, as measured by the BSI, for the British Asian sample, and whether stress and western physiological causes were associated with somatic symptoms for the British sample.

Table 6.9 Inter-correlations between the BSI total and the four categories of beliefs for the two cultural groups

<table>
<thead>
<tr>
<th>Categories of causes</th>
<th>British Asians</th>
<th>Britons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>.63***</td>
<td>.35*</td>
</tr>
<tr>
<td>Western Physiology</td>
<td>.39**</td>
<td>.21</td>
</tr>
<tr>
<td>Supernatural</td>
<td>.69***</td>
<td>.09</td>
</tr>
<tr>
<td>Non-western physiology</td>
<td>.64***</td>
<td>.02</td>
</tr>
</tbody>
</table>

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

As predicted (hypothesis XIV), there were high inter-correlations between the BSI total and supernatural causes and non-western physiological causes for the British Asian sample. However, inter-correlations between the BSI total and stress attributions, were similar. A lower inter-correlation was found causes related to western physiology and the BSI total. As predicted for the British sample, there was a moderate correlation between the causal attributions of stress and the BSI total. Against prediction, there was no association between western physiological causal attributions and the BSI total for this sample (Table 6.9).
6.4.4 Factors in GP consultations

6.4.4.1 Differences in the two cultural groups in frequency of GP consultations

An equivalent number of British Asians (9 - 8.8%) and Britons (9 - 20.5%) had consulted the GP once in the last year. Marginally more British Asians (33 - 34.4%) than Britons (15 - 34.1%) had consulted the GP twice/three times during the last year. More British Asians (56 - 54.9%) than Britons (19 - 43.2%) had consulted the GP more than three times or more during the last year.

6.4.4.2 Determinants of frequency of GP consultation

In order to determine which factors were associated with frequency of GP visits, inter-correlations were carried out between frequency of GP visits and socio-demographic variables, causal beliefs of their own illness, attitudes to the GP and the BSItotal.

6.4.4.3 Inter-Correlations between frequency of GP visits and culture, age, sex, religion, education and income

Inter-correlations carried out between frequency of GP visits and culture, age, sex, religion, education and income showed significant correlations, at the .01 level of significance, between GP visits and education (Spearman’s rho = -.27, p < .01) and GP visits and income (rho = -.31, p < .001).

6.4.4.4 Inter-Correlations between frequency of GP visits and causal attributions of patient’s distress

Inter-correlations carried out between the four categories of causal beliefs of illness and the frequency of GP visits, in the two groups separately, found that beliefs in stress causes only were significantly correlated to GP visits at the .05 level of significance.
(\(\text{rho}=.33 p<.05\)) for the British sample only. There were no significant correlations for the British Asian sample.

### 6.4.4.5 Inter-Correlations between frequency of GP visits, BSI total and attitudes towards being open about distress.

Inter-correlations were carried out between frequency of GP visits, BSI total scores, whether it was considered appropriate to tell the GP when you were anxious or sad and how frequently the patient had talked to the GP when they were anxious or sad. This was done in order to see differences in the association between GP visits, distress levels and attitudes about being open with the GP about their emotional distress (Table 6.10).

<table>
<thead>
<tr>
<th>Number of GP visits in the year</th>
<th>Think it is appropriate to tell GP about problems</th>
<th>Number of times talked to GP about problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Asians</td>
<td>British Asians</td>
<td>Britons</td>
</tr>
<tr>
<td>Think it is appropriate to tell GP about problem</td>
<td>.22*</td>
<td>.04</td>
</tr>
<tr>
<td>Number of times talked to GP about problems</td>
<td>.22*</td>
<td>.23</td>
</tr>
<tr>
<td>BSI total</td>
<td>.38***</td>
<td>.18</td>
</tr>
</tbody>
</table>

As predicted (hypothesis XV and XVI), inter-correlations found between frequency of GP visits, BSI total, thinking it appropriate to tell the GP when they were anxious or sad and the number of times patient talked to the GP were significant at the .01 level of significance for the British Asian sample, ranging from .22 to .39. The highest inter-correlation for this sub-sample was between BSI total and the number of times patient had talked to the GP when they were anxious or sad (\(\text{rho}=.39\)).

There was a significant correlation between thinking it appropriate to tell the GP and number of times had talked to the GP when anxious or sad (\(\text{rho}=.29\)) only for Britons.
6.4.5 Integration of the observed relations

The results of both the first and second study had found causal attributions of mental distress to be the most significant predictors of attitudes towards seeking help (over and above culture and other socio-demographic variables, in some cases). It was decided, therefore, to investigate the direct and indirect relationships, in this study, between causal attributions of one’s own illness, mental distress expressed both psychologically and somatically, and frequency of GP visits.

As in the previous study, it was necessary to conceptualise an overall model suggesting causal paths between the different variables, to obtain a clearer picture of the interrelations among these variables. In this study, it was done in order to investigate the interrelations between the proposed predictive variables and the frequency of GP visits.

The variables were the four categories of the causal beliefs of mental distress, levels of psychological distress, i.e. the sub-scales of the GHQ found for this sample, and somatic distress, as measured by the BSI.

In this investigation, the assumption was that the causal attributions made about one’s own illness would predict presentation of distress (as opposed to the previous study, in which mental health had been hypothesised to influence the causal attributions that people made of mental distress). This point has pertinence to the psychologisation vs. somatisation issue. Therefore, it was predicted that:

- Attributions made to stress causes about their own illness would predict psychological distress as measured by the GHQ-28 sub-scales;
- Attributions made to supernatural causes would predict somatic distress, as measured by the BSI_{total};
- Attributions made to physiological causes, whether western or non-western, would predict somatic distress, as measured by the sub-scale of somatic symptoms of the GHQ-28 as well as the BSI_{total};
- Somatic distress would predict frequency of GP visits.

The principal form of analysis was path analysis. Path analysis, which is a form of causal modeling, was computed using multiple regression analysis. As in the previous study, the
method of regression used was hierarchical, and was chosen because it deals with the problem of multi-collinearity (Cohen and Cohen, 1983). This procedure is described in detail in Chapter 5, Section 5.7.

Again, as in the last causal path analysis, the variables that were entered into the path analytic models were chosen on the grounds of both theoretical importance as well as the findings of the current study. Variables were entered into the hierarchical regression in a pre-determined order. This order was based on a logical causal sequence whereby those variables thought to cause subsequent variables were entered first (Cohen and Cohen, 1983).

Hence, the four categories of causal beliefs of mental distress were entered in Step 1, because these were assumed to be cultural beliefs that would determine causal attributions of one's own distress. The four scales of the 28-item GHQ were entered in Step 2, since these were measures of the psychological aspect of mental distress. The BSI total was entered in Step 3. Although the somatic expression of distress would occur at the same time as the psychological aspects of distress (as measured by the GHQ), it is entered later on in the model. This is done because of the high inter-correlation between the BSI total and the GHQ scores and the problem of multi-collinearity, which has been detailed earlier. The dependent variable was frequency of GP consultation.

Entering variables in this hierarchical format means that those on the left side of the diagrams are given priority in the analysis. Hence, entering causal attributions first means that those variables entered later have to account for significant variance over and above that already accounted for by these variables. This order of entry means that for the four GHQ sub-scales to be significant predictors of either somatic presentation of distress, or frequency of GP visits, they must account for variance that has not been accounted for by all the variables preceding them in the path model. Therefore, entering the variables hierarchically ensures that this method attributes the variables entered in earlier stages both unique variance and also any overlapping variance that exists between them and variables entered later, since they are given priority in the analysis.

Causal path models are shown in stages for ease of explication. The first stage of this analysis shows a 'partial' causal path model (Figure 6.1), illustrating a causal path with
the four causal belief categories of mental distress regressing onto the four sub-scales of the GHQ. The second stage shows a 'partial' causal path model (Figure 6.2) illustrating a causal path with the four causal belief categories of mental distress and the four sub-scales of the GHQ regressing onto the BSItotal. The full causal path model (Figure 6.3) illustrates a causal path with the four causal belief categories of mental distress, the four sub-scales of the GHQ and the BSItotal as predictor variables and frequency of GP visits as the dependent variable.

The β coefficients are shown in the path models rather than the bs. As explained in the earlier study, the βs reflect the strength of the relationship between two variables but one which has been standardized, in comparison to the b coefficient which uses the original units of the scales employed. Again, in this study, it could be argued that the original units are, to some extent, arbitrary because they reflect questionnaire scales. Therefore, only βs will be printed on the models for the sake of clarity. Solid lines in the model show the direct path to frequency of GP visits. Dotted lines show all other earlier paths in the model (see Figures 6.1 and 6.2 for beta values of earlier paths).
Figure 6.1 Predictors of the four GHQ-28 subscales

- **Severe Depression**
  - Attributions to non-western physiology: $\beta = 0.36$
  - Attributions to supernatural Causes: $\beta = 0.24$
  - Attributions to non-western physiology: $\beta = 0.23$
  - Attributions to western physiology: $\beta = 0.22$
  - Attributions to stress Causes: $\beta = 0.38$

- **Somatic symptoms**
  - Attributions to stress Causes: $\beta = 0.36$

- **Anxiety and Insomnia**
  - Attributions to western physiology: $\beta = 0.23$

- **Social dysfunction**

**Key:**
- $\rho < 0.05$
- $\rho < 0.01$
- $\rho < 0.001$

Frequency of GP visits:

BSI(total)
Attributions to stress causes

Somatic symptoms

Attributions to western physiology

Anxiety and Insomnia

BSI_total

Attributions to supernatural causes

Social dysfunction

Attributions to non-western physiology

Severe Depression

Frequency of GP visits

Key:

--- p<.05

--- p<.01

--- p<.001

Figure 6.2 Predictors of the BSI_total

(R=0.84 R^2=0.70; F(5,125)=36.27, p<0.0001)
Figure 6.3 Predictors of frequency of GP visits
(R=.41 R²=.17; F(6,120)=2.68, p<.01)
6.4.5.1 Predictors of frequency of GP visits

In examining the relationship between the variables in the causal path models, it can be seen that, as hypothesised, stress causal attributions predicted psychological distress. Attributions made to stress causes for one's own illness were significant predictors of two of the GHQ sub-scales, social dysfunction (β.38, t=3.01, p<.01) and severe depression (β.36, t=3.21, p<.01).

As predicted, attributing one's illness to supernatural causes predicted somatisation, as measured by the BSI total (β.21, t=2.86, p<.01) as well as somatic symptoms, as measured by the GHQ-28 (β.23, t=2.19, p<.05). Supernatural causal beliefs were also significant predictors of psychological distress as measured by sub-scale of anxiety and insomnia (β.23, t=2.169 p<.05) and severe depression (β.24, t=2.24, p<.05).

As hypothesised, attributing one's illness to western physiological causes predicted somatic symptoms, as measured by the GHQ (β.22, t=3.08, p<.01).

Contrary to prediction, beliefs in non-western physiology causes did not predict somatic symptoms of the GHQ-28 or somatic distress as measured by the BSI total. Attributions to non-western physiological causes predicted anxiety and insomnia (β.36, t=3.26, p<.001) (Figure 6.1).

As would be expected, somatic symptoms, as measured by the GHQ, predicted the BSI total (β.47, t=4.92, p<.001). (Figure 6.2)

Figure 6.3 gives the full causal path model with socio-demographic variables, the four causal belief categories of mental distress, the four factors of the GHQ and the BSI total as predictor variables and frequency of GP visits being the dependent variable.

In the full causal path model, as predicted, the BSI total was a significant (and only) predictor of frequency of GP visits (β.49, t=3.14, p<.01), indicating the variance accounted for by the BSI total over and above that accounted for by causal attributions or the GHQ scales for predicting frequency of GP visits (Table 6.11).
Table 6.11  \( R, R^2 \) and \( t \) values of predictors of frequency of GP visits

<table>
<thead>
<tr>
<th>Predicting frequency of GP visits</th>
<th>B</th>
<th>( \beta )</th>
<th>( t )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Causal Attributions of one's illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress causes</td>
<td>0.032</td>
<td>0.061</td>
<td>0.413</td>
</tr>
<tr>
<td>Western physiology causes</td>
<td>0.037</td>
<td>0.058</td>
<td>0.606</td>
</tr>
<tr>
<td>Supernatural causes</td>
<td>-0.121</td>
<td>-0.200</td>
<td>-1.558</td>
</tr>
<tr>
<td>Non-western physiology causes</td>
<td>-0.114</td>
<td>-0.120</td>
<td>-0.966</td>
</tr>
<tr>
<td><strong>Step 2</strong> Factors of the GHQ-28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>-0.025</td>
<td>-0.169</td>
<td>-0.942</td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.010</td>
<td>0.057</td>
<td>0.332</td>
</tr>
<tr>
<td>Social dysfunction</td>
<td>-0.014</td>
<td>-0.097</td>
<td>-0.553</td>
</tr>
<tr>
<td>Depression</td>
<td>0.026</td>
<td>0.205</td>
<td>1.229</td>
</tr>
<tr>
<td><strong>Step 3</strong> Bradford Somatic Inventory Total</td>
<td>0.018</td>
<td>0.488</td>
<td>3.143**</td>
</tr>
</tbody>
</table>

**\( p < 0.01 \)**
Chapter 6

Study 3: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation

6.5 Discussion

As hypothesised, British Asians had significantly higher levels of somatic presentation of distress than the British sample, as measured by the BSI. This result confirms the findings of many studies showing somatisation of distress to be a common feature of non-western cultures. As had also been hypothesised, British Asians also had significantly higher levels of distress on the four sub-scales of the GHQ-28 i.e. somatic symptoms, anxiety and inosomnia, social dysfunction and severe depression compared to the British sample. As predicted, there were high inter-correlations (ranging from .68 to .84) between all four measures of the GHQ and the total score of the BSI for the British Asian sample. This confirms Mirdal’s (1985) assertion that somatic expressions of distress are an accompaniment, rather than an alternative, to expressing psychological distress. As Mumford (1992) had also argued, the cultural language of distress, in its outward expression, is somatic, but the personal affect is both emotional and psychological.

For the British sample, there were low to moderate significant inter-correlations between the total score of the BSI and three sub-scales of the GHQ – somatic symptoms, anxiety and insomnia and social dysfunction. There was no association between the BSITotal and severe depression for this sample. It seems, therefore, that the somatic expression of distress, as measured by the BSI, in this sub-sample, does not seem to be indicative of psychological distress to the same extent as for the British Asian sample.

Against prediction, and contrary to the findings of earlier studies (Mumford, 1989), no significant sex differences were found for the total score of the BSI, although results indicated that females had higher scores than men. However, as Mumford et al, (1991b) had also found, both sexes with a psychiatric/functional diagnosis had similar scores on the BSITotal. In view of the generally high scores for the British Asian sample, it could be argued that many of the individuals consulting the GP, particularly from the British Asian sample, were suffering some form of psychological distress. There were also no sex differences on any of the four GHQ sub-scales.

Significantly high levels of somatic symptoms, as measured by the BSITotal, were found for older people, low income and for religion, Muslims having the highest mean scores.
As expected, there was an effect of age on levels of somatic symptoms for the whole sample. It could be argued that those above a certain age would, along with physical ill-health, have more familial, economic and social burdens, which might contribute to increased psychological distress. There was, however, a significant interaction between age and culture, with older Asians consulting the GPs with particularly high scores on the BSI compared to those under the age of thirty-five of their own community, as well as to the older Britons.

It may be that in the middle years of life, along with socio-economic pressures, there are other stressors that are felt more acutely, such as a feeling of isolation or the perception of a loss of cultural traditions and values. It is the older people in this community, as Yasmin Ali-Bhai-Brown (1998) notes, that find themselves in an increasingly culturally alien world with lessening personal resources. There is little understanding of their sense of emotional loss, even from the younger members of their own families. In the West, too, the prevalence of depression has been linked to cognitive factors, such as powerlessness and negative self-evaluation (Birchwood, Cochrane & Macmillan, 1993). However, age did not seem to make a difference to the measures of psychological distress, i.e. the sub-scales of the GHQ. It may be, therefore, that scores of the BSI might be measuring distress that is more physical than psychological in older people, or that the older individuals find it difficult to express personal and emotional distress in psychological terms.

Low income, as predicted, was also shown to have an effect on distress levels. Unlike age, however, low income contributed not only to the high scores of the BSI but also to all four sub-scales of the GHQ. There seems no doubt, therefore, that low income, with its concomitant socio-economic disadvantages, can be one of the greatest stressors for individuals, leading to high levels of mental distress. Unlike the interaction that was shown between age and culture, the stress of being disadvantaged cuts all cultural groups, as no interaction was found between income and culture. This result is in keeping with data from the Fourth National Survey which suggests that class effects are similar for ethnic minority and white people (Nazroo, 1997a).

There was an effect of religion on distress levels, both for the BSI-total as well as for all...
four scales of the GHQ. Significant differences in the mean scores of the BSI for religious sub-groups indicated that Muslims have a higher level of somatisation than any other religion. Muslims, along with Sikhs, had significantly higher mean scores for the sub-scale of somatic symptoms compared to other religious groups i.e. Hindus, Christians and those of no religious affiliation.

This result confirms the findings of the first study, which showed religion to have an effect on mental health. It is also in line with the findings of earlier studies showing high levels of both physical and mental ill-health in Muslim samples in comparison to other religious groups in the British Asian community. As most of the Muslims that are migrants in the UK from the Indo-sub-continent are from Pakistan and Bangladesh, it is not surprising that these two sub-groups have the highest scores on the BSI.

However, Nazroo, (1998) argues against linking any particular illness, whether it is mental distress or coronary heart disease, (Gupta, Belger & Hughes, 1995) to one particular sub-group. He points out that to term any disorder a 'Muslim' or a 'Pakistani and Bangladeshi' disease, is to treat such divisions as 'natural and fixed'. These assumptions, rather than contributing to the understanding of the nature and importance of factors that are associated with health and illness, lead to cultural stereotyping. As earlier discussions have shown, the reasons behind their health disadvantages may have little to do with their culture or religion but more to do with their socio-economic position in UK. Pakistanis and Bangladeshis are the poorest of all ethnic minority groups in the UK, as reported by research carried out by the Institute for Social and Economic Research at Essex University (reported in The Times – Monday November 23, 1998). While Indians earned £ 317 a week, the Pakistanis and Bangladeshis earned £ 220 a week. 39 percent of them were unemployed against 17 % Indians.

These results demonstrate the assertion by Smaje (1995), that separating cultural influences from structural factors, to explain mental health levels or use of health services is not easy. Nevertheless, the results seem to support the notion that while culture, in the form of religious beliefs and idiomatic expressions, might contribute to the somatic presentation of distress, structural factors, such as income, determine the actual level of the distress.
As predicted, significant differences were found between first and second generation British Asians in the BSI total score, with first generation having higher levels of somatic distress. The first generation was also found to have higher means for all four sub-scales of the GHQ. These findings, too, are an indicator that high levels of psychological distress exist alongside high levels of somatization, and that the BSI is not measuring somatic distress to the exclusion of psychological distress. However, these findings contradict the findings of the Fourth National Survey. Lower rates of depression, (as well as of schizophrenia), were found in the Asian migrant community for those who had migrated after the age of 11 and not for those who were born here or had lived here since their early childhood (Berthoud & Nazroo, 1997).

Length of stay also had an effect, with those who had been in the UK more than 15 years liable to have higher somatic distress levels. Although one might assume that 'acculturative stress', - the process of cultural and psychological change that is the result of coming into contact with another culture and moving towards it, (Berry, 1998) - would lessen with the passage of time for a migrant community, this result gives evidence that it is not necessarily so. Interestingly, however, length of stay did not have a significant effect on any of the four sub-scales of the GHQ. The difference in the results for somatic distress as opposed to psychological might be an indication of an interaction between length of stay and age, leading to higher somatic symptoms.

There was an effect of proficiency in English for the British Asian sample for somatic distress as measured by the BSI. Those with no proficiency in English had double the mean scores of those who were proficient in English, reinforcing Mumford's (1992) suggestion that cut-off points for the BSI scores be adjusted for illiterate subjects. While proficiency in English would certainly affect the ability to articulate psychological affect, resulting in somatisation, proficiency also had a significant effect on psychological distress as measured by the GHQ. There were higher levels of psychological distress measured for those with little or no proficiency in English for all four sub-scales of the GHQ compared to those who were proficient in English. It seems that, as in the case of religion, factors that might be embedded within the general state of not being able to communicate in English or of being illiterate, need to be unpacked.
Poor English or a lack of proficiency in English, in people from the Indo-subcontinent, often means lower levels of education or no education. This was confirmed by findings of this study which also demonstrated that those with lower levels of education (analysed for the entire sample) had much higher levels of distress as measured by the BSI than the levels of distress of those with higher education. This result confirms Mechanic’s (1978) conclusions that those who express mental distress somatically tend to have low levels of education. Other factors would also be implicated. Inevitably, no secondary education is associated with unskilled jobs or even unemployment, which are in their turn associated not only with socio-economic, but also with other, perhaps more psychologically negative, disadvantages. Analysis showed that education also had a significant effect on the scores of four GHQ scales. Furthermore, as the participants of the British Asian sample who had professed themselves to not be proficient in English had had the questions read to them in Urdu, it is also likely that quite different reasons could account for their higher means. An oral administration as opposed to written self-administration might elicit more extreme responses. While, on the one hand, experimenter effects might lead to inhibition of expression, in this case, the immediacy of the spoken word might have lead to a ‘pouring out’ of one’s symptoms. This might also occur because, answering a question in your own mother tongue facilitates self-expression of an emotion or symptom that might have been expressed previously in similar terms to oneself or others. This point highlights two important issues in the measurement of distress - the importance of language in the expression of emotions and the difficulty of achieving conceptual equivalence in translations of questionnaires, as has been pointed out earlier by Lewis-Fernandes and Kleinman (1994).

It had been expected that attributing the cause of one’s illness to physiological causes, whether western or non-western, would be significantly associated with presentation of somatic symptoms for both the British Asian and the British sample. As expected, both types of physiological beliefs were significantly correlated with the BSI score for British Asians. Non-western physiological attributions, however, along with supernatural and stress causal attributions, were found to have higher inter-correlations with the BSI total
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than western physiological attributions.

Against expectation, there was no association between western physiological attributions and levels of somatic presentation for the British sample. Only attributions to stress causes were significantly correlated with the BSITotal for the British group. This latter finding confirms similar results found in the first study, showing a link between the causal attributions of stress and the mental health of a British sample.

This result illustrates the differences between the two cultural samples in two ways. Firstly, causal beliefs relating to the patient's own illness, in the case of the British Asians, were more holistic, embracing all categories. Their causal beliefs were wide ranging and all, both western and non-western, categories of causal beliefs were associated with somatic distress, as measured by the BSITotal. Secondly, non-western explanations of causal attributions that were made for their own illness had higher inter-correlations with somatisation (as measured by the BSITotal) than western explanations.

On the other hand, for the British sample, the relationship between stress category and BSITotal score seemed to indicate that high levels of somatic distress might contribute to higher levels of beliefs in stress causes. When this result is considered in conjunction with the finding, in the second study, that stress causes are associated with the mental health of Britons, it is evident that, even in the case of the latter, physical and psychological distress is difficult to separate.

This assertion is confirmed by the inter-correlations done for associations between causal beliefs of one's own illness and the frequency of GP consultation. No significant correlations were found for either sample, with one exception. Only stress causal attributions and GP visits were significantly correlated, for the British sample only. Since stress causal beliefs were also significantly related to the BSITotal for the British sample, these results suggest a relationship between stress beliefs, high levels of distress, and consequently, more GP visits.

For the British Asians, while there was a strong association between causal beliefs of distress and somatic presentation, this association did not exist between causal beliefs and number of GP visits. It seems that causal attributions of distress do not seem to play a role in the choice of this particular pathway of help-seeking for this sample and that, as

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asserted by Smaje (1996), distress levels are the deciding factor. However, it is well to remember that choices of therapies that are available in this country congruent with their conceptual beliefs are limited, unlike in the British Asians' countries of origin. Additionally, as mentioned in earlier discussions, one major factor for consulting a GP is that this service is both readily available and free, making it the most practical choice. A higher number of GP visits had been expected for the British Asian sample, because of higher levels of mental distress within this group compared to the British group. Predictably, the British Asian sample, as a whole, had more GP visits than the British sample, in the last year, with more British Asians consulting the GP twice or three times a year compared to the British sample. As predicted, there was a significant association between BSItotal and frequency of GP consultation for the British Asian sample only. This suggests that, above all, it is high levels of somatic distress that lead to the choice of consulting a GP. In other words, as Smaje (1996) put it, it is the perceived need to seek help, rather than the perceived causes of distress, that determine the decision to consult a GP.

There were no significant associations between feeling that it was appropriate to talk to the GP about feeling sad and anxious and GP visits for either sample. Although there was a significant correlation between the frequency of having talked to the GP when one was anxious or sad and GP visits, the correlation was low (rho=.26p<.05) for the British sample. A similar correlation was found for the British sample, which did not reach significance, possibly because of the smaller size of the sample. Unsurprisingly, there was a significant correlation between those who felt it was appropriate to talk to the GP about feeling sad and anxious and the number of times they had talked to the GP about their problems in that year, for the British Asians (rho=.39p<.01). This correlation, too, was not significant for the British sample.

Results found for the British Asian sample show a strong association between somatic symptoms, as measured by the BSI total scores, and attitudes towards being open with the GP. The BSItotal was significantly correlated with thinking it appropriate to tell the GP about feeling sad and anxious for the British Asian sample only. For the British sample, there was a negative correlation between the BSItotal and considering it
appropriate to tell the GP about feeling sad and anxious. The highest significant correlation, in the British Asian sample, was between the Bsitotal and how often the patient had talked to the GP about feeling sad and anxious. Again, there was a negative, although low, correlation between BSI total and having talked to the GP about emotional problems for the British sample. Being more open about emotional distress may have been possible for the British Asian sample in this study because all the GPs in the two surgeries where the research was carried out, were Asians and therefore, patients could communicate with the doctors more easily than with an English doctor.

The difference found between the two cultural samples may also be for the latter reason – the indigenous population might not have found it easy to communicate with Asian doctors. This latter point is made, not so much from the linguistic point of view (as all Asian doctors would be relatively fluent in English) but from the point of view of the communication of thoughts and feelings. It is likely that Britons might not consider consulting a GP as an appropriate person to consult for help seeking for psychological problems. However, the more reasonable assumption is that the BSI total, for the British sample, may well be measuring distress that is not only quantitatively different, but also qualitatively different from the British Asian sample.

The causal path analysis done for the whole sample showed that, as predicted, attributing one’s illness to stress causes predicted psychological distress, as in the sub-scales of social dysfunction and severe depression. As also predicted, attributions to supernatural causes significantly predicted somatisation, as measured by the BSI total, (as had been expected), as well as predicting the GHQ scales of somatic symptoms, anxiety/insomnia and severe depression. As predicted, attributions of western physiological causes predicted somatic symptoms as measured by the GHQ although these beliefs did not predict the BSI total. Contrary to prediction, attributions of non-western physiological causes did not predict somatic symptoms, either as measured by the GHQ or the BSI total but predicted anxiety/insomnia. Also to contrary to prediction, it was not somatic symptoms (as measured by the GHQ) that significantly predicted somatisation, as measured by the BSI but the sub-scale of anxiety/insomnia that, along with supernatural attributions, significantly predicted the BSI total. Although this is the only sub-scale of
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the GHQ-28 to predict the BSITotal, this result can be understood in remembering that the four scales of the GHQ are themselves highly correlated. Thus, from these results, it seems that both attributions about one's illness and psychological distress leads to somatisation, measured by the BSI.

With BSITotal as the only significant predictor of GP visits, it could certainly be argued that symptoms of a purely physical nature might be predicting frequency of GP visits. However, inter-correlations showed a high association between the four scales of the GHQ and the BSITotal for the British Asian sample, indicating that the BSITotal represents a more complex measure in this group than the expression of physical distress. Some interesting comparisons are found in comparing this particular causal path model to that of consulting a doctor/GP found in the previous study, which was carried out in a lay population. In the previous study, lay beliefs about supernatural causes negatively predicted consulting a GP and psychological distress was not a significant predictor of considering consulting a GP/doctor as an appropriate pathway of help-seeking. This causal path model shows that supernatural causal beliefs of patients significantly predict somatisation, which is a significant predictor of frequency of GP consultations. This is evidence, therefore, that in a patient population at primary care level, while causal attributions are predictors of expression of distress, the level of distress significantly predicts frequency of GP visits. The difference between the two causal path models can also be understood in the context of the difference between attitudes, intentions and actual behaviour.

Although these pathways and direction of pathways were predicated on theoretical grounds, the direction of causality is almost certainly not uni-directional. While this causal path analysis was constructed to show differences in the relationship between causal attributions of one's illness and psychologisation and somatisation, if any, causal attributions themselves will be shaped by distress levels, symptoms and, has been shown earlier in this study, by more contextual factors. In addition, while this study has found evidence for the inseparable nature of distress, whether expressed psychologically or somatically, it has also highlighted the fact that somatic distress can be purely physical, without an attendant psychological element. This distinction would be difficult to make.
as no data was collected on the participant’s medical history that could confirm some of these findings. Furthermore, the sample, in this study, was relatively small (particularly the British sample). Therefore, while these results may be illustrative of the relationships between different aspects of the explanatory models of individuals, only tentative conclusions can be drawn about the evidence found for the hypothesised pathways.

6.6 Summary

The third study examined the factors that influenced the choice of one particular pathway of seeking help for mental distress, consulting a GP. These included levels of mental distress as measured by the General Health Questionnaire and the Bradford Somatic Inventory separately, and the causal beliefs that the patient held about his/her own illness. Differences were investigated between two cultural groups, British Asians and the indigenous population. Both samples were obtained from those attending GP surgeries.

*Hypothesis I:* As hypothesised, British Asians expressed distress somatically much more than the British sample.

*Hypothesis II:* Against prediction, there was no main effect of sex and no interactions.

*Hypothesis III:* As predicted, there were significant effects of income and education on the BSItotal with higher means for those of lower income compared to those of higher income and for those of lower levels of education compared to those of higher levels of education. There was a main effect of religion, with Muslims having higher means than other sub-groups, and of age, with older people having higher means than younger people.

*Hypothesis IV:* Against prediction, there were significant differences for the BSItotal between Indians, Pakistanis, Bangladeshis and East Africans.

*Hypothesis V:* As predicted, there was a significant effect for place of birth. First generation British Asian had higher scores than second generation British Asians. There was an effect of length of stay in the UK. Those who had lived in the UK more than 15 years had higher scores than those who had lived in the UK less than 15 years.

*Hypothesis VI:* As predicted, there was an effect of proficiency in English on the
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BSI\text{total}. Those who were not proficient in English (and had the questionnaires administered to them) had higher scores than those who were proficient in English and had self-administered the questionnaires.

*Hypothesis VII:* As predicted, British Asian had more psychological distress as evidenced by the higher scores for all four sub-scales of the GHQ-28 compared to the British sample.

*Hypothesis VIII:* As hypothesised, there was a main effect of religion for combined variables of the GHQ and for somatic symptoms at the <.01 level of significance. Muslims and Sikhs had higher scores for somatic symptoms than Hindus, Christians or those of no religious affiliation.

*Hypothesis IX:* As hypothesised, there was a main effect of income at the .001 level of significance for all four sub-scales of the GHQ. Those with lower income (less than £15,000 annually) had higher scores on all four sub-scales than those with higher income.

*Hypothesis X:* Against hypothesis, there was no main effect for sex, at the .01 level of significance, for the combined variables or for any sub-scale or for age or education.

*Hypothesis XI:* As predicted, there was an effect of place of birth for the combined variables of the GHQ and for sub-scales of the GHQ. Means indicated higher scores on all four GHQ sub-scales for the first generation of British Asians compared to the second generation.

*Hypothesis XII:* Against prediction, there was an effect of proficiency in English for the combined variables as well as for the sub-scales of the GHQ. Means indicated higher scores on all four GHQ sub-scales for those who were not proficient in English compared to those who were proficient in English.

*Hypothesis XIII:* As predicted (hypothesis XI), the somatic expression of distress was highly associated with the psychological expression of distress for the British Asian sample, as there were high inter-correlations between the measures of the GHQ and the BSI\text{total}. Low inter-correlations were found between the three sub-scales of the GHQ and the BSI, for the British sample.

*Hypothesis XIV:* As predicted, there were moderate to high inter-correlations found for the British Asians sample for all categories of causal beliefs and the BSI\text{total}. For the
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British sample, significant correlation was found only for beliefs in stress causes and the BSItotal.

*Hypothesis XV:* As also predicted, a significant correlation also was found for the BSItotal and frequency of GP visits for the British Asian sample and not for the British sample.

Causal path models constructed to examine predictors of the pathways for frequency of GP consultation showed that the attributions made to supernatural causes predicted both psychological distress, as measured by sub-scales of the GHQ-28 and somatisation, as measured by the BSItotal. The BSItotal was the only significant predictor for frequency of GP visits.
CHAPTER 7

Discussions and Conclusions
Chapter 7 Discussions and conclusions

7.1 Introduction

The aim of this thesis was to examine cross-cultural differences in the causal beliefs of mental distress. Therefore, there was an under-lying assumption that culture would play a significant role in informing beliefs and concepts about mental distress and illness. More specifically, the thesis set out to examine differences in the explanatory models of mental distress between western and non-western cultures. It was argued that the impact of culture on the concepts relating to health and illness, particularly in non-Western cultures such as that of the Indo-subcontinent, is communicated through culture-specific influences, notably religious beliefs.

However, it was also argued that cultural boundaries were becoming increasingly permeable, so that culturally rooted concepts were open to change from a variety of influences. While some culturally rooted concepts would be consistent and durable, such as those relating to traditional and religious concepts of the causes of mental distress, others might be complex and changeable. Furthermore, culturally specific notions of mental distress would not easily be distinguishable from those shared by cultural groups. This point, it was argued, would not only be important for an investigation into the beliefs of a migrant community, but with the increasing globalisation of the world, for research across all cultures. The findings of these studies shall, therefore, be discussed in the context of the two somewhat opposing points of view – the cultural specificity of beliefs on the one hand, and, on the other, the shifting nature of ‘culture’ and associated generality of beliefs about health and illness.

This thesis investigated factors that play a role in shaping the causal attributions about mental distress and their influence on the attitudes towards seeking help for mental distress. In the following sections of the chapter, the empirical findings of the thesis are summarised very briefly and the main research issues are discussed in the light of the findings. The chapter concludes by reviewing the major limitations of this work and by considering some questions that might be raised by future investigations in this area.
7.2 Summary of empirical findings

7.2.1 Study 1: The causal attributions of mental distress and attitudes underlying help-seeking for mental distress

The first study of the thesis (see Chapter 4) examined patterns of differences and similarities in causal beliefs about mental distress and attitudes underlying psychological help-seeking behaviour between three cultural groups, British Pakistanis living in the UK, a British sample and Pakistanis living in Pakistan. Western and non-western distinctions in the causal attributions of mental distress, as postulated by Eisenbruch (1990), were partly confirmed by the findings of this study. Significant differences existed between the Pakistani and British groups for all four causal categories. However, these differences could not be dichotomised as western and non-western differences since there were significant differences in western explanations of mental distress between all three cultural groups. Furthermore, assumptions about cultural similarities between culturally similar groups, i.e. British Pakistanis and Pakistanis’ causal beliefs, were not confirmed, as beliefs relating to non-western explanations of mental distress of British Pakistanis were significantly different from those held by Pakistanis.

No significant differences were found, between the three groups, in an over-all positive attitude to seeking help for mental distress. However, British Pakistanis had significantly lower scores on stigma tolerance than the British group. The Pakistani group, although not significantly different from the British group, also had lower scores on this sub-scale. As no significant differences were found between first and second generation Pakistani immigrants either for this sub-scale, these findings might be seen as confirming assumptions about a cultural attitude that plays a role in influencing underlying attitudes towards seeking help. Religion, sex and education were significant predictors of a positive attitude towards seeking help for mental distress, with higher education and religion (Christians) predicting a more positive attitude and sex (men) predicting a negative attitude towards seeking help.

The causal attributions of mental distress held by the two Asian groups only, were found
to be significant predictors of a positive attitude towards seeking help for mental distress.

7.2.2 Study 2: Levels of mental distress, causal attributions and attitudes towards help-seeking pathways

Following the findings of the first study, the second study (see Chapter 5) examined the relationship between levels of mental distress in the three cultural groups and causal attributions of mental distress. The study also examined differences between cultural groups in help-seeking pathways that might be considered appropriate for mental distress. Although the prediction was that British Pakistanis would have lower scores on measures of mental health, (on the assumption that there would a negative effect of immigration), differences between the British Pakistanis and Pakistanis were not significant. Significant differences were found between the Pakistani group and the British group, with results showing that the former had higher levels of psychological distress, indicating a poorer state of mental health. There was a significant effect for religion on mental health, showing Muslims to have the highest scores on psychological distress and ‘loss of behavioural and emotional control’.

In contrast to the previous study, both British Pakistanis and Pakistanis had more beliefs in supernatural and non-western physiological causes than Britons. No association was found between the mental health of British Pakistanis and causal attributions while there was a weak association between causal beliefs of stress and mental distress of Pakistanis. There was a significant positive association between causal beliefs of stress and mental distress for the British sample only. This finding could be taken as an indication of the consistency of causal beliefs of mental distress of Asians.

Causal path models constructed to examine predictors of help-seeking pathways for mental distress indicated that culture was a direct predictor only of talking to family members, indicating a negative relationship between Britons and talking to family members as a help-seeking option. However, culture significantly predicted supernatural causal attributions of mental distress, which were significant predictors of pathways of self-reliance and consulting a hakim/alternative healer and negative predictors of consulting a doctor/GP and taking medication. Attributions to stress causes significantly
predicted taking medication while beliefs in western physiological causes significantly predicted consulting a doctor/GP.

**7.2.3 Study 3: Factors in the choice of one pathway of help-seeking for mental distress: GP consultation**

The third study examined the factors that influenced the choice of one particular pathway of seeking help for mental distress, consulting a GP (see Chapter 6). These included levels of psychological distress (as measured by the GHQ), somatic distress (as measured by the BSI), and the causal beliefs that the patient held about his/her own illness. Differences were investigated between two cultural groups, British Asians and the indigenous population. Both samples were obtained from those attending GP surgeries. British Asians expressed distress somatically, as measured by the BSI, much more than the British sample. British Asians also had higher scores for all four sub-scales of the GHQ-28 than the Britons. High inter-correlations between the measures of the GHQ and the BSI total, for the British Asians, indicated that somatic expression of distress accompanied psychological distress. Inter-correlations between the scales of the GHQ and the BSI, for the British sample, were weak.

In contrast to the previous study, the mental health of British Asians (as measured by the BSI total) was significantly associated with all categories of causal attributions made about their own illness. Similar to the findings in the previous study, significant correlation was found only between the BSI total and stress causal attributions for the British sample.

A significant correlation was found for the BSI total and frequency of GP visits for the British Asian sample and not for the British sample.

Causal path models constructed to examine predictors of frequency of GP consultation showed that attributions to stress causes predicted the sub-scales of 'social dysfunction' and 'severe depression' of the GHQ. However, supernatural causal attributions also predicted psychological distress i.e. the three sub-scales of the GHQ of 'somatic symptoms', 'anxiety and insomnia' and 'severe depression'. Supernatural attributions also predicted somatisation, as measured by the BSI total. The BSI total was the only
significant predictor for frequency of GP visits.

**7.3 Overall results and their implications**

This research attempted to investigate the significance of cultural beliefs and practices relating to mental distress. In contrast to purely *emic* investigations, which would give a detailed insight into culture specific concepts but might lack the analytical power to test hypotheses concerning these relationships, it attempted to use an *etic* methodology. The research agenda was rooted in a theoretical framework, which focused on the changing cultures of today, by the study of both differences and similarities in three cultural groups and in the sub-groups within these samples. The issues raised by this cross-cultural research are discussed with reference to the findings of this research. These were:

- Were there differences and similarities in the causal attributions of mental distress and attitudes towards help-seeking between cultural groups and between their sub-groups? Could these be understood as a western/non-western distinction?
- In the case of cultural differences, what were the main culture-specific factors that contributed to these cultural differences? Were there other, for example, structural factors such as education and income, that were implicated in differences between cultural groups?
- What was the relationship between causal attributions of mental distress and attitudes towards help-seeking for mental distress?
- Finally, did the *etic* methodology used in this research fulfill its aim in demonstrating that it is a valid tool for cross-cultural investigations

Some cultural distinctions emerged from the investigation of the explanatory models of distress of the three cultural groups. On the basis of the results from the studies, however, differences in western and non-western explanation of mental distress were not distinct, being moderated by an interaction between cultural, social and historical influences. This was in line with Klienman's (1986) assertion that explanatory models of health and illness are socio-historical products. It was on this basis that the three groups were predicated to be three separate cultural groups.
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As the findings of the first study demonstrated, cultural distinctions did not separate the two Asian samples from the Western (British) sample. Significant differences were found between all three cultural groups in the two western causal categories (stress and western physiology) of beliefs. Secondly, although the durability of health beliefs found amongst different Asian groups has often been noted by earlier research (Kakar, 1982; Roland, 1988), there were significant differences, in the first study, between the British Pakistanis and the Pakistanis in the two non-western causal categories of mental distress.

This finding demonstrated that cultures are far from static and that health and illness beliefs are dynamic processes (Currer, 1996). Krause's (1995), has explained culture as having two aspects - a 'generative' as well as an 'interactive' aspect. The former refers to the culture passed on from generation to generation, the latter to one that is constituted from interactions and personal experiences. While the former might contribute to similarities in the two Asian groups, the latter would contribute to differences. Where both the generative and interactive aspects of culture would be similar, more similarities would be expected than differences.

Secondly, although the predominantly physical perceptions in the West (Shweder & Bourne, 1991) have often been cast in opposition to Indo-subcontinental concepts of health and illness, the latter too, have been shaped by the long western tradition of biomedication in the sub-continent (Arnold, 1984). The consequence is that western and non-western distinctions are no longer distinguishable, or indeed, perceived in the conceptualisations of these beliefs in the cultures of the subcontinent. This is pertinent not only in the socio-historical context of the Indo-subcontinent but also in the light of a noted feature of Asians' conceptualisation of illness, i.e. its holistic and assimilative nature, found most clearly in the results of the Pakistani group.

There was evidence of this unified approach from the high scores, from both the first and second studies, that the Pakistani group gave to all causal attributions. Although evidence from the first study suggested that the pluralistic explanatory models of the British Pakistani migrant group might be somewhat modified compared to the Pakistani group, findings from the second study suggest that this group too, made high attributions to all causal categories of beliefs. There was also evidence, although to a lesser extent, from
British Asians’ attributions of their own illness, in the third study. The over-all results confirm Weiss’s (1997) assertion that distinctions between etic and emic concepts, whether conceptualised as ‘western’ and ‘non-western’ or ‘lay’ and ‘professional’ are not easy and that both types of explanations shape and form the explanatory models of lay populations. These findings make sense of Jodelet’s (1993) argument that all ‘lay psychologies’, irrespective of western or non-western labels, should be viewed as indigenous.

Nevertheless, in the over-all interpretation of the results from the three studies, there were some cultural themes that emerged which illustrated the more powerful important elements of the ‘culture’ of a group. As had been found in earlier research (Landrine & Klonoff, 1994), supernatural causal beliefs of mental distress provided the principal contrast between western and non-western differences of cultural beliefs. Both the first and second studies showed that the two Asian groups, over-all, had higher means for supernatural causes than the British group. Results also showed that these beliefs, in the two Asian groups, remained relatively consistent and were not modified by the mental health of the individuals. If these findings are taken as valid, and not an artefact of the methodology or as a result of a response bias, they demonstrate that attributing the causes of mental illness to metaphysical explanations play a fundamental role in the cultures of the Indo-subcontinent.

Although it had been argued that the religions of the Indo-subcontinent are important determinants of these traditional beliefs, findings from the first study found no effect of religion on causal attributions of mental distress. However, the results of the second study showed that, as had been expected, there was a significant effect of religion on supernatural causal attributions. Muslims had higher means for this category compared to Christians or those of no religious affiliation, confirming the findings from earlier research that Muslims generally attribute illness to God’s will. The greatest difference, in this category, lay between the Muslims and those of no religious affiliation, a group that was negligible in all Asian samples in all three studies.

As has been found in earlier research, religion was also one of the major determinants of attitudes towards help-seeking. In the first study, there was a significant effect of religion
on a positive attitude to seeking help for mental distress as well as on recognition of need for help, with Muslims having the lowest scores on both these scales, compared to Christians and those of no religious affiliation. This was confirmed by the finding that religion was the most significant predictor of a positive attitude to help-seeking, showing the two other sub-groups as having a more positive attitude towards seeking help for mental distress than Muslims. The findings of the second study also showed that religiosity predicted saying prayers as an appropriate pathway of help seeking for mental distress. Given that 31% of Britons had no religious affiliation compared to none in either the British Pakistani sample or the Pakistani sample, it is a safe assumption that it is primarily the religiosity of the two Asian groups that predicts saying prayers as a help-seeking pathway for mental distress.

The recurring theme of the role of religion in these findings confirmed the emphasis placed on religion by some psychiatrists (Royes, 1962) as well as anthropologists (Littlewood, 1997), as a way of understanding the experience of mental illness in non-Western cultures. Additionally, the findings from the second study, indicated that the British Pakistani group and the Pakistani group were not significantly different in their attitude to self-reliance and acceptance in preference to active help seeking. While these results, for the Pakistani group, could be attributed to lack of available health services, the fact, that there were also no significant differences for self-reliance between British Asian sub-groups or first and second generation British Asians, highlight culturally salient themes in understanding and dealing with mental illness. This typically non-western construction of perceived ‘fatalism’, far removed from the western notions of illness and help-seeking, has often led to Asians being stereotyped as passive (Littlewood, 1997). Nevertheless, these religious ideologies of the subcontinent provide culturally sanctioned ways of coping with distress, and allow the expression of distress in a social acceptable way.

While the part that religion plays in the concepts of mental illness and associated behaviours has been well documented, and is confirmed by the findings of this research, results from the second and the third studies showed that religion is also implicated in levels of mental distress. Muslims were found to have higher scores for psychological
distress, both in the second study (compared to Christians and those of no religious affiliation) and in the third study, (compared to all other religious sub-groups). The most immediate conclusions to be drawn from these results would be the isolating nature of Islam, with its rigid strictures on behaviour and obedience, particularly relevant in the context of living within a "permissive" society. However, earlier discussions have shown that there are structural factors, such as socio-economic disadvantages, that are embedded within the more apparent religious groupings and that these are more likely determinants of some aspects of mental health (Modood et al, 1997). Additionally, findings demonstrated that while culture and sex determined causal attributions of mental distress, age, education and income also mediated in attitudes towards help-seeking.

In the third study, somatization, another aspect of mental distress associated with Asians, was found to be higher in the British Asian group than in the British group. Even if comparisons are not made (in view of Lonner's (1979) reservation about two-group comparisons), scores for British Asians, compared to the cut-off scores indicating psychiatric morbidity in earlier research (Mumford, Tareen, Bhatti, Bajwa, Ayub & Pevaiiz, 1991), were high.

Another culture-specific feature, language, was shown to play a part in the expression of somatic distress, with high somatization scores of those who were not proficient in English. While it might be expected that somatization would be the result of being less articulate in presenting symptoms to the GP, it is surprising that distress is expressed somatically even in administered questionnaires. While the latter findings may well be due to experimenter effects, it is also clear that the issue of somatisation implicates more than just language, or indeed, the 'culture' of the individual. Firstly, being less proficient in English means, for someone from the Indo-subcontinent, other disadvantages. This might include lower levels of education and therefore, more socio-economic disadvantage. It would also mean that immigrants in this country who were not fluent in English might feel more isolated, leading perhaps to more stress. Lastly, those individuals who were not proficient in English would hold more traditional concepts of mental distress. As Stacey (1988) has argued, health beliefs are conditioned not only by education and culture but also by social position and power.
Chapter 7

Discussions and conclusions

While the above reasons allude to the structural elements of a section of a community that might be relatively disadvantaged, culture also plays a moderating role, in the form of traditional supernatural causal attributions. As the results of the third study demonstrate, attributing one's own illness to supernatural causes predicts high levels of somatisation. Mental distress is expressed somatically because, as Currer (1986) also found, worries about the ‘self’ and the future are seen as out of order in a belief system in which the focus is not on the individual and the future is in God’s hands.

Results of the third study indicated that, as Mumford (1989) and others had found earlier, that Asians’ somatisation did not preclude the psychological experience of distress. Psychological distress levels, for British Asians, were also found to be higher than the British group, as well as in comparison to the cut-off point for the GHQ-30 (Goldberg & Hillier, 1979). Firstly, this finding might be contrasted to that for the Britons, where a relatively weak association was found between psychological distress and somatisation. Secondly, while in this study, both psychological and somatic distress was expressed (in answers to the GHQ-28 and the BSI), research has noted that there is little psychological presentation to the GP in comparison to somatic presentation on the part of Asians (Bal, 1987). These results suggest, therefore, that while there is an association between psychological affect and somatic sensation of distress, Asians concepts of mental distress do not incorporate ‘psychologised’ forms of expression.

While the above similarities illustrated that the conceptualisations of the two Asian groups had several common features, differences found in the first study, between the two groups, demonstrated that the concepts of mental distress had been modified in the British Pakistani group. Results demonstrated that British Pakistanis’ causal attributions, although predictive of a positive attitude towards seeking help, were not as significant as those of the Pakistani sample. As such, the findings from the first study showed that the migrant group seemed to hold the middle ground between the two cultures, that of Pakistan on the one hand and, on the other, that of Britain. Findings from the second study also confirmed this pattern between the three cultural groups in their attitudes towards help-seeking pathways. While the discriminant analysis carried out in the second study showed that self-reliance, saying prayers and talking to family were among the
most distinguishing features of cultural attitudes towards seeking help for mental distress, British Pakistanis were more likely (although marginally) to be grouped as Britons. On the other hand, it could also be argued that concepts in this group, living in a very different social context than the Pakistanis, would be different. The findings of the first study had demonstrated that British Pakistanis did not differ significantly in non-western explanations of mental distress from the British group. Other similarities, between the British Pakistanis and Britons, were also found in attitudes to some help-seeking pathways, with these two groups being significantly more in favour of consulting a doctor/GP as well as for consulting an alternative healer/vaid/hakim than the Pakistani group. This last point indicates the inevitably contextual nature of even the most traditional beliefs and attitudes, and furthermore, demonstrates that an understanding of both cultural and social factors are necessary in the conceptualisations of mental distress of cultural groups. As groupings are not only defined by what is different but also by what is shared, results have confirmed this point. Moreover, results also showed income, education and age as significant mediators in beliefs about the causes of mental distress and associated attitudes rather than what might be considered purely cultural influences. Finally, one of the main aims of this research was to demonstrate the relationship between causal attributions of mental distress and attitudes towards seeking help for mental distress. In the first study, causal attributions of mental distress were significant predictors of a positive attitude towards seeking help for both the British Pakistani and the Pakistani group, and not for the British group. Although this association was not as strong for the migrant group as for the Pakistanis, this finding could be seen as evidence of stronger links between the causal concepts of mental distress held by Asians and subsequent behaviour compared to the western British group. Findings of the second study seemed to confirm this, by showing that traditional ideas of the causes of mental distress, particularly those related to the supernatural, significantly predict how mental distress is coped with and, therefore, attitudes towards help-seeking. Since causal path modelling was done for the entire sample, these types of beliefs would predict subsequent behaviour for all cultures. However, the causal path model showed that being Pakistani predicts beliefs in supernatural causes. Since both
Asian groups had significantly higher means for this category compared to the British group, it is probable that it is the supernatural causal attributions held by both Asian groups that predict self-reliance and acceptance. At the same time, supernatural attributions also predicted consulting a hakim or alternative healer and an inverse relationship with consulting a GP. However, it was the two groups of British Pakistanis and Britons who considered these pathways as more appropriate help-seeking pathways, compared to the Pakistanis. Supernatural attributions of mental distress also predicted an inverse relationship with taking medication, although there were no significant differences between the cultural groups on scores of this particular pathway. In contrast to the finding that showed an inverse relationship between beliefs in supernatural causes and consulting a GP, the results of the third study demonstrated that attributions made to supernatural causes about one's illness predicted somatization, which predicted frequency of consulting a GP. Thus, the difference found between the second and third studies, in the role of supernatural causes as mediators in associated attitudes towards help-seeking might well be illustrating the difference between lay explanatory models and patients' explanatory models, as posited by Kleinman (1980). Notwithstanding the differing moderating role played by causal attributions in lay and patients' explanatory models, results of all three studies could be taken as evidence that the two aspects of mental distress, i.e. attributions of mental distress and attitudes to help seeking, are closely linked. This relationship appeared to be particularly applicable to the conceptualisations of mental distress of Asians.

7.4 Limitations of the research

The final issues revolve around the strengths and limitations associated with this methodology. The empirical findings of this thesis have demonstrated the significance of culture. Findings from these studies have shown concepts that are considered culture-specific to the Asian culture, such as the importance of causal attributions related to supernatural
agencies as well as particular perspectives on coping with mental distress, such as the role of prayers and family. As such, these findings have confirmed the findings from previous research using qualitative *emic* methodology (Currer, 1986; Beliappa, 1991; Bowes & Domokos, 1993). However, it is inevitable that some aspects of cultural dimensions might be inaccessible to this particular form of cross-cultural research. These would inevitably demand a more *emic*, qualitative methodology to be used for research within a specific culture (although translation remains a thorny issue). Furthermore, there is no doubt that many of the criticisms made by the ‘new’ cross-cultural psychology’ of an *etic* methodology, presented in earlier discussions in great detail from the point of view of the ‘new’ cross-cultural psychology, could almost certainly be applied to this research. While this investigation might have accessed some cultural features found to be common between the Asian groups, it does not provide rich descriptive details of their culture-specific concepts.

On the other hand, findings have also shown concepts that are shared between Asian and Western (British) cultures, such as psychosocial attributions of mental distress and a positive attitude to seeking help - similarities that have also been found by earlier research (Huxley, 1993; Gillam et al, 1989). However, notwithstanding the arguments presented in favour of this methodology for cross-cultural research, an evaluation of this work should take into account a number of theoretical and methodological limitations that raise problems for comparisons across cultures.

Firstly, the ‘derived etic’ approach of this research has argued that ‘culture’ cannot be isolated and has attempted to go beyond simple universalistic assumptions based on cultural factors. It has, therefore, attempted to examine patterns of differences and similarities that exist between a Western cultural group, a non-Western migrant group and a non-Western non-migrant group. This has been carried out by by examining effects of purely cultural factors such as religion and language as well as factors that might be confounded for culture, such as acculturisation effects. As a consequence, in analysing questions (sometimes on an item by item level) and exploring fully the relationship between these dependent variables and the independent variables, a large number of multiple comparisons have been made between groups. As a result, the probability of at
least some tests showing significance, even when the null hypothesis was true, has been
higher than the conventional significance level. Significance levels, therefore, of results
were adjusted to the <.01 level of significance to ensure that these differences were
meaningfully significant.
However, while highly significant differences found between cultural groups reveal
meaningful aspects of this research, it has been considered just as important to report and
discuss non-significant differences between groups. In the context of looking at patterns
of differences and similarities between three cultural samples, it is often differences that
are not significant, in other words the similarities between groups, that illustrate the
argument that has been put forward by this thesis.
Secondly, a major limitation of this research has been the sampling methods used to
gather data from the three samples. Since data gathering was carried out by opportunity
sampling, all samples were biased being drawn largely from urban areas and being
largely middle-class, with generally high levels of education. The Pakistanis in both
studies were mostly bilingual, being proficient in English and their first language. Given
that both Pakistanis and British Pakistanis were from relatively affluent backgrounds, it
is most likely that results found in the first two studies would be very different if the
same investigations were carried out in rural, non-Westernised, poorer communities in
Pakistan or in more disadvantaged communities of British Pakistanis. These
shortcomings might apply just as much to the British group, albeit not to the same extent
as for the Asian groups. Ideally, an equivalent, representative quota sample should have
been used in these studies.
A further limitation of this research relates to the cultural groupings themselves. In
examining the existence of the broader western and non-western dichotomies in beliefs
on the one hand and the narrower culture specific (Asian) beliefs of mental distress on
the other, it has been argued that varying levels of generality need varying levels of
analysis. However, this rationale leads to a cultural heterogeniety in the samples that
make any conclusions drawn about purely cultural influences problematic. This
shortcoming is further compounded by the fact that the samples themselves do not reflect
the demography of the populations from which they are drawn, making any
Chapter 7 Discussions and conclusions

generalisation of findings limited.
There have also been conceptual problems in this investigation that need clarification. Despite the apparent structural similarities between the three cultural groups, the highly differential contexts of the two studies carried out in both Pakistan and the UK posed a problem in trying to find equivalence for several constructs. For example, 'religiosity' might be perceived and evaluated in different ways in the two countries. Being very religious in the context of a largely disaffected Western society would possibly not be the same as being religious in Pakistan, where religious rituals and prayers play an important part in daily life.

This point of finding equivalence also related, more concretely, to the measurement of income. Firstly, the standard and cost of living is much lower in Pakistan than in the UK, therefore, incomes are lower in comparison. Secondly, the disparity between the sterling £ and the rupee is such that a reasonable income in Pakistan would be considered very low by UK standards. Thirdly, both British Pakistanis and Pakistanis, often work in family businesses, where there is no clear-cut amount of income that is drawn at regular intervals. Therefore, this automatically means that an estimation of one's income is approximate. While this research attempted to circumvent this problem by examining income effects only in the British Pakistani and the British sample, this is considered a major limitation of this research, given the detrimental affect of socio-economic factors on mental health. The fact that the three samples, in the first two studies, were mainly middle class, because of constraints of time and opportunity, further restricted the range of income differences.

The above problem was not present, to the same extent, in the third study, since this study included only a sample of British Asians and a sample from the indigenous population. The two samples in this study varied much more in their socio-economic status than in the first two studies. This may be the reason why, in this study, there is an effect of income on the mental health of the British Asian group as compared to the first two studies. However, the samples in the third study were relatively small, (particularly the British sample), thereby making generalisations more problematic.

In terms of demographic details, while every attempt had been made to gather all relevant
information from the respondents, it is evident from the findings that some important questions had been omitted. In the case, of British Pakistanis (first and second studies) and British Asians (third study), 'age at migration' would be a crucial variable in studying acculturative effects, as well as perhaps, reason for migration. Questions relating to social support networks might also have shed light on factors that determine mental health, especially in relation to the migrant group.

The measures used in this study, although chosen on the basis of their particular suitability to the investigations, posed different problems. The findings of the studies highlighted the heuristic nature of western/non-western explanations, as postulated by Eisenbruch (1990) in the MDEMQ. While this measurement instrument provided a way of understanding the different 'multi-cultural' explanatory models of people, it made cultural distinctions difficult. However, the heuristic nature of the categories itself points to the fact that people's explanatory models cannot be nicely compartmentalised.

Unlike both the GHQ (Goldberg, 1972) and the BSI (Mumford, 1989), whose usefulness and validity, found in earlier research, was confirmed by results of this investigation, the sub-scales of the ASPH used in the first study achieved relatively low to moderate levels of reliability for this sample. Although findings illustrate an important aspect relating to Asians' attitudes towards seeking help, (the scores of stigma tolerance being low for both Pakistani groups compared to the British group), they also demonstrate the difficulties in the choice of measurement tools to be used in cross-cultural research.

Findings from the MHI, used in the second study, demonstrated that, although this instrument was not constructed as a tool for cross-cultural investigations, it might be a reliable and valid tool for investigations across cultures. However, findings cannot be generalised until more investigations are carried out to establish its validity as a useful measure to be used across diverse cultural groups.

Finally, while conclusions, in this research, have been drawn about relationships between causal attributions of mental distress and attitudes towards seeking help, they can only be tentative, particularly in relation to actual health related behaviour. Firstly, there is much previous research that has shown the tenuous link between attitudes and behaviour. Secondly, while most causality has been assumed to be uni-directional, there is,
undoubtedly, reciprocal causality between health, beliefs and associated behaviour.

7.5 Application of findings

On the basis of the results of this research, it is clear that beliefs about the causes of mental distress and illness play an important part in its representation and that these substantially influence attitudes towards seeking help for illness both in a lay and clinical population. However, application of the findings of this research to the latter setting could be useful if health service providers want to ensure a more equitable provision of services for all cultural groups.

In the context of the United Kingdom, where Western models of body and mind results in offering psychiatric services according to diagnosis rather than need, there is little understanding of the importance that these beliefs have for other cultures or the significance of the relationship between beliefs and attitudes. These findings, therefore, might be particularly useful in the context of ethnic groups in the UK where the picture relating to use of health services for mental health problems is far from clear.

While various explanations have been put forward for the under-utilisation of mental health services by the British Asian migrant group, the findings of this research provide further insight into how different cultures perceive mental illness and the relationship between this understanding and help-seeking behaviour. It is, therefore, suggested that an approach to therapy or treatment is needed which accepts and incorporates the fact that the cultural beliefs that people have about their illness can have a profound effect on the management of their illness. As Bhugra (1997) suggests, the expanding emphasis on community care means that health services provided for the British Asian community could work from a bottom-up approach and be based on models that include culturally salient representations of illness.

Additionally, although findings from this research have confirmed assumptions that Asians’ notions of illness behaviour need not involve active help-seeking, and that their preference might be to be self reliant and turn to family members, earlier research (Gupta, 1991) has found that Asians seek help for their mental distress where services provided
are viewed as culturally sympathetic. Given the high rates of both somatic and psychological distress expressed by a population of primary care users in the third study, it is also evident that Asians are attempting to seek help for distress but not, perhaps in a way that is recognised by the medical practitioner. In order to provide a more culturally sensitive service, training could be given to professionals who deal with ethnic minorities which would provide them with an understanding of how ethnic minorities represent illness and present symptoms.

7.6 Future research

Additional research, employing Flaherty, Gaviria, Pathak, Mitchell, Wintrob, Richman, and Birz’s (1988) suggestions, is required to work out a method for the selection, adaptation and validation of instruments designed in one culture for use in other culture (discussed in detail in Chapter 3). However, it is emphasised that this would be in the absence of the necessary measurement tools constructed for use in cross-cultural research, or in the interim, while more work is done on the construction of tools that would be appropriate for examining concepts across cultures. These suggestions might be useful in improving the range of valid measures currently available for quantitative, cross-cultural research, particularly in migrant communities. This point is especially important in the context of the continuing acculturising process in these communities, particularly in younger and future generations.

In addition, much more representative sampling is needed before the findings and conclusions of the present investigations can be accepted and generalised. This point relates to the composition of the British Asian sample particularly, in the third study. Although, given the complexity of the issues involved, even epidemiologists have argued that ‘fuzzy logic’ (Hahn & Stroup, 1994) might need to apply in sampling in this community, the definition of the basis for sampling is important (Bhopal, 1997). The representative nature of sampling is perhaps particularly important with reference to income. Because this factor implicates other important social differences, more representative groups could be sampled according to occupation, areas of residence or
housing ownership.
Finally, as Bracken (1993) has argued and, it is hoped that this research has shown, future use of quantitative methodology would be useful in cross-cultural research as long as the research is carried out with a full awareness of both its limitations and its strengths. One of the primary aims of future quantitative research should be to avoid the imposition of a priori notions and ideas about the universality of concepts but also a priori notions that have been incorporated into the representations of a particular culture.

7.7 Conclusions

From a methodological perspective, this research has been carried out as an attempt to counter the post-modern critiques of objectivist enquiry, which have often sought to demonstrate its failings without providing an alternative positioning. This is with particular reference to cross-cultural investigations. Although there have been several suggestions of ways of marrying emic and etic methodologies (Jablensky, 1992; Berry, 1998), the transformation of culture-specific concepts into concepts that can be understood equivalently in other cultures has still to be demonstrated adequately. Finally, it is hoped that this research has demonstrated that research such as this, carried out in contemporary, largely middle class, largely bilingual, lay population needs a process of critical reflection, leading to a re-formulation of both the universalist discourse of psychology and the relativist discourse of anthropology.

Notwithstanding the theoretical and empirical limitations, the findings presented in this thesis demonstrated the significance of culture to provide some insight into the effect of this variable on concepts of mental distress. Although this research demonstrated important differences between all three cultural groups, it also showed just as important similarities between the British Pakistanis and Britons, on the one hand, and British Pakistanis and Pakistanis, on the other. The comparisons of the differences and similarities between the three cultural groups suggest that ‘culture’ is no longer a ‘binary division’ (Littlewood, 1997) between ego-centric and psychologised cultures on the one hand and socially oriented cultures on the other.
Nevertheless, there were some commonalities to be found in the findings of the two Asian groups, such as more holistic concepts of mental distress, the impact of religion on the understanding that people have of distress and illness, and a tendency to express distress somatically. There was a stronger relationship between the causal attributions made about mental distress and attitudes towards help seeking for mental distress for Asians than for Britons. Several findings also demonstrated that British Pakistanis were more likely to have similar views to Britons than to Pakistanis, such as in their attitudes towards consulting a doctor/GP and a hakim/alternative healer.

In conclusion, the present thesis demonstrated both the importance of culture in mediating in the concepts of mental distress as well as their fluidity, despite cultural influences. Nevertheless, the investigation of the role of the variable was not exhaustive and further research is required to fully explore and elucidate the effect of both culture and context on the conceptualisations of mental distress and attitudes towards help-seeking for mental distress.
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MENTAL DISTRESS EXPLANATORY MODEL QUESTIONNAIRE

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

People explain mental distress in a variety of ways. Some explanations are listed below. We would like to know what you think can cause people to suffer mental distress. How likely is it that the following causes could contribute. There is no right or wrong answer. Please circle the appropriate point for each item (from 'not at all likely' (1) to 'highly likely' (7). You should respond to every item even if you are not sure. Please feel free to write any comments you would like to make at the end.

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I THINK THAT MENTAL DISTRESS CAN BE CAUSED BY:

1. Bad experiences during childhood
   1 2 3 4 5 6 7
2. Being intentionally physically harmed by another person
   1 2 3 4 5 6 7
3. Exposure to a fright or shock
   1 2 3 4 5 6 7
4. The pace of modern life
   1 2 3 4 5 6 7
5. Being hot (but not from fever or weather
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6. Wind or gas or currents flowing through the person's body
7. Contact with something or someone taboo
8. Bad nerves in the body
9. The effects of old age
10. Infection
11. Genetic or inherited defect
12. Being born this way (e.g. inheriting bad/low/weak/cold blood)
13. Eating food which is wrong for that person
14. The person's body being out of balance or harmony (e.g. yin/yang, hot/cold)
15. Physical illness
16. Chemical imbalance in the brain
17. One or more of the person's vital organs being disrupted (e.g. liver, blood or vital fluids).
18. Having had an accident
19. The person had a bad or ominous dream or sensation
20. Bad luck or chance
21. Doing the wrong thing during pregnancy
22. Death of a relation or close friend
23. Failure to properly observe rituals after giving birth
24. Brain damage or head injury

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<td>Doing the wrong thing when menstruating</td>
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<td>Astrological destiny</td>
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<td>The person's karma (what happened to him/her in previous lives)</td>
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<td>29</td>
<td>A dangerous unprovoked spirit</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>A spirit who was angry because someone did something wrong</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>The person's soul temporarily leaving the body or becoming scattered</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Migration to a new country</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Not having enough money</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Contact with something or someone &gt;dangerous=, 'unclean= or 'contaminated'</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>Doing something forbidden by social or cultural rules</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Too much work or study</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Someone unwittingly casting a spell e.g. the evil eye</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Someone wanting to hurt the person and casting a spell</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Conflict or break-up of family or relationship</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Someone engaging a witch or shaman to cast a spell</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Unemployment</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>The person seeing, hearing or feeling something ominous</td>
<td>1  2  3  4  5  6  7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 4.2

(URDU VERSION OF THE MDEMQ)
25 سکنی پر اورا اہلیہ دکھ
26 ہعلے کی دو ہرات یہ منعت چیز پر ہرجت را
27 روشن دار باوقاری دسمہ یہ موت دوجن میں
28 ہیرس نہ چاہئے پرم رواج ہشاگد مہرہ شدہ ہے پردا نازک سی
24 سرم ہد میں کوچھ سیہ کی
25 منھبہ پر معاشرتی ہے خیفہ صنفیت پر اہم نا (نہیں پر اہم نا)
26 سوار یہ دوران خفیف ہے سردی
27 سندھ سے جنگپن سیسی (سنڈان لفظیت کی لینی)
28 یہ نئی نظریہ (ڈئی کی)
29 یہ نئی نظریہ (ڈئی کی)
30 یہ نئی نظریہ (ڈئی کی)
31 یہ نئی نظریہ (ڈئی کی)
32 یہ نئی نظریہ (ڈئی کی)
33 یہ نئی نظریہ (ڈئی کی)
34 یہ نئی نظریہ (ڈئی کی)
35 یہ نئی نظریہ (ڈئی کی)
36 یہ نئی نظریہ (ڈئی کی)
37 یہ نئی نظریہ (ڈئی کی)
38 یہ نئی نظریہ (ڈئی کی)
39 یہ نئی نظریہ (ڈئی کی)
40 یہ نئی نظریہ (ڈئی کی)
41 یہ نئی نظریہ (ڈئی کی)
42 یہ نئی نظریہ (ڈئی کی)
43 یہ نئی نظریہ (ڈئی کی)
44 یہ نئی نظریہ (ڈئی کی)
45 یہ نئی نظریہ (ڈئی کی)
46 یہ نئی نظریہ (ڈئی کی)

APPENDIX 4.3

(ENGLISH VERSION OF THE ASPH)

ATTITUDES TO SEEKING PSYCHOLOGICAL HELP

Below are a number of statements pertaining to psychology and mental health issues. Read each statement carefully and indicate your agreement or disagreement with it by circling your response that could range from ‘Disagree strongly’ (1) to ‘Agree strongly’ (7). Please express your frank opinion on rating the statements. There are no wrong answers. The only right ones are whatever you honestly feel or believe. It is important that answer every item.

<table>
<thead>
<tr>
<th>Disagree Strongly</th>
<th>Disagree quite strongly</th>
<th>Disagree mildly</th>
<th>Neither agree nor disagree</th>
<th>Agree mildly</th>
<th>Agree quite strongly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

1. Although there are clinics for people with mental troubles, I would not have much faith in them.

2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.

3. I would feel uneasy about going to a psychiatrist because of what some people might think.

4. A person with a strong character can get over mental conflicts by himself, and would have little need for a psychiatrist.

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal and emotional problem.

6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
<table>
<thead>
<tr>
<th>Disagree Strongly</th>
<th>Disagree quite strongly</th>
<th>Disagree mildly.</th>
<th>Neither agree nor disagree</th>
<th>Agree mildly</th>
<th>Agree quite strongly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.

9. Emotional difficulties, like many things, tend to work out by themselves.

10. There are certain problems which should not be discussed outside of one's immediate family.

11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

14. Having been a psychiatric patient is a blot on a person's life.

15. I would rather be advised by a close friend/relative than be a psychologist, even for an emotional problem.

16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.

17. I dislike a person - professionally trained or not - who wants to know about my personal difficulties.

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
<table>
<thead>
<tr>
<th>Disagree Strongly</th>
<th>Disagree quite strongly</th>
<th>Disagree mildly</th>
<th>Neither agree nor disagree</th>
<th>Agree mildly</th>
<th>Agree quite strongly</th>
<th>Agree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

20. Having been mentally ill carries with it a burden of shame.  

21. There are experiences in my life I would not discuss with anybody.  

22. It is probably best not to know everything about oneself.  

23. If I were experiencing a serious emotional crisis at this point in my life, I would not discuss with anyone.  

24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.  

25. At some future time, I might want to have psychological counselling.  

26. A person should work out his own problems; getting psychological counselling would be a last resort.  

27. Had I received treatment in a mental hospital, I would not feel that it ought to be kept secret.  

28. If I thought I needed psychiatric help, I would get it no matter who knew about it.  

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers and priests.
APPENDIX 4.4
(URDU VERSION OF THE ASPH)

(1) مطالعہ میں ہونے والے ایکسٹریور ہوئے ہے۔
(2) کریپ نمایاں کی مدد سے کریپ کی مدد سے
(3) گھریلو ہوئے ہے۔
(4) کریپ نمایاں کی مدد سے کریپ کی مدد سے
(5) گھریلو ہوئے ہے۔
(6) کریپ نمایاں کی مدد سے کریپ کی مدد سے
(7) گھریلو ہوئے ہے۔
(8) کریپ نمایاں کی مدد سے کریپ کی مدد سے

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 theoretically, the best way to approach this problem is to...
### BACKGROUND INFORMATION  
(Please tick in appropriate box)

<table>
<thead>
<tr>
<th>1. Age</th>
<th>18-21</th>
<th>36-40</th>
<th>51-55</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22-30</td>
<td>41-45</td>
<td>56-60</td>
</tr>
<tr>
<td></td>
<td>31-35</td>
<td>46-50</td>
<td>60-65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. What is your ethnic origin?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
</tr>
<tr>
<td>Pakiastani</td>
</tr>
<tr>
<td>Bangladeshi</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Where were you born?</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
</tr>
<tr>
<td>Pakistan</td>
</tr>
<tr>
<td>Bangladesh</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. How long have you lived in this country?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 years</td>
</tr>
<tr>
<td>6-10 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. What is your religion?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islam</td>
</tr>
<tr>
<td>Christian</td>
</tr>
</tbody>
</table>

---

346
7. Are you:

<table>
<thead>
<tr>
<th>Very religious</th>
<th>Quite religious</th>
<th>Not at all religious</th>
</tr>
</thead>
</table>

7. What is your mother tongue?

<table>
<thead>
<tr>
<th>English</th>
<th>Hindi</th>
<th>Bengali</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urdu</td>
<td>Punjabi</td>
<td>Other</td>
</tr>
</tbody>
</table>

8. Is your English:

<table>
<thead>
<tr>
<th>Fluent</th>
<th>Quite fluent</th>
<th>Not fluent</th>
<th>Not at all fluent</th>
</tr>
</thead>
</table>

9. What is your educational background?

<table>
<thead>
<tr>
<th>No formal education</th>
<th>Secondary Education: Matriculation/Olevel/A level (Put M or O or A)</th>
<th>University Degree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Education only</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Are you:

<table>
<thead>
<tr>
<th>Single</th>
<th>Married</th>
<th>Divorced</th>
<th>Widowed</th>
</tr>
</thead>
</table>

11. Do you live in an Extended Family (with mother/father or in-laws):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

12. Are you:

<table>
<thead>
<tr>
<th>Employed</th>
<th>Self Employed</th>
<th>Housewife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>Unemployed</td>
<td></td>
</tr>
</tbody>
</table>

13. What is the family income annually (roughly)?

<table>
<thead>
<tr>
<th>3,000-5,000</th>
<th>10,000-15,000</th>
<th>20,000-25,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000-10,000</td>
<td>15,000-20,000</td>
<td>25,000 +</td>
</tr>
</tbody>
</table>
### APPENDIX 4.6

(URDU VERSION OF THE DEMOGRAPHIC QUESTIONNAIRE)

<table>
<thead>
<tr>
<th>عمر (سنوات)</th>
<th>شمردان</th>
<th>نانستین</th>
<th>مرد</th>
<th>نام مادر</th>
<th>نام پدر</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5</td>
<td>26</td>
<td>19</td>
<td>43</td>
<td>6</td>
<td>44</td>
</tr>
<tr>
<td>5 - 10</td>
<td>23</td>
<td>17</td>
<td>48</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>10 - 15</td>
<td>21</td>
<td>15</td>
<td>51</td>
<td>7</td>
<td>45</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>آگهی</th>
<th>کورس</th>
<th>آگاهی</th>
<th>کورس</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>پرستاری</th>
<th>نورپرستی</th>
<th>سرپرستی</th>
<th>شبکه</th>
<th>یکتنا نشین</th>
<th>یکتی نشین</th>
</tr>
</thead>
<tbody>
<tr>
<td>پاکستان</td>
<td>ایران</td>
<td>ایران</td>
<td></td>
<td>نپردازی</td>
<td>نپردازی</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>لقب نسبت</th>
<th>اسم</th>
<th>نام</th>
<th>عنوان</th>
</tr>
</thead>
<tbody>
<tr>
<td>یضا</td>
<td>مهربان</td>
<td>مهربان</td>
<td>مهربان</td>
</tr>
<tr>
<td>یسا</td>
<td>مهربان</td>
<td>مهربان</td>
<td>مهربان</td>
</tr>
</tbody>
</table>

348
لیا آپ میں کی بیانی؟
کیسے مزینی؟
تاکی نہیں

<table>
<thead>
<tr>
<th>کوئی دلیل</th>
<th>کوئی نہیں</th>
</tr>
</thead>
<tbody>
<tr>
<td>بذری</td>
<td>بذری</td>
</tr>
<tr>
<td>اکثری</td>
<td>اکثری</td>
</tr>
<tr>
<td>کوئی دسری</td>
<td>بچا</td>
</tr>
</tbody>
</table>
APPENDIX 4.7

Factor analysis of the ASPH

Exploratory and Confirmatory factor analyses was conducted on the 29 item-responses of the ASPH. The aim was, on the one hand, to confirm the hypothesised factor structure of the ASPH (namely, recognition of need for help, interpersonal openness, stigma tolerance and confidence in mental health practitioner) and on the other, to investigate the theoretical number of factors that would adequately fit the data.

There were two major concerns that informed the parameters set for factor analysis. Firstly, correlation coefficients tend to be less reliable when estimated from groups very much smaller than two hundred cases; therefore, it was not considered advisable to factor analyse each of the three groups separately. On the other hand, factor analysis for the sample as a whole was also not advisable because, according to Tabachnick and Fidell (1996), 'pooling results from diverse groups in factor analysis may obscure differences rather than illuminate them'.

After examination of an initial exploratory factor analysis for the three samples separately, the decision was made to factor analyse the 29-item responses of the Asian sample only (British Pakistani and Pakistanis), thereby maximising cases as well as producing a solution with the greatest scientific utility, consistency and meaning. This solution could thereafter be analysed and interpreted for cross-cultural differences between the Asians and the British sample.

A principal component analysis with VARIMAX rotation was performed for the whole sample. Accepting all components with an eigenvalue of greater than one produced nine factors, which accounted for 62.8 % of the variance. To improve adequacy of extraction and interpretability of factors, a confirmatory factor analysis was performed. Factors to be extracted were restricted to three after examining the Scree plot (Appendix 4.7) derived from this factor analysis, with a cut-off of .30 to identify loading of items on factors.

Confirmatory factor analysis accounted for 33.94% of the variance.

Factor I, with an eigen value of 5.08, accounted for 12.29% of the variance and could be interpreted as 'Self reliance and acceptance in preference to seeking help for mental
distress’.

Factor II, with an eigen value of 2.94, accounted for 11.35 % of the variance and could be interpreted as ‘Recognition of the need for help for mental distress’.

Factor III, with an eigen value of 2.07, accounted for 11.22 % of the variance and could be interpreted as 'Awareness of stigma associated with seeking help'. (Appendix 4.7).

**Factor Loadings for the 29 item Attitudes to Seeking Help Questionnaire**

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor loadings</th>
</tr>
</thead>
</table>
| **Factor I – Negative attitude to seeking help for mental distress for fear of stigmatisation**  
(eigen value 5.07, variance 12.99%)                                               |                 |
| 3. I would feel uneasy about going to a psychiatrist because of what some people might think.       | .74             |
| 14. Having been a psychiatric patient is a blot on a person’s life.                                      | .60             |
| 19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. | .57             |
| 8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. | .56             |
| 20. Having been mentally ill carries with it a burden of shame.                                             | .53             |
| 6. Considering the time and expense involved in psychotherapy, it would have doubtful value for me.         | .48             |
| 22. It is probably best not to know everything about oneself.                                               | .47             |
| 17. I resent a person - professionally trained or not - who wants to know about my personal difficulties.   | .45             |
| 29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers and priests. | .44             |
| 1. Although there are clinics for people with mental troubles, I would not have much faith in them.         | .42             |
| 15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.     | .36             |
| 21. There are experiences in my life I would not discuss with anybody.                                       | .33             |
| **Factor II – Self reliance and acceptance in preference to seeking help for with mental distress**        |                 |
| (eigen value 2.83, variance 10.69%)                                                            |                 |
| 26. A person should work out his own problems; getting psychological counselling would be a last resort.   | .66             |
| 24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help. | .66             |
| 4. A person with a strong character can get over conflicts by himself and would have little need for a psychiatrist. | .62             |
| 13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.             | .54             |
| 10. There are certain problems which should not be discussed outside of one’s family.                      | .53             |
| 9. Emotional difficulties, like many things, tend to work out by themselves.                             | .49             |
| 23. If I were experiencing a serious emotional crisis at this point in my life, I am not sure psychotherapy would have great value for me. | -.48            |
### Factor III – Recognition of need for professional psychological help

(eigenvalue 1.99, variance 10.86%)

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. I would want to get psychiatric attention if I was worried or upset for a long period of time.</td>
<td>.67</td>
</tr>
<tr>
<td>12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>.65</td>
</tr>
<tr>
<td>16. A personal with a emotional problem is not likely to solve it alone; he is likely to solve it with professional help.</td>
<td>.65</td>
</tr>
<tr>
<td>25. At some future time, I might want to have psychological counselling.</td>
<td>.49</td>
</tr>
<tr>
<td>5. There are times when I have felt completely lost and would have welcomed professional advice for a personal and emotional problem.</td>
<td>.49</td>
</tr>
<tr>
<td>7. I would willingly confide matters to an intimate matters to an appropriate person if I thought it might help me or a member of my family.</td>
<td>.49</td>
</tr>
<tr>
<td>2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.</td>
<td>.45</td>
</tr>
<tr>
<td>11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.</td>
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<td>27. Had I received treatment in a mental hospital, I would not feel that it ought to be 'covered up'.</td>
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<td>28. If I thought I needed psychiatric help, I would get it no matter who knew about it.</td>
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APPENDIX 4.8

Scree plot of items of Attitudes to Seeking Psychological Help questionnaire
This questionnaire measures how you have been feeling in the last month. Please read each item and indicate your response by crossing the appropriate circle. It is important that you answer every question.

1. **How happy, satisfied, or pleased have you been with your personal life during the past month?**

   (1) Extremely happy, could not have been more satisfied or pleased □
   (2) Very happy most of the time □
   (3) Generally satisfied, pleased □
   (4) Sometimes fairly satisfied, sometimes fairly unhappy □
   (5) Generally dissatisfied, unhappy □
   (6) Very dissatisfied, unhappy most □

2. **How much of the time have you felt lonely during the past month?**

   (1) All of the time □
   (2) Most of the time □
   (3) A good bit of the time □
   (4) Some of the time □
   (5) A little of the time □
   (6) None of the time □

3. **How often did you become nervous or jumpy when faced with excitement or unexpected situations during the past month?**

   (1) Always □
   (2) Very often □
   (3) Fairly often □
   (4) Sometimes □
   (5) Almost never □
   (6) Never □

4. **During the past month, how much of the time have you felt that the future looks hopeful and promising?**

   (1) All of the time □
   (2) Most of the time □
   (3) A good bit of the time □
   (4) Some of the time □
   (5) A little of the time □
   (6) None of the time □

5. **How much of the time, during the past month, has your daily life been full of things that were interesting to you?**

   (1) All of the time □
   (2) Most of the time □
   (3) A good bit of the time □
   (4) Some of the time □
   (5) A little of the time □
   (6) None of the time □

6. **How much of the time, during the past month, did you feel relaxed and free of tension?**

   (1) All of the time □
   (2) Most of the time □
   (3) A good bit of the time □
   (4) Some of the time □
   (5) A little of the time □
   (6) None of the time □

7. **During the past month, how much of the time have you enjoyed the things you usually do?**

   (1) All of the time □
   (2) Most of the time □
   (3) A good bit of the time □
   (4) Some of the time □
   (5) A little of the time □
   (6) None of the time □

8. **During the past month, have you had any reason to wonder if you were losing your mind, or your memory?**
9. Did you feel depressed during the past month?

(1) Yes, to the point that I did not care about anything for days ☐
(2) Yes, very depressed almost everyday ☐
(3) Yes, quite depressed several times ☐
(4) Yes, a little depressed now and then ☐
(5) No, never felt depressed at all ☐

10. During the past month, how much of the time have you felt loved and wanted?

(1) All of the time ☐
(2) Most of the time ☐
(3) A good bit of the time ☐
(4) Some of the time ☐
(5) A little of the time ☐
(6) None of the time ☐

11. How much of the time, during the past month, have you been a very nervous person?

(1) All of the time ☐
(2) Most of the time ☐
(3) A good bit of the time ☐
(4) Some of the time ☐
(5) A little of the time ☐
(6) None of the time ☐

12. When you got up in the morning, this past month, about how often did you expect to have an interesting day?

(1) Always ☐
(2) Very often ☐
(3) Fairly often ☐
(4) Sometimes ☐
(5) Almost never ☐
(6) Never ☐

13. During the past month, have you felt tense or high strung?

(1) All of the time ☐
(2) Most of the time ☐
(3) A good bit of the time ☐
(4) Some of the time ☐
(5) A little of the time ☐
(6) None of the time ☐

14. During the past month, have you been in firm control of your behaviour, thoughts, emotions, feelings?

(1) Yes, very definitely ☐
(2) Yes, for the most part ☐
(3) Yes, I guess so ☐
(4) No, not too well ☐
(5) No, and I am somewhat disturbed ☐
(6) No, and I am very disturbed ☐

15. During the past month, how often did your hands shake when you tried to do something?

(1) Always ☐
(2) Very often ☐
(3) Fairly often ☐
(4) Sometimes ☐
(5) Almost never ☐
(6) Never ☐

16. During the past month, how often did you feel that you had nothing to look forward to?

(1) Always ☐
(2) Very often ☐
(3) Fairly often ☐
(4) Sometimes ☐
(5) Almost never ☐
(6) Never ☐

17. How much of the time, during the past month, have you felt calm and peaceful?

(1) All of the time ☐
(2) Most of the time ☐
(3) A good bit of the time ☐
(4) Some of the time ☐
(5) A little of the time ☐
(6) None of the time ☐
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

18. How much of the time, during the past month, have you felt emotionally stable?
(1) All of the time □ (4) Some of the time □
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

19. How much of the time, during the past month, have you felt downhearted?
(1) All of the time □ (4) Some of the time □
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

20. How often have you felt like crying, during the past month?
(1) Always □ (4) Sometimes □
(2) Very often □ (5) Almost never □
(3) Fairly often □ (6) Never □

21. During the past month, how often did you feel that others would be better off if you were dead?
(1) Always □ (4) Sometimes □
(2) Very often □ (5) Almost never □
(3) Fairly often □ (6) Never □

22. How much of the time, during the past month, were you able to relax without difficulty?
(1) All of the time □ (4) Some of the time □
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

23. During the past month, how much of the time did you feel that your love relationships, loving and being loved, were full and complete?
(1) All of the time □ (4) Some of the time □
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

24. How often, during the past month, did you feel that nothing turned out for you the way you wanted it to?
(1) Always □ (4) Sometimes □
(2) Very often □ (5) Almost never □
(3) Fairly often □ (6) Never □

25. How much have you been bothered by nervousness, or your nerves during the past month?
(1) Extremely so, to the point where I could not take care of things □ (4) Bothered some, enough to notice □
(2) Very much bothered □ (5) Bothered just a little by nerves □
(3) Bothered quite a bit by nerves □ (6) Not bothered at all by this □

26. During the past month, how much of the time has living been a wonderful adventure

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for you?
(1) All of the time   □  (4) Some of the time   □
(2) Most of the time □  (5) A little of the time □
(3) A good bit of the time □  (6) None of the time □

27. How often, during the past month, have you felt so low that nothing could cheer you up?
(1) Always □  (4) Sometimes □
(2) Very often □  (5) Almost never □
(3) Fairly often □  (6) Never □

28. During the past month, did you ever think of taking your own life?
(1) Yes, very often □  (4) Yes, at one time □
(2) Yes, fairly often □  (5) No, never □
(3) Yes, a couple of times □

29. During the past month, how much of the time have you felt restless, fidgety or impatient?
(1) All of the time □  (4) Some of the time □
(2) Most of the time □  (5) A little of the time □
(3) A good bit of the time □  (6) None of the time □

30. During the past month, how much of the time have you been moody or brooded about things?
(1) All of the time □  (4) Some of the time □
(2) Most of the time □  (5) A little of the time □
(3) A good bit of the time □  (6) None of the time □

31. How much of the time, during the past month, have you felt cheerful, lighthearted?
(1) All of the time □  (4) Some of the time □
(2) Most of the time □  (5) A little of the time □
(3) A good bit of the time □  (6) None of the time □

32. During the past month, how often did you get upset or flustered?
(1) Always □  (4) Sometimes □
(2) Very often □  (5) Almost never □
(3) Fairly often □  (6) Never □

33. During the past month, have you been anxious or worried?
(1) Yes, extremely so, to the point of being sick or almost sick □
(2) Yes, very much so □  (5) A little bit □
(3) Yes, quite a bit □

34. During the past month, how much of the time were you a happy person?
(1) All of the time □  (4) Some of the time □
(2) Most of the time □  (5) A little of the time □
(3) A good bit of the time □  (6) None of the time □

35. How often, during the past month, did you find yourself having difficulty trying to calm down?
36. During the past month, how often have you been in low, or very low, spirits?
(1) All of the time □ (4) Some of the time □
(2) Most of the time □ (5) A little of the time □
(3) A good bit of the time □ (6) None of the time □

37. How often, during the past month, have you been getting up feeling fresh and rested?
(1) Always, every day □ (4) Some days, but usually not □
(2) Almost every day □ (5) Hardly ever □
(3) Most days □ (6) Never wake up feeling rested □

38. During the past month, have you been under, or felt you were under, any strain, stress or pressure?
(1) Yes, almost more than I could stand or bear □ (4) Yes, some, about normal □
(2) Yes, quite a bit of pressure □ (5) Yes a little bit □
(3) Yes, some, more than usual □ (6) No, not at all □
APPENDIX 5.2
(URDU VERSION OF THE MHI)

(1) پیغام نشر - مطالعہ اور نوش - موضوع اور ہدف
(2) نشر
(3) ادبیات
(4) جغرافیہ
(5) تاریخ
(6) تمثیل نشر
(7) مطالعہ

(1) پیغام نشر - مطالعہ اور نوش - موضوع اور ہدف
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(2) نشر
(3) ادبیات
(4) جغرافیہ
(5) تاریخ
(6) تمثیل نشر
(7) مطالعہ

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<tr>
<th>کیچ ہیں میں کتنے ہے آپ کو ہماویں کے کام کرنا ہے میں زروآں</th>
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<td>(2) ہوئے وقت</td>
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(۳۳) چپہ سنی میں گارڈ آپ کو محسوس نہ ہونے کے لیے کئی نیاز کیوں نے لے کم ہو رہے ہیں?
(۱) پوج ئے وقت
(۲) ہوا
(۳) ہوئے وقت

(۳۴) چپہ سنی میں گارڈ آپ کو محسوس ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا؟
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۳۵) چپہ سنی میں آپ کا محسوس ہونے سے چوہتہ پرنا نے کی?
(۱) تحقیق یا فن کے تک کر
(۲) کوئی چیز
(۳) نیا شہر
(۴) صنعت
(۵) عادت

(۳۶) چپہ سنی میں آپ کو محسوس نہ ہونے کے لیے آپ کا چہوڑنے کا تجربہ چاہتا ہیں؟
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۳۷) چپہ سنی میں گارڈ آپ کو محسوس نہ ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا?
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۳۸) چپہ سنی میں آپ کو محسوس نہ ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا؟
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۳۹) چپہ سنی میں آپ کو محسوس نہ ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا؟
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۴۰) چپہ سنی میں آپ کو محسوس نہ ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا?
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا

(۴۱) چپہ سنی میں آپ کو محسوس نہ ہونے کے لیے آپ کا جنگجو اپنی تجاویز پر کام کیا؟
(۱) پوج ئے
(۲) ہوا
(۳) ہوئے وقت
(۴) حالات
(۵) للہ کا خوش ہوا
Many people suffer mental distress/mental illness in their lives. People can experience and manifest mental distress/mental illness in many ways. Such distress can be mild or severe. Sometimes they feel sad or anxious. Sometimes they are unable to cope. Or sometimes they are out of touch with what is going on around them. They may have experiences of strange beliefs. Sometimes their behaviour becomes disorganised. They may become destructive towards themselves or others.

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

How likely is it that the following causes could contribute. There is no right or wrong answer. Please circle the appropriate point for each item (from 'not at all likely' (1) to 'highly likely' (7). You should respond to every item even if you are not sure. Please feel free to write any comments you would like to make at the end.
APPENDIX 5.4

(URDU VERSION OF INSTRUCTIONS WITH THE MDEMQ)
(SEE APPENDIX 4.2 FOR THE URDU VERSION OF THE MDEMQ)

دیاگو ضروری بیلی کے لئے مثالی سوالات

ار فرمول ہے:

یہ لوگ ایسے زندگی کی دنیا میں بہت چھوٹے ہیں. لیکن کہ دیکھیں اس کے بارے میں:

اہم حالات کے طور پر نہ وہ پہنچ چکے ہیں. لیکن وہ اس دن ہاتھ کی ہدایتکاری سے ہر شروع میں ہوئی ہے:

لیکن دیکھیں اور پرینسپل کا قریبی اس کے بارے میں۔ اگر وہ اس کے قریبی اس کی پہلی بار رہا ہے۔ اگر ہے، تجربہ کے بارے میں کہا ہے، سلسلہ میں کعبہ (کے ہاتھ) جانے والی وہ قومی باب حرم میں جا سکتی ہے۔

یہ سوالات اور یہ جوابات نئے، ناہنی اور ناہنی سوالات ہو گی گیج ہو گی، جس سے بات کہ ہر جواب بات کہ ہے۔

اپنی سوالات، اپنی اچھی قسم سوالات گیا ہے گی جس سے بات کہ ہر جواب بات کہ ہے۔

ار دوبارہ،

لہذا دماغی بیلی سے لوگوں کے سوالات سے سمجھا گیا ہے کہ چھوٹے، گھروں کے بچوں نے ہدایتکاری کے سوالات سے سمجھا گیا ہے۔

جدی دلیل کے ذریعہ اس کی بات کہ بنی سوالات کی ہے۔ وہی سوالات ہے جس سے بات کہ ہر جواب بات کہ ہے۔

یہ سوالات ہر کسی کو سوالات ہوں گیں، اس لئے اس کو دکھایا جائے گا۔

آپ یہ سوالات کا کوئی جواب دینے ہیں؟ اسے جواب دینے ہیں؟ (دیکھ کر مہم ہوئی)۔

لگنے جا کر لگنے جا کر مسلم ہوں گے۔
APPENDIX 5.5
(ENGLISH VERSION OF THE PATHWAYS TO SEEKING HELP QUESTIONNAIRE)

This questionnaire measures what would you consider the most appropriate way of seeking help for mental health problems. The choices include:

Consulting a doctor or GP? Talking to a mullah, pir or priest? Consulting a psychologist?
Consulting a hakim, a vaid or another alternative healer? Saying prayers? Consulting a psychiatrist?
Self-reliance and acceptance in preference to seeking help for mental distress? Taking medicine?
Talking to family member/s? Consulting a psychotherapist?

Please read each item and indicate your response that best represents your attitude to each of the choices given below by ticking the appropriate number.

<table>
<thead>
<tr>
<th>Most Inappropriate</th>
<th>Quite Inappropriate</th>
<th>Neither Inappropriate Nor Appropriate</th>
<th>Quite Appropriate</th>
<th>Most Appropriate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Consulting a psychotherapist?
Talking to a mullah, pir or priest?
Consulting a doctor or GP?
Self-reliance and acceptance in preference to seeking help for mental distress?
Consulting a psychiatrist?
Talking to family member/s?
Taking medicine?
Saying prayers?
Consulting a psychologist?
Consulting a hakim, vaid or another alternative healer?

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APPENDIX 5.6
(URDU VERSION OF THE PATHWAYS TO SEEKING HELP QUESTIONNAIRE)

Have you had a feeling of constriction of your head, is it surging forward, or has it dropped behind?

Have you had any symptoms of discomfort in your neck, is it painful and sometimes goes down your spine?

Have you felt a tightness or pressure in your head, like you are being squeezed or pressed tightly in front of your eyes?

Have you had any symptoms of vision loss or blurring of vision?

Have you had a feeling of constriction in your throat, is it dry or painful?

Have you had a feeling of constriction in your chest, is it painful or sometimes goes down your spine?

Have you felt a tightness or pressure in your chest, like you are being squeezed or pressed tightly in front of your eyes?

Have you had any symptoms of vision loss or blurring of vision?

Have you had a feeling of constriction in your chest, is it painful or sometimes goes down your spine?

Have you felt a tightness or pressure in your chest, like you are being squeezed or pressed tightly in front of your eyes?

Have you had any symptoms of vision loss or blurring of vision?
We should like to know if you have had any body symptoms over the past month. Please answer all the questions simply by ticking the appropriate box. Remember that we want to know about the past month, not symptoms you have had before that. It is important that you try to answer all the questions. Thank you very much for your co-operation.

**“ During the past month . . . . . . . ”**

<table>
<thead>
<tr>
<th>Question</th>
<th>Absent</th>
<th>Present on LESS than 15 days in past month</th>
<th>Present on MORE than 15 days in past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had severe headaches?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you had fluttering or a feeling of something moving in your stomach?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you had pain or tension in your neck and shoulders?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has your skin been burning or itching all over?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you had a feeling of constriction of your head, as if it was being gripped tightly from outside?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you felt pain in the chest or heart?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has your mouth or throat felt dry?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has there been darkness or mist in front of your eyes?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you felt a burning sensation in your stomach?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you felt a lack of energy (weakness) much of the time?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has your head felt hot or burning?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you been sweating a lot?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you felt as if there was pressure or tightness on your chest or heart?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you been suffering ache or discomfort in the abdomen?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Has there been a choking sensation in your throat?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have your hands or feet had pins and needles or gone numb?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you felt aches or pains all over the body?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Have you had a feeling of heat inside your body?</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

continued overleaf . . . .
During the past month...

<table>
<thead>
<tr>
<th>Question</th>
<th>Absent</th>
<th>Present on less than 15 days in past month</th>
<th>Present on more than 15 days in past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you been aware of palpitations (heart pounding)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt pain or burning in your eyes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you suffered from indigestion?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been trembling or shaking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been passing urine more frequently?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been having low back trouble?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your stomach felt swollen or bloated?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your head felt heavy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been feeling tired, even when you are not working?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been getting pain in your legs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been feeling sick in the stomach (nausea)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a feeling of pressure inside your head, as if your head was going to burst?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had difficulty in breathing, even when resting?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt tingling (pins and needles) all over the body?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been troubled by constipation?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Have you wanted to open your bowels (go to the toilet) more often than usual?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Have your palms been sweating a lot?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had difficulty in swallowing, as if there was a lump in your throat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been feeling giddy or dizzy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a bitter taste in your mouth?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your whole body felt heavy?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a burning sensation when passing urine?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Have you been hearing a buzzing noise in your ears or head?</td>
<td></td>
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</tr>
<tr>
<td>Has your heart felt weak or sinking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you suffered from excessive wind (gas) or belching?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have your hands or feet felt cold?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 6.2

(URDU VERSION OF THE BRADFORD SOMATIC INVENTORY)

<table>
<thead>
<tr>
<th>نمبر</th>
<th>سوال</th>
<th>جانب</th>
<th>جانب</th>
<th>جانب</th>
<th>جانب</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>کا یاپک کارس مندرج ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2</td>
<td>کا یاپک کارس معنی متعارف ہے کہ کہ کالم کا کارس متعارف ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3</td>
<td>کا یاپک کارس معنی سرمایہ ہے کہ کہ کالم کا کارس سرمایہ ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4</td>
<td>کا یاپک کارس توانائی ہے کہ کہ کالم کا کارس توانائی ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>8</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12</td>
<td>کا یاپک کارس کنیا ہے کہ کہ کالم کا کارس کنیا ہے؟</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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Appendix 6.3
(English Version of the General Health Questionnaire)

Please read this carefully:

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

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently:

1 — been feeling perfectly well and in good health?
   Better than usual | Same as usual | Worse than usual | Much worse than usual

2 — been feeling in need of a good tonic?
   Not at all | No more than usual | Rather more than usual | Much more than usual

3 — been feeling run down and out of sorts?
   Not at all | No more than usual | Rather more than usual | Much more than usual

4 — felt that you are ill?
   Not at all | No more than usual | Rather more than usual | Much more than usual

5 — been getting any pains in your head?
   Not at all | No more than usual | Rather more than usual | Much more than usual

6 — been getting a feeling of tightness or pressure in your head?
   Not at all | No more than usual | Rather more than usual | Much more than usual

9 — been having hot or cold spells?
   Not at all | No more than usual | Rather more than usual | Much more than usual

14 — lost much sleep over worry?
   Not at all | No more than usual | Rather more than usual | Much more than usual

18 — had difficulty in staying asleep once you are off?
   Not at all | No more than usual | Rather more than usual | Much more than usual

21 — been managing to keep yourself busy and occupied?
   More so than usual | Same as usual | Rather less than usual | Much less than usual

22 — been taking longer over the things you do?
   Quicker than usual | Same as usual | Longer than usual | Much longer than usual

28 — felt on the whole you were doing things well?
   Better than usual | About the same | Less well than usual | Much less well

30 — been satisfied with the way you’ve carried out your task?
   More satisfied | About same as usual | Less satisfied than usual | Much less satisfied
**HAVE YOU RECENTLY:**

<table>
<thead>
<tr>
<th>Question</th>
<th>More so than usual</th>
<th>Same as usual</th>
<th>Less useful than usual</th>
<th>Much less useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>35 — felt that you are playing a useful part in things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 — felt capable of making decisions about things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39 — felt constantly under strain?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 — been able to enjoy your normal day-to-day activities?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44 — been getting edgy and bad-tempered?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45 — been getting scared or panicky for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47 — found everything getting on top of you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51 — been thinking of yourself as a worthless person?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52 — felt that life is entirely hopeless?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55 — been feeling nervous and strung-up all the time?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56 — felt that life isn’t worth living?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 — thought of the possibility that you might make away with yourself?</td>
<td></td>
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<tr>
<td>8 — found at times you couldn’t do anything because your nerves were too bad?</td>
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<tr>
<td>9 — found yourself wishing you were dead and away from it all?</td>
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<tr>
<td>0 — found that the idea of taking your own life kept coming into your mind?</td>
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</tbody>
</table>
APPENDIX 6.4
(URDU VERSION OF THE GENERAL HEALTH QUESTIONNAIRE)

<table>
<thead>
<tr>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
</tr>
</thead>
<tbody>
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<td>ما کوٹر</td>
<td>ما کوٹر</td>
</tr>
</tbody>
</table>

1. ہر ایک ہدف کا جواب دیں ہے۔
2. ہر ایک ہدف کا جواب دیں ہے۔
3. ہر ایک ہدف کا جواب دیں ہے۔
4. ہر ایک ہدف کا جواب دیں ہے۔
5. ہر ایک ہدف کا جواب دیں ہے۔
6. ہر ایک ہدف کا جواب دیں ہے۔
7. ہر ایک ہدف کا جواب دیں ہے。
8. ہر ایک ہدف کا جواب دیں ہے۔
9. ہر ایک ہدف کا جواب دیں ہے。
10. ہر ایک ہدف کا جواب دیں ہے。
11. ہر ایک ہدف کا جواب دیں ہے。
12. ہر ایک ہدف کا جواب دیں ہے。
13. ہر ایک ہدف کا جواب دیں ہے。

374
<table>
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<tr>
<th>ما کچھ الگا ہے</th>
<th>ما کچھ الگا ہے</th>
<th>ما کچھ الگا ہے</th>
</tr>
</thead>
<tbody>
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<td>ما کچھ الگا ہے</td>
</tr>
</tbody>
</table>

64 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
65 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
66 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
67 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
68 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
69 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
70 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے
71 کچھ سروراگی ہو گیا ہے جو اسی پریس پر موجود ہے

375
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<thead>
<tr>
<th>درصد</th>
<th>توضیحات</th>
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</thead>
<tbody>
<tr>
<td>10</td>
<td>توضیحات 1</td>
</tr>
<tr>
<td>20</td>
<td>توضیحات 2</td>
</tr>
<tr>
<td>30</td>
<td>توضیحات 3</td>
</tr>
<tr>
<td>40</td>
<td>توضیحات 4</td>
</tr>
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<td>توضیحات 5</td>
</tr>
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<td>توضیحات 7</td>
</tr>
<tr>
<td>80</td>
<td>توضیحات 8</td>
</tr>
<tr>
<td>90</td>
<td>توضیحات 9</td>
</tr>
</tbody>
</table>

**توجه:** تصویر این صفحه به‌طور خاص برای اینکه از اطلاعات جمع‌آوری شده در آن بهره‌برداری شود و بررسی سطحی از آن حاصل شود تهیه شده است.
APPENDIX 6.5
(ENGLISH VERSION OF ATTITUDE TO DOCTOR AND CAUSAL BELIEFS ABOUT ONE'S ILLNESS QUESTIONNAIRE)

Please tick the questions below.

1. How many times have you seen the doctor in the past year?

<table>
<thead>
<tr>
<th>Once</th>
<th>2-3 times</th>
<th>More than three times</th>
</tr>
</thead>
</table>

2. Do you think it is appropriate to tell a doctor when you feeling anxious or sad?

<table>
<thead>
<tr>
<th>Definitely Yes</th>
<th>Probably Yes</th>
<th>Probably No</th>
<th>Definitely No</th>
</tr>
</thead>
</table>

3. How often have you talked to the doctor when you were feeling anxious or sad?

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

4. Do you think that the problems or symptoms for which you want to consult the doctor are due to any of the following:

<table>
<thead>
<tr>
<th>Bad nerves in the body</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The effects of old age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetic or inherited defect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being born this way</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical imbalance in the brain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brain damage or head injury</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please continue overleaf)
| Being hot but not from climate or temperature |
| Wind or gas or currents flowing through the body |
| Eating food which is wrong for that person |
| The person's body being out of balance |
| One or more of person's vital organs being disrupted |
| Bad experiences during childhood |
| Intentionally physically harmed by another person |
| Exposure to a fright or shock |
| Pace of modern life |
| Having had an accident |
| Death of a relation or close friend |
| Migration to a new country |
| Not having enough money |
| Too much work or study |
| Conflict or break-up of family relationships |
| Unemployment |
| Contact with something or someone taboo |
| The person had bad or ominous dream or sensation |
| Bad luck or chance |
| Doing the wrong thing during pregnancy |
| Failure to properly observe rituals after giving birth |
| Birth control against religion and culture |
| Doing the wrong thing when menstruating |
| Astrological destiny |
| The person's karma |
| A dangerous unprovoked spirit |
| Spirit angry because someone did something wrong |
| Person's soul leaving the body and becoming scattered |
| Contact with something / someone dangerous / unclean |
| Doing something forbidden by social or cultural rules |
| Someone unwittingly casting a spell |
| Someone wanting to hurt person by casting spell |
| Someone engaging a witch/shaman to cast spell |
| The person seeing/hearing/feeling something ominous |
APPENDIX 6.6
(URDU VERSION OF ATTITUDE TO DOCTOR AND CAUSAL BELIEFS ABOUT ONE’S ILLNESS QUESTIONNAIRE)

ابدہ سال کے پہلے ہیں؟ اپنے طبی دفتریں کا دفتر کا دفتر

* ابتدا خانہ سے کب ہے؟* ہیں سے پہلے اپنے دفتر سے دتے باد

<table>
<thead>
<tr>
<th>شاپرے</th>
<th>شاپریان</th>
<th>لفظیات</th>
</tr>
</thead>
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کیا رفع کیے ہوں؟ اپنے دفتریں کی دفتر سے کب باد

<table>
<thead>
<tr>
<th>کثیریہ</th>
<th>ملک</th>
<th>نقل</th>
</tr>
</thead>
</table>

ابدہ نے خانہ سے کب ہے؟ دفتر سے دتے باد؟

بہت ہیں ہیں دفتریں سے

<table>
<thead>
<tr>
<th>قبضہ</th>
<th>قبضہ مالی</th>
<th>قبضہ مالی</th>
</tr>
</thead>
</table>

کسی دفتریے نہیں؟ اپنے دفتریں ہیں سے پہلے

<table>
<thead>
<tr>
<th>کیا ہے</th>
<th>نہیں</th>
<th>نہیں</th>
</tr>
</thead>
</table>

کسی کافر نہیں؟ دفتر سے دتے باد

<table>
<thead>
<tr>
<th>ہے</th>
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<th>نہیں</th>
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کسی حساب نہیں؟ دفتر سے دتے باد

<table>
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<th>نہیں</th>
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</thead>
</table>

کسی نیک ون نہیں؟ دفتر سے دتے باد

<table>
<thead>
<tr>
<th>ہے</th>
<th>نہیں</th>
<th>نہیں</th>
</tr>
</thead>
</table>
پہلے بیٹھنا

پہلے بیٹھنا

ہمارے دو دل کے لئے مرا

ہمارے دو دل کے لئے مرا

رب نے ہمارے دو دل کو مرا

رب نے ہمارے دو دل کو مرا

ہمارے دو دل کو مرا

ہمارے دو دل کو مرا

ہمارے دو دل کو مرا

ہمارے دو دل کو مرا

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ہمارے دو دل کو مرا

ہمارے دو دل کو مرا

ہمارے دو دل کو مرا
APPENDIX 6.7

Factor analysis of the GHQ

Exploratory and Confirmatory factor analyses was conducted on the responses of the 28-item GHQ. The aim was, on the one hand, to confirm the hypothesised factor structure of the GHQ for this sample, and on the other, to investigate the theoretical number of factors that would adequately fit the data. In view of the fact that the sample, in this study, was relatively small, the decision was made to factor analyse the 28-item responses of the entire sample thereby maximising cases.

A principal component analysis with VARIMAX rotation was performed for the whole sample. Accepting all components with an eigenvalue of greater than one produced four factors, which accounted for 67.16% of the variance. These four factors extracted from the GHQ for this sample, with a cut-off of .40 to identify loading of items, were taken as the sub-scales of the GHQ.

Factor extraction of the GHQ-28, for this sample, did not exactly replicate the four factors of the GHQ-28. The order of the factors in the emerging factor structure was somewhat different to that hypothesised by Goldberg (1972). However, the four factors extracted for this sample corresponded, by and large, to Goldberg’s original sub-scales, although there were some differences in the composition of the sub-scales.

Factor I, with an eigen value of 14.14, accounted for 50.49% of the variance. Although it corresponded to the original ‘anxiety and insomnia’ sub-scale of the GHQ, with all five ‘anxiety’ items, the two ‘insomnia’ items did not load on to this factor. It also had three items from the original ‘severe depression’ scale (‘thinking yourself as worthless’, ‘life entirely hopeless’ and ‘life not worth living’), and a weak loading from a ‘social dysfunction’ item (enjoy normal activity). This factor was interpreted as ‘anxiety and unhappiness’.

Factor II, with an eigen value of 1.83, accounted for 6.53% of the variance, and corresponded to the ‘somatic’ scale of the GHQ. It consisted of five ‘somatic items’ and two ‘insomnia’ items, (‘lost sleep over worry’ and ‘difficulty staying asleep’). Two items from the original sub-scale of ‘somatic symptoms’ loaded onto the fourth factor. Nevertheless, this factor was interpreted as ‘somatic symptoms’.
Factor III, with an eigen value of 1.60, accounted for 5.72% of the variance and corresponded closely to the ‘social dysfunction’ scale. It consisted of six of the original items from that scale. One item from the original scale loaded onto the first factor of ‘anxiety and unhappiness’. This factor was therefore interpreted as ‘social dysfunction’, as in the 28-item GHQ.

Factor IV, with an eigen value of 1.24, accounted for 4.42% of the variance. This factor corresponded to the ‘severe depression’ scale of the GHQ. It consisted of four items from the original scale as well as two items from the ‘somatic symptoms’ scale of the GHQ, (‘pains in head’ and ‘pressure in your head’). This was interpreted as ‘suicidal thoughts’.

Table 6.4 Factor Loadings for the 28 item General health Questionnaire

<table>
<thead>
<tr>
<th>Items of the GHQ</th>
<th>Factor loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factor I – Anxiety and unhappiness</strong></td>
<td>eigenvalue 14.14, 50.49% of the variance</td>
</tr>
<tr>
<td>Felt constantly under strain</td>
<td>.70</td>
</tr>
<tr>
<td>Been able to enjoy your normal day to day activities</td>
<td>.41</td>
</tr>
<tr>
<td>Been getting edgy and bad tempered</td>
<td>.74</td>
</tr>
<tr>
<td>Been getting scared or panicky for no good reason</td>
<td>.60</td>
</tr>
<tr>
<td>Found everything getting on top of you</td>
<td>.75</td>
</tr>
<tr>
<td>Been feeling nervous and strung up all the time</td>
<td>.63</td>
</tr>
<tr>
<td>Thinking of yourself as a worthless person</td>
<td>.70</td>
</tr>
<tr>
<td>Felt that life is entirely hopeless</td>
<td>.60</td>
</tr>
<tr>
<td>Felt that life is not worth living</td>
<td>.66</td>
</tr>
<tr>
<td><strong>Factor II – Somatic symptoms and insomnia</strong></td>
<td>eigenvalue of 1.83, 6.53% of the variance</td>
</tr>
<tr>
<td>Been feeling perfectly well and in good health</td>
<td>.60</td>
</tr>
<tr>
<td>Been feeling in need of a good tonic</td>
<td>.61</td>
</tr>
<tr>
<td>Been feeling run down and out of sorts</td>
<td>.78</td>
</tr>
<tr>
<td>Felt that you are ill</td>
<td>.63</td>
</tr>
<tr>
<td>Been having hot or cold spells</td>
<td>.52</td>
</tr>
<tr>
<td>Lost much sleep over worry</td>
<td>.60</td>
</tr>
<tr>
<td>Had difficulty in staying asleep once you are off</td>
<td>.71</td>
</tr>
</tbody>
</table>
### Factor III – Social dysfunction

<table>
<thead>
<tr>
<th>Item</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been managing to keep yourself busy and occupied</td>
<td>.67</td>
</tr>
<tr>
<td>Been taking longer over the things you do</td>
<td>.50</td>
</tr>
<tr>
<td>Felt that on the whole you are doing things well</td>
<td>.75</td>
</tr>
<tr>
<td>Been satisfied with the way you have carried out tasks</td>
<td>.65</td>
</tr>
<tr>
<td>Felt that you are playing a useful part in things</td>
<td>.77</td>
</tr>
<tr>
<td>Felt capable of making decisions about things</td>
<td>.78</td>
</tr>
</tbody>
</table>

Eigenvalue of 1.60, 5.72% of the variance

### Factor IV – Suicidal thoughts

<table>
<thead>
<tr>
<th>Item</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been getting pains in your head</td>
<td>.53</td>
</tr>
<tr>
<td>Been getting a feeling of tightness or pressure in your head</td>
<td>.52</td>
</tr>
<tr>
<td>Thought of the possibility that you might make away with yourself</td>
<td>.76</td>
</tr>
<tr>
<td>Found that you could not do anything because your nerves were too bad</td>
<td>.52</td>
</tr>
<tr>
<td>Found yourself wishing you were dead and away from it all</td>
<td>.65</td>
</tr>
<tr>
<td>Found that the idea of taking your own life kept coming into your head</td>
<td>.84</td>
</tr>
</tbody>
</table>

Eigenvalue of 1.24, 4.42% of the variance

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383
### Factor III – Social dysfunction

<table>
<thead>
<tr>
<th>Item</th>
<th>Eigenvalue</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Been taking longer over the things you do</td>
<td>.50</td>
</tr>
<tr>
<td>Felt that on the whole you are doing things well</td>
<td>.75</td>
</tr>
<tr>
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<td>.65</td>
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<tr>
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</tr>
<tr>
<td>Felt capable of making decisions about things</td>
<td>.78</td>
</tr>
</tbody>
</table>

Eigenvalue of 1.60, 5.72% of the variance

### Factor IV – Suicidal thoughts

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<th>Item</th>
<th>Eigenvalue</th>
</tr>
</thead>
<tbody>
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<td>.84</td>
</tr>
</tbody>
</table>

Eigenvalue of 1.24, 4.42% of the variance