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Depression in women in Dubai : an exploratory study of symptoms, concepts and coping strategies.

Sulaiman, Sultana Othman Yousof

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DEPRESSION IN WOMEN IN DUBAI:

AN EXPLORATORY STUDY OF

SYMPTOMS, CONCEPTS AND COPING STRATEGIES

By

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Thesis submitted for the degree of Doctor of Philosophy

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ABSTRACT

Reports on the language of emotion suggest that one group's concept of depression may differ from another group's. Many non-Western groups do not appear to have emotional terms equivalent to the English word 'depression'. Hence, applying categories that were developed for a particular culture to members of another culture (or mixing elements from different realms), on the incorrect assumption that they are like in kind, will cause a category fallacy. Until recently, psychiatrists in Dubai used the Western symptomatologies of depression, since insufficient data existed to indicate whether the same depressive symptoms are present in the native population in Dubai.

In the present project, an attempt was made to respond to the needs highlighted by reviews of cross-cultural studies. This dissertation reports an exploratory investigation of depression in women in Dubai. The main aims of the study were: (a) to investigate depression in women in Dubai, and to explore its association with socio-demographic variables such as age and marital, educational, occupational, and socio-economic status; (b) to assess the symptom profile of depression in this population; (c) to explore the concept of depression among the native people of Dubai through the vocabularies used by them to express feelings of sadness or depression; (d) to explore the coping strategies that women in Dubai use to deal with depression; and (e) to develop an instrument for measuring depression in the indigenous language of Dubai (Arabic) using emic models of understanding.

Four inter-related studies were carried out. The first was a pilot investigation, in a clinical population, of symptoms of depression and their association with socio-demographic variables. Fifty-six native female patients were interviewed at Rashid Hospital in Dubai. The results showed that whenever level of education or socio-economic status are low, severer depressive symptoms appear. The study also showed that patients in Dubai tend to score higher on the somatic symptoms of depression than on the psychological symptoms. The second study investigated symptoms of depression, and strategies used for coping with depression, in a community sample of 100 native females randomly selected from the community, or selected by a snowball technique. Results showed that severer forms of depression appear in housewives and in low-income groups, and that the major components of depression in this sample are sadness, dissatisfaction, self-accusation, irritability, and fatigability. The study of strategies for coping with depression showed that those preferred by women in Dubai are domestic work, religious behaviour, and self-care activities.

The third study explored the concepts of depression, and the words and expressions denoting depressed mood. A community sample of 20 native males and 20 native females was recruited for four focus group sessions; a further 100 native males and 100 native females were selected, also from the community, to list the expressions that they use for their feelings. The results of this study led to a checklist of indigenous Arabic words used in Dubai to express depressed feelings.

In the fourth study, this new checklist was piloted with a clinical and community sample, using a standardized and well-established instrument as a comparison. Fifteen native

female patients were interviewed at Rashid Hospital, and 100 native females were selected from the community. The results showed that the new instrument was sensitive as a measure of depressive symptoms among the clinical and community samples and was easily understood by subjects.

Our findings show that native expressions of depression exist in Dubai; mental health professionals should be encouraged to use them.

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DEDICATION

To my *Grandmother*, who developed in my mind the thought that the real power in a woman is in her strong will which leads her to be what she wants to be.

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Chapter 1

Introduction

1.1. General introduction

The discovery of oil in the United Arab Emirates (UAE) turned a traditional society into a very wealthy one in less than a generation. These developments have exposed the people to the influence of many nationalities, and to modern Western culture in particular.

New patterns of life in response to the rapid socioe-conomic developments have begun to change and disrupt the traditional support systems in the society of the UAE. The impact of the changes on the population has been very strong, and they have not had adequate time to fully absorb and evaluate its consequences. Thus there are culture conflicts, and value conflicts.

The changes are still proceeding apace and the results of such rapid and extensive change include the disorganization of society and a disruption of customs, communication, authority systems, traditional ways of co-operation and shared values, such that serious moral and other problems emerge (Ghubash, 1992).

The negative factors of this development phase have social aspects which are related

directly to women's lives. For instance, family ties have become weakened; polygamy and divorce are becoming increasingly significant social problems, and have created a large number of single-parent families, which now comprise 10% of all families. Furthermore, men are more often marrying women from different nationalities and cultures, and the numbers of older men marrying younger women have increased (see Chapter 3).

Nevertheless, many positive factors have also influenced women in the UAE during this development phase, beginning with equal educational and social opportunities. Women are becoming recognized as independent personalities as they assume roles outside the family and contribute to their society. Their position within the family is correspondingly elevated (Soffan, 1986).

It is interesting also to note that women in the UAE constitute less than 32% of the entire population. The male-to-female birth ratio is 103:100, which approximates to that found in other countries. Female adult literacy is currently two-thirds that of the male population; and the number of women in the work-force is 3.3% of the total (Ghubash, 1992). However, prospects for higher levels of participation in the labour force are clear, even though female levels of representation are still low (Soffan, 1986).

Overall, there are many studies that suggest that social change, stressful life events and women's position in society create vulnerability to psychological and psychiatric disorders (e.g., Bebbington, 1978; Kleinman & Good, 1985; Ghubash, 1992); depression is the most common of these (see Chapter 3, section 3.6).

A large number of studies of mental illness focus on empirical descriptions, but there are few cross-cultural comparisons. During the past two decades, there has been considerable research interest in cross-cultural variations in the epidemiology of depression. However, owing to limitations in currently available research methods and other reasons, we still know little about the nature and prevalence of depression across cultures (Marsella, 1987). There are strong theoretical reasons to believe that both the level and manifestation of depression vary significantly across cultures (Kleinman, 1985, 1986; Marsella, 1987) (see Chapter 2).

1.2. Anthropological Factors

Kleinman (1987) has noted that for ethnographical comparisons, anthropology is essentially a field of detailed, intensive, single-culture studies in which comparisons are made by a review of the literature on other cultures rather than by controlled cross-cultural comparisons. He also stated that anthropological research points to the importance of studies of mental illness in one culture in deepening our understanding of cultural differences.

The application of categories developed for a particular cultural group to members of another culture will produce a category fallacy. Kleinman (1987) has stated that to avoid category fallacies, cross-cultural research must be grounded in the local ethnographic context _that is, he advocates the emic approach.

Fetterman (1989) has stated that it is important for researchers using an ethnographic

approach to start collecting data from the emic perspective, then try to make sense of what we have collected in terms of both the native's view and our own scientific analysis. Just as thorough fieldwork requires an insightful and sensitive cultural interpretation combined with rigorous data collection techniques, so good ethnography requires both emic and etic perspectives (see Chapter 2, section 2.3.2).

1.3. Studies in Dubai

Overall, many studies have examined whether levels of psychological distress are higher in some cultural settings than in others (Zung, 1977, cf. Krause & Liang, 1992). Other studies have concerned the potential differences in the way symptoms of distress are manifested in diverse cultural settings (Marsella, 1987, cf. Krause & Liang, 1992). Although researchers have identified potentially important cross-cultural variations in both the prevalence and presentation of symptoms of psychological distress in different societies, until recently there have been no quantitative data in the UAE to indicate whether significant depressive symptomatology is present in the native female population _and, if it is, what its nature is and whether it manifests itself differently from depression in women from other cultures.

It proved especially difficult to find empirical studies on the prevalence of depressive symptoms among women in Dubai. In fact, only two studies in English could be identified on this topic. The first (Ghubash, 1992) fortunately focused on the morbidity of mental illness among women in Dubai and provided data for depression in women. It indicated that depression is the most common mental disorder in women in Dubai (13%

of the sample).

The second study (Ghareeb, 1992) examined the nature of adolescent depression in the UAE, and indicated that the adolescent distribution seems to depart from normality towards low levels of depression; no age differences were found in this population, but a gender difference in depression was apparent. Adolescent girls have higher depression scores than adolescent boys, and the male-to-female ratio of depressed subjects is approximately 2:3. This result agrees with many previous studies which have indicated that the rate of depression among women in most societies is approximately twice the rate among men (e.g., Myers & Weissman, 1976, cf. Brodsky & Hare-Mustin, 1980; Weissman & Klerman, 1977, cf. Brodsky & Hare-Mustin, 1980; Kleinman, 1986; Hill, Murray, & Thorley, 1989; Ashurst & Hall, 1991; MIND, 1992; Andrew, Hawton, Fagg, et al., 1993).

Some of these studies suggest that certain circumstances and women's position in society create vulnerability to depression (MIND, 1992). Others have investigated socio-demographic variables, stressful life events and insufficient social support as factors which contribute to this higher incidence of depression among women (e.g., Bebbington, 1978; Weissman, Myers, & Thompson, 1981; Kleinman & Good, 1985; Mahatme, Dhavale, & Patkar, 1989; Avasthi, Khan, & Elroey, 1991; Olfson & Klerman, 1992; Lehtinen & Joukamaa, 1994; Paykel, 1994). Stoppard (1989) and Moretti & Meichenbaum (1989) (cf. Dion & Giordano, 1990) have pointed to societal discrimination and the disadvantaged socio-economic status of women in society as perhaps the key factors underlying the development of learned helplessness and the

greater proneness of women than men to depression.

Depression is the most common mental disorder (e.g., Lehtinen & Joukamaa, 1994; Nakane, Ohta, Radford, et al., 1991; Carta, Carpiniello, Morosini, et al., 1991; Weissman Myers, & Thopson, 1981; Ghubash, 1992; Fuhrer, Antonucci, Gagnon, et al., 1992; Gupta, Singh, Verma, et al., 1991) (see Chapter 2, section 2.2.3). Interest in depression stems not only from this high prevalence but also from the problems in its treatment.

The UAE, and especially Dubai, is a multicultural nation in which customs, habits and social structure vary markedly for people of different racial and ethnic groups. Hence, it is important to have quantitative data about the prevalence of depression among women in Dubai and the nature of its symptoms in different ethnic groups, and about the cultural and social factors that affect presentation, symptoms, the account of their illness that sufferers give to the psychiatrist and their subsequent response to treatment (see Chapter 5).

As mentioned above, socio-cultural change in UAE society has been rapid and comprehensive. This change was not planned, but spontaneous and largely haphazard. The process of change that took two centuries in Western societies took only twenty years in the UAE. Such changes seem to have shaken the infrastructure of society, societal norms and traditions, and may be manifested in an increase in psychological distress.

Ghubash (1992) has observed that in the UAE there is a possible age and gender divergence in relation to social change, with younger women welcoming the possibilities

offered by the social and economic changes, especially the images offered by the mass media, while older women and men may look back fondly on traditional ways.

Although there is some evidence regarding the prevalence of depression among women in Dubai, there have been insufficient data about its symptoms among the women of this culture, their concept of depression and how they cope with it. It may be postulated that an exploratory investigation into the symptoms of depression among depressed patients is an essential precursor for further investigations about symptoms, concept and coping strategies among subjects in the community.

1.4. Direction of The Present Study

The present study adopted the step-by-step model as the superordinate model which allowed for answering most of the research questions. Theoretically, investigators of such topics must specify, and then operationalize, a number of characteristics of each topic. The decisions are further determined by limitations of time and resources. In practical terms, the researcher has to make a choice between either testing hypotheses with statistically large samples and so having to limit the study to perhaps one topic and using short and easily administered methodological techniques in an essentially cross-sectional study, or testing all the topics of interest at the expense of sample size, but with the option of using a longitudinal research design and more time-consuming assessment procedures. The present study opted for the second of these choices. This decision was governed by several considerations, both theoretical and methodological.

The primary aim was to investigate depressive symptoms among women in Dubai, and to explore the association of depression with several socio-demographic variables. It was postulated that the clinical symptoms of depression among these women to be revealed first; the intent was therefore to explore these symptoms among those who were considered to be clinically depressed. Because of limitations on time, the lengthy prospective research required for this type of scientific enquiry was beyond the scope of the present study. The focus, then, was on exploring these symptoms among the patients who were available during the research period (see Chapter 5, section 5.4.1).

The second step of the study was to identify the symptom profile of depression and the coping strategies used by women from the community. Again, in line with the research recommendations to date, a decision was made to use only a healthy community sample with no history of physical or mental illness. It should also be noted that, in the light of the cultural focus of the present study, an effort was made to select only those women who were from Dubai. Again, though, this limited the numbers of individuals suitable for inclusion in the study. The selection procedures are described in detail in Chapter 5 (see section 5.4.2).

The second aim of the study was to explore the concept of depression among the native people of Dubai through the language and vocabularies used to express feelings of sadness and depression. Subjects therefore had to be native and speak fluent Arabic, which further limited the sample size. It was considered necessary to choose only native people because the quantity and quality of verbal expressions related to the concept of depression would be expected to differ substantially from one culture to another. Details

on this procedure are given in Chapter 4 (see section 4.4.3).

A checklist of depressive words generated from the above procedure was then used as a self-report instrument for measuring depressive symptoms. Section 5.4.4 in Chapter 5 details the findings relating to the reliability and validity of this instrument, and describes how it was constructed. Sensitivity and specificity across the different types of subject (depressed patients and community samples) are reported and compared with another instrument, the Beck Depression Inventory (BDI).

The present study explores the possibility that there are established local idioms for depression in Dubai and that these could be used for assessing depression among native people. It revealed also that there are many metaphorical meanings in each language which would not be tapped by standard research instruments or translating practices, yet which are important for psychiatric assessment.

Chapter 2

Literature Review

2.1. Introduction

The present study takes its inspiration from several areas of psychology. This chapter consists of a review of the literature in those areas within the context of depression. Section 2.2 deals with depression: its definition, classification, diagnosis, and epidemiology, and aetiological theories of depression. Section 2.3 focuses on culture and its influences on mental health, emotions, and the concept of depression. Finally, section 2.4 investigates the existence of coping styles peculiar to depressed individuals.

2.2. Depression

2.2.1. Definition of Depression

Etymologically, depression is from the Latin *depressus* (past participle of *deprimere* _ to press or weight down). It is also a place or site pressed down or sunken below a surrounding surface, or the condition characterizing it. It is a lowering in quality, vigour, or amount; the state of being lowered or reduced in force, activity, intensity, etc. (Gove, 1961; Churchill, 1990; Simpson & Weiner, 1991). The term depression is also used in economics to denote a major downswing in the business cycle.

Depression as an illness has been known and described unmistakably from at least the time of Hippocrates (the fourth century BC); he called it 'melancholia'. The *Encyclopaedia Britannica* (1973) defined depression in psychiatry as not an illness, following no regular course and having no particular or specific outcome. It may be fleeting or permanent, mild or severe, acute or chronic. There is no clear line of distinction between normal and abnormal in depression; its intensity determines whether a depression is pathological. It is a type of emotional reaction with distinctive characteristics; the roots of these characteristics exist in everyone. Depression nevertheless has specific characteristics which distinguish it from all other emotional states. It represents a whole class of disorders whose chief features are a reaction to a sense of loss. The reaction is typified by an emotional or psychic state which is expressed by a loss of interest in the world outside the self, loss of activity, loss of capacity to love, and loss of feeling of self-regard to a point that finds expression in self-reproach and self-reviling; the reaction may culminate, in extreme instances, in a delusional expectation of punishment and in suicidal impulses.

Indeed, descriptions and discussions of depression are presented from classical times through the Middle Ages and into modern times. According to Magill, Rodriguez, and Turner (1996), the first comprehensive description of depression in English was provided by Timothy Bright (*Treatise of Melancholia*, 1586). In 1624, Robert Burton provided his own major work on depression (*The Anatomy of Melancholy*). Most of the credit for developing the modern understanding of affective disorders, however, is given to Emil Kraepelin. It was in Kraepelin's system that the term 'depression' first assumed importance.

Since classical times, there have been debate and controversy over whether depression is best

considered an illness or a response to an unhappy situation. Indeed, it is obvious to the most casual observer that sadness is a normal response to unhappy events. Even now, there is less than complete agreement on when fluctuations in mood should be considered pathological and when they are within normal limits. To help resolve this problem, diagnostic criteria have been developed, and structured interviews are often used to determine whether a particular individual should be considered depressed (Magill, Rodriguez, and Turner, 1996).

2.2.2. Classification and Diagnosis of Depression

As mentioned earlier, Kraepelin (1904) was the first to isolate the cluster of symptoms later referred to as depression in the context of 'manic-depressive illness'. He presented the view that the underlying (biological) cause of both depression and mania was one and the same.

Through the years, a number of competing classification systems of depression based on the theoretical predilections and orientations of theorists and clinicians have evolved. These systems emphasize unitary, dualistic or pluralistic classification and diagnostic assumptions. The unitary approach claims that there is basically one type of depression that varies in terms of severity. Within this framework, depression can be classified as mild, moderate, or severe. This viewpoint enjoys only limited popularity (Corsini, 1994).

The dualistic approach assumes that there are two types of depression: those that have clear psychological aetiologies, short-term courses, and relatively benign outcomes; and those with biological aetiologies, long-term courses, and relatively poor outcomes. Among the dualistic patterns are reactive versus autonomous, neurotic versus psychotic, exogenous versus endogenous, and justified versus somatic depressions (Corsini, 1994).

Pluralistic systems of classification include many types of depressive disorder. The American Psychiatric Association and the Mental Health Programme of the World Health Organization (WHO) have both supported a pluralistic view of depressive disorders. Over the course of several decades, these two organizations engaged in programmes aiming to improve the diagnosis and classification of mental disorders. These efforts have led to the various improved editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases* (ICD). The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), developed by the WHO, was published in 1992, while the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) was published in 1994. The developers of DSM-IV and ICD-10 considered that it was impossible to develop absolute and infallible criteria for depression, and so believed that revisions would be required in due course.

DSM-IV and ICD-10 are the most widely used classification schemes for psychiatric disorders around the world, and their wide international acceptance suggests that they are useful in describing mental disorders as they are experienced by individuals throughout the world. Nonetheless, evidence also suggests that the symptoms and course of a number of DSM-IV and ICD-10 disorders are influenced by cultural and ethnic factors.

To facilitate its application to individuals from diverse cultural and ethnic settings, DSM-IV includes a new section that covers cultural features. This section describes the ways in which varied cultural backgrounds affect the content and form of symptom presentation (e.g., depressive disorder characterized by a preponderance of somatic symptoms rather than sadness in certain cultures), preferred idioms for describing distress, and information on

prevalence when it is available.

The second type of cultural information provided pertains to 'culture-bound syndromes' _ that is, those that have been described in just one, or a few, societies. DSM-IV provides two ways of increasing the recognition of culture-bound syndromes: (1) some (e.g., amok, *ataque de nervios*) are included as separate examples in 'Not Otherwise Specified' categories; and (2) an appendix of culture-bound syndromes has been introduced in DSM-IV; this appendix includes, for each syndrome, the name for the condition, the cultures in which it was first described, and a brief description of the psychopathology.

These ethnic and cultural considerations were designed to enhance the cross-cultural applicability of DSM-IV, and to increase sensitivity to variations in how mental disorders may be expressed in different cultures. It should help to reduce unintended bias stemming from the clinician's own cultural background (American Psychiatric Association, 1994).

On the other hand, because culture-specific disorders appear to have been expressed less often in recent years, and because the attempts of researchers to classify these culture-specific disorders have failed, they have not been separately classified in ICD-10. Because the descriptions of these disorders currently available in the literature suggest that they may be regarded as local variants of anxiety, depression, somatoform disorder, or adjustment disorder, the nearest equivalent code should be used if required, together with an additional note of which culture-specific disorder is involved (World Health Organization, 1992).

DSM-IV and ICD-10 classify mood disorders in almost identical ways, but in different

patterns. In ICD-10, mania, bipolar disorder and depressive episode are discussed in that order, while DSM-IV begins with depressive disorder, then discusses bipolar disorder.

It is clear that many attempts have been made to divide depressive disorder into sub-types, but only the bipolar versus unipolar distinction has been widely accepted around the world. Unipolar depression is much more common than bipolar depression and so will continue to attract a large share of research attention (Magill, Rodriguez, and Turner, 1996).

2.2.3. Epidemiology of Depression

According to Gotlib and Hammen (1992), depression is by far the most common of psychiatric disorders, accounting for 75% of all psychiatric hospitalizations. Each year more than 100 million people world-wide develop clinically recognizable depression. Furthermore, during the course of a lifetime, it is estimated that 25% of the general population will experience at least one debilitating episode of depression.

The question which arises here is whether such figures reflect clinical depression or the depressive symptoms which, in their mildest form, affect virtually everyone.

It seems that it is not easy to draw a distinct line between depression proper and plain moodiness or low sprit. This difficulty characterizes most depression research (Diamond, Epting, & Gage, 1987; Von Korff, Shapiro, Burke, et al., 1987).

Lehtinen and Joukamaa (1994) suggested that there are two problems facing epidemiological

studies of depression. The first concerns the concept and definition of depression, as it has not been possible to define the kind of diagnostic criteria for depressive disorders that could be accepted and used in the same way by every clinician or researcher. The second problem concerns classification. The practice had been to classify depression according to different dichotomies. This variation and the ambiguity in the definition of depression are the main reasons why its epidemiology is still far from clear.

Lehtinen and Joukamaa (1994) reviewed studies concerning the prevalence of depressive symptoms and of clinically defined depressive disorders. Regarding the prevalence of depressive symptoms, they provided a summary of ten population surveys conducted between 1957 and 1989. One-tenth to one-third of subjects reported depressive symptoms. These symptoms were more prevalent in women than in men: the prevalence for women varied between 18% and 34%, and that for men between 10% and 19%. The male-to-female ratio was 1:2 in almost every study. On the other hand, the prevalence of clinical depression in selected population surveys conducted between 1965 and 1992 showed that the prevalence of depression varies in men from 2.6% to 5.5%, and in women from 6.0% to 11.8%. The mean prevalence in those studies was 4% for men and 7.9% for women.

Numerous epidemiological studies of depression have stated that there are specific demographic variables associated with a relatively high incidence of depression. These variables are discussed below.

2.2.3.1. Gender

Women are consistently reported to have a greater prevalence of depressive disorder than

men, and there is some evidence that the excess of depression is greater during women=s reproductive lives. The male-to-female ratio of prevalence of depression is 1:2 (Weissman & Klerman, 1977). Many explanations have been offered for this sex difference. Some focus on biological theories which relate to the female hormonal system, implicating oestrogen and progesterone in the aetiology of depression; others suggest a genetic predisposition to depression in females. The support for the genetic explanation is weak. Gotlib and Colby (1987) reviewed many studies indicating that depressed males are more genetically deviant than are depressed females, and that the relatives of male and female depressed persons were equally likely to be diagnosed as depressed. Therefore, there is currently no consistent evidence that the observed gender differences in depression are due to biological factors.

More psychosocially oriented theories have focused on the sex roles of women, their lower social status, and their greater experience of role conflict in society (Pearson, 1995; Bernandez, 1984). Bebbington (1996) and Bebbington and his colleagues (1998) reviewed several lines of investigation in order to assess the relative importance of social, psychological and biological influences on the sex difference in depression. They concluded that the evidence for environmental effects is much better for social than for physical factors, and that a plausible case can be made for a developmental perspective involving the interaction of social experience and psychological attributes. Even so, their attempts to explain the sex differences in depression by social variables were unsuccessful. In conclusion, none of these theories has received unqualified support, and the evidence is, at best, confusing.

2.2.3.2. Age

The incidence of depression rises shortly after puberty, peaks between the ages of 25 and 44 years, and declines somewhat in later years (Weissman, Myers & Thompson, 1981, cf. Gotlib & Colby, 1987). Depression seems to occur for the first time at a younger age in women than in men. Although the incidence of depression in women is greatest before 35 years of age and tends to decrease with age, the peak prevalence of depressive symptoms in men appears in the 45-65 year age range (Gotlib & Colby, 1987). Bebbington, Dunn, Jenkins et al. (1998) indicated that under the age of 55 the prevalence of depression in women is about twice as high as in men, while in the older group women actually form a minority of subjects suffering from depression.

2.2.3.3. Marital Status

The relationship between depression and marital status is complicated. Some authors (Weissman & Klerman, 1977; Weissman et al., 1987) consider that being married connotes more stress for women than for men. Others have found that marital status has different associations with affective disorder in different cultures. For instance, married women are at low risk of disorder in Mediterranean countries (Mavreas, Beis, Mouyias, et al., 1986; Vazquez-Barquero, Diez-Manrique, Pena, et al., 1987), in rural New Zealand (Romans-Clarkson, Walton, Herbison, et al., 1988), and in British Orthodox Jews (Lowenthal, Goldblatt, Gorton, et al., 1995). These societies all accord a high value to the home-making role. This suggests that the association with relatively simple socio-demographic factors may itself be affected by more subtle socio-cultural influences. Renne (1971) (cf. Gotlib & Colby, 1987) reported that both men and women who are unhappily married are more depressed than are their separated and divorced counterparts.

2.2.3.4. Socio-economic Status

Numerous epidemiological and community studies have provided evidence that more depressive disorders are found in individuals from lower socio-economic backgrounds than in those from higher socio-economic classes (Brown & Harris, 1978; Weissman & Myers, 1978a, 1978b, 1980; Surtees, Ingham, Kreitman, et al., 1983).

The Black Report (Townsend & Davidson, 1982) discussed four possible explanations for the association between poor socio-economic circumstances and all causes of mortality. The first explanation considered was that the variables are artefacts. This approach suggests that both health and class are artificial variables thrown up by attempts to measure social phenomena and that the relationship between them may itself be an artefact and therefore of no causal significance. Difficulties arise in interpreting the available sources of routine data on mortality since many instruments are biased towards some classes. This problem has been covered recently in most research by using standardized instruments and interviews, which are less likely to show any information bias.

The second explanation was social selection, or reverse causality, that those with poor health are more likely to drift into lower social classes, or have lower income. Lewis (1996) criticized this explanation and indicated that there is no evidence concerning social selection on income; however, there has been some investigation of social selection in relation to social class and mental health, using a 1958 birth cohort. The main finding was that there is still a social class gradient in those who have remained in the same social class as their parents. Also, adjusting for parental social class and behavioural problems at age 16 reduces, but does not eliminate, the social class gradient. Social selection cannot therefore explain the

relationship between social class and mental health.

The other two explanations considered by the Black Report were labelled behaviourist and materialist. The former explained the inequalities in mortality as resulting from differences in behaviour, or, at most, sub-cultural life-styles, while the latter emphasizes that behaviour is constrained by the lack of education, income, and opportunities for those in lower socio-economic groups. Lewis (1996) indicated that the explanation for the inequalities in mental health is uncertain, but that they could be due to the increased stress and uncertainty that are a consequence of low income.

2.2.3.5. Educational Status

Data on the association between education and depression are inadequate because the focus of most epidemiological studies has been more descriptive than analytic. Nonetheless, education is generally associated with psychopathology, in that the less educated are more likely to be depressed (Pahkala, Kesti, Kongas-Saviro, et al., 1995; Costello, 1991; Rajala, Uusimaki, Keinanen-Kiukaanniemi, et al., 1994). The Epidemiologic Catchment Area (ECA) study, which examined the rates of depression in five sites in the United States, has provided the only contrary evidence for this association. According to ECA data, the prevalence of major depression was slightly higher among persons with 12 years of education or more than among those with less education (Weissman, Beuce, Leaf, et al., 1991, cf. Beckham & Leber, 1995).

2.2.3.6. Occupational Status

There have been many studies of psychological ill-health in the unemployed. Most have been

cross-sectional comparisons of employed and unemployed samples (e.g., Crepet, Piazzi, Vetrone, et al., 1993). In these studies unemployment has usually been associated with depression. Many other studies concerning social support in relation to mental health have indicated that the lack of social support makes unemployed people more vulnerable to setbacks (Leavy, 1983).

Bolton and Oatley (1987) found a connection between insufficient social support and depression when unemployment lasted for more than six months. The effects of unemployment on mental well-being have usually been studied in randomly chosen unemployed subjects. As a rule, the unemployed subjects of these studies were suffering from depression, impaired capacity to work, and impaired mental well-being more often than people with jobs (Viinamaki, Koskela, Niskanen, et al., 1993).

Surtees and his colleagues (1983), in their report of a community study in Edinburgh on psychiatric disorder in women, found that the highest prevalence of psychiatric disorder was among those women who were not employed (ranging from just over twice the prevalence found among the employed). These findings suggest that employment could be considered as one of the elements of social support in threatening life situations that may lead to depression.

2.2.4. Aetiological Theories of Depression

Theories of the causes of depression have been proposed on two different bases: (a) biological theories, and (b) psychological theories.

In brief, the biological theories can be sub-divided into two general approaches: (1) genetic approaches, which suggest that depression is the result of inheriting genes that predispose to depression; and (2) neurotransmitter approaches, which consider that brain biochemistry is an aetiological factor in unipolar depression. These approaches have focused on two monoamine neurotransmitters: norepinephrine (NE) (noradrenaline) and serotonin (5-HT). Researchers in this field originally believed that depression was due to a depletion of NE in the brain, and later to depletion of both NE and 5-HT (for further discussion see Amsterdam, 1991; Halbreich, 1987; Mann & Kupfer, 1993; Montgomery & Corn, 1994; Paykel, 1992). Since the focus of this project is not associated with biological bases of depression, the biological approach is not further discussed in this chapter.

The psychological theories of the causes of depression can be grouped into several categories, such as psychoanalytic, behavioural, cognitive, and interpersonal approaches. The approaches which are considered for the purposes of this project are discussed in more detail below.

2.2.4.1. Cognitive Behavioural Approaches

The cognitive revolution in psychology in the 1960s brought with it a number of explanations of depression which reflect the range of cognitive factors deemed to be important in the cognitive-behavioural analysis of depression. A central aspect of these theories is that a depressed individual selectively attends to negative information and thus receives a distorted view of the world. In support of this point, Lewinsohn, Mischel, Chaplin, et al. (1980) found that the self-perception of the depressed subjects in their study had become more unrealistic.

One of the most influential of these theories was proposed by Aaron Beck in 1967. Beck

(1967, 1991) argued that all individuals possess cognitive structures, called schemas, that guide the ways in which information in the environment is attended to and interpreted. Such schemas are determined from childhood by our interactions with the external world. If these interactions are constantly negative, the individual may begin to believe these negative things about himself, and he may then interpret every failure as further evidence of his negative feelings toward himself. If this negative processing of information is not changed, it will become an enduring part of his schemas. When this schema is activated, it will predispose the individual to depressive feelings.

Beck (1967, 1991) stated that, as a result of this faulty information processing, depressed persons demonstrate a cognitive triad of negative thoughts _ about themselves, the world, and the future. This cognitive set centres around the appraisal of loss of a valued object or attribute which pervades other areas of the individual's life; as a result, depressed persons perceive themselves as inadequate, as lacking the necessary skills and opportunities to make up the perceived deficits and inadequacies. Their world is seen as full of obstacles, and the future is perceived as unchanging and empty.

Beck's theory described the depressed person's processing of events as habitual errors of reasoning. These errors fall into a number of categories: (a) arbitrary inference (drawing a negative conclusion in the absence of supporting data); (b) selective abstraction (focusing on the detail, often negative, and usually at the expense of more salient information); (c) overgeneralization (arbitrarily drawing conclusions about a wide variety of things on the basis of single events); (d) magnification and minimization (making errors in evaluating the importance and implications of events); (e) personalization (relating external, often negative,

events to the self when there is no reason for doing so); (f) absolutist dichotomous thinking (thinking in polar opposites, such as that something is either all good or a total disaster) (Twaddle & Scott, 1991).

According to Beck, there are three important aspects of these distortions or depressive cognitions. *First*, they are automatic B that is, they occur without reflection or forethought. *Second*, they appear to be involuntary. *Third*, the depressed person accepts these thoughts as plausible, even though others would clearly not view them in the same manner. Since the overt behavioural symptoms of depression followed from cognitive distortion and the activation of a latent dysfunctional schema, cognitive therapy involved the identification and subsequent confrontation of these distortions in the face of objective experience (Beck, Rush, Shaw, et al., 1979).

Currently, cognitive approaches are among the most widely studied theories in the aetiology of depression. A large number of studies investigating the cognitive aspects of depression have found that depressed individuals do indeed differ from control groups in their thought content and thought processing. Weintraub, Segal, and Beck (1974), for example, observed that negative bias in thinking correlated significantly with ratings of depression. Blackburn and Bishop (1983) found highly significant correlations between scores on the Beck Depression Inventory (BDI) and a negative view of self, the world, and the future as measured by semantic differential techniques. Giles and Shaw (1987) found that negative views of self, world, and future were inter-related and were specific to depression. The most important support for cognitive theory comes from studies demonstrating the experimental induction of mood which show that mood can be alerted by manipulating a person's

cognitions. Williams (1992) considered that although the experimental evidence may not tell us anything that is unique to depression, it should alert clinicians to the possibility that depression has cognitive antecedents and should not be analysed in purely biological terms. It appears that a cognitive vulnerability plays a role in symptom formation for at least some individuals, and in the maintenance of ongoing episodes of depression for many depressed persons.

2.2.4.2. Stress and Cognitive Appraisal Approaches

Stress has been recognized as a contributing factor to mental and physical health and illness. In the extreme, stress can apparently induce a psychological state requiring clinical intervention. Accordingly, there have been repeated attempts to tie stress to clinical depression. Perhaps the perceived inability to cope with stress will, in some individuals, yield not merely a relatively mild pessimism but instead a severe depressive state. The first important theorist who attempted to account for stress was Walter B. Cannon in the early years of the twentieth century. He claimed that the sympathetic nervous system is activated by signals from the brain when a person is exposed to an emotionally arousing stimulus; the confrontation with this stimulus produces both the feelings and physiological reactions which are associated with stress (Magil, Rodriguez, & Turner, 1996). While the contributions of Cannon were important, he did not take into consideration the role played by psychological and behavioural factors in overall stress response.

Following the same approach as Cannon, Hans Selye (1956) claimed that stress is non-specifically induced and can be caused by diverse stimuli. Seyle labelled the body's response to stress the *general adaptation syndrome* (GAS). This process occurs in three

stages: (1) the alarm reaction, during which the body is activated in order to handle the perceived danger at hand; (2) the resistance stage, during which the person either adapts to or resists the source of stress; the longer this stage lasts, the greater is the danger to the person; (3) the exhaustion stage, which demonstrates the finite nature of the body's ability to cope with or adapt to stress. It is considered that Cannon and Selye clearly focus on stress as a biological response to a wide range of stimuli.

In contrast, John Mason (1971), who adopted an interactionist approach to stress, viewed stress as dependent on emotional responses to situations. He indicated that the nature of a person's emotional response will play an important role in the probability that stress will lead to a disease. People who are not psychologically aware of the existence of a potentially stressful event are least likely to experience a stress response. Mason criticized Selye's approach for not providing ample opportunities to explain why some people develop stress-related disorders and others do not.

Lazarus (1975) adopted a psychological approach to stress, claiming that the key to the stress response cannot be found in either the nature of a specific stressful event or the person's response to that event. Rather, the most important factors are cognitive ones. Lazarus believes that it is the person's perception of an event that is crucial. This perception involves a combination of the person's perception of the potential danger of an event and his or her perceived ability to cope with that event. Stress will occur in those circumstances in which the person perceives that he or she does not have the ability or resources needed to cope with the situation. Thus Lazarus adopted an appraisal approach to the aetiology of stress.

Later, in his work with Suzan Folkman (Lazarus & Folkman, 1984), Lazarus delineated three important cognitive mechanisms for appraisal of the situation: (1) the primary appraisal, which refers to an assessment of whether a situation is neutral, challenging, or potentially stressful; (2) the secondary appraisal, which involves the coping options or manoeuvres that the individual has at his or her disposal; and (3) the reappraisal or coping strategies, with which the person re-evaluates the stressful potential of a situation on the basis of access to new thoughts and information. The actual reappraisal or coping strategies that may be used are either *problem focused* (those that involve altering the circumstances that are eliciting the stress response) or *emotion focused* (those that involve directly lowering physiological arousal or the cognitive determinants of the stress response).

Lazarus also discussed a number of factors which can influence the appraisal of what could be viewed as a stressful situation. He divided these factors into two parts. The first comprised personal characteristics, which included commitments (what is important to the person, what has meaning for him or her) and beliefs (which usually operate at a tacit level to shape a person's perception of his or her relationship to the environment). These variables influence appraisal by (1) determining what is salient for well-being in a given encounter; (2) shaping the person's understanding of the event, and in consequence his or her emotions and coping efforts; and (3) providing the basis for evaluating outcome.

The second part comprised situational factors, which Lazarus identified as: (1) novelty (a situation not previously experienced will result in an appraisal of threat only if some aspect of it has previously been connected with harm); (2) predictability (refers to some

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type of warning that something painful or harmful is about to happen); (3) event uncertainty (which introduces the notion of probability); (4) three temporal factors _imminence (how much time there is before an event occurs), duration (refers to the length of time during which an event is occurring), and the temporal uncertainty (refers to not knowing when an even will occur); (5) ambiguity (refers to unclear or insufficient information necessary for appraisal, or, in other words, lack of situational clarity); (6) the timing of stressful events in the life cycle (refers to the 'off time' occurrence of life events; these 'off time' events are more threatening because they are not expected and therefore deprive the person of the full sense of satisfaction that would accompany an event had it been on time, or the opportunity to prepare or engage in anticipatory coping). Lazarus indicated that situational and personal factors are always interdependent, and that their significance for stress and coping derives from the operation of cognitive processes that give weight to one in the context of the other.

It was considered that appraisal processes are integral to understanding how a potential stressor will affect a person and how the person will respond. They are important also in explaining individual differences in response to stresses and in developing better techniques to help people cope with stress.

Although not all psychologists agree with the particulars of Lazarus's theory, what is significant is the generally accepted view that psychological stress involves appraisal processes concerned with judgments of stimuli as stressors, and with decisions as to how to cope with stressful events (Magill, Rodriguez, & Turner, 1996).

Having presented the above data it is clear that stress produces a cognitive appraisal which differs from one person to another. People differ in their perceptions of stress according to their cognitive processes; this applied to the subjects involved in this study.

2.2.4.3. Learned Helplessness Approaches

Learned helplessness is considered as a special case of the outcome of a stressful encounter or a series of such encounters (Lazarus & Folkman, 1984). The idea of learned helplessness as an element of depression was advanced by Martin Seligman (1975), and was based on his research on avoidance learning in animals. Seligman found that animals trapped in situations in which they can no longer escape from harm or punishment become unresponsive or 'helpless'. He found that this response pattern resembled depression in many respects, and coined the term *learned helplessness* to describe the phenomenon. As research with humans progressed, however, a number of investigators pointed to the inadequacy of the theoretical constructs originating in animal helplessness for understanding helplessness in humans (e.g., Blaney, 1977; Buchwald, Coyne, & Cole, 1978; Golin & Terrell, 1977; Miller & Norman, 1979).

In 1978, Abramson, Seligman, and Teasdale presented an attributional framework in order to resolve several of the controversies surrounding the effects of uncontrollability in humans. The reformulated hypothesis states that when a negative outcome is thought to be a product of the person's effort (internality), there will be a loss of self-esteem and a greater likelihood of depression than if the outcome is seen as the result of external factors. If such attribution is viewed as the result of stable personal factors, the effects of uncontrollability will be chronic as well. Moreover, there is an added attributional factor

of globality B that is, a generalization of helplessness from a specific context to the overall life context.

Garber and Seligman (1980) suggested that the cornerstone of the original learned helplessness model of depression is that learning that outcomes are uncontrollable produces the motivational, cognitive, and emotional deficits leading to non-adaptive behaviour and depression. The term 'motivational deficit' refers to passivity in the face of a condition of helplessness. The cognitive deficit consists of the person failing to notice that his or her coping response might be connected to a favourable outcome. The emotional deficit is no longer simply depression, as in the original formulation, but can be anxiety: now, only when the person sees the situation as hopeless is there depression. It is clear that the reformulation of the theory of learned helplessness in humans emphasizes the importance of the attributional dimensions of internal-external, stable-unstable, global-specific in modulating helplessness deficits. This attributional analysis was proposed in order to resolve the inadequacies of the original helplessness hypothesis with respect to self-esteem, chronicity, and generality.

Perhaps the primary significance of learned helplessness is its model of how a person's perception of a life event can influence the person's behaviour, and can therefore affect his or her life and possibly the lives of others. Seligman (1975) believes that the way in which people perceive and explain the things that happen to them may be more important than what actually happens. These perceptions can have serious implications for a person's mental and physical health. Many people have learned to react in helpless ways to stress, becoming afflicted with migraine headaches, peptic ulcers and severe back

problems, and possibly even other psychosomatic disorders.

The idea that helplessness could be learned has opened the door to many exciting new approaches to disorders formerly considered to be personality related or biologically oriented, such as psychosomatic disorders, victimization by gender, and depression. The idea that individuals actually do have an effect on their environment is of tremendous importance to people suffering from depression, because most mention a general feeling of hopelessness; the feeling implies that one is powerless over one's reactions and behaviour. Miller (1980) (cf. Garber & Seligman, 1980) provided evidence, from her work on measuring choice of potential control, that people do have the power to influence their perceptions of their environment and, therefore, change their reactions to it.

If the research on perception and learned helplessness is accurate, a logical next step is to discover how explanatory styles originate and how they can be changed. Some suspected influences are how a child's first major trauma is handled and how teachers present information to be learned, as well as teacher=s attitudes toward life events, and parental influence. Perhaps the most promising aspect of the research on learned helplessness is the idea that what is learned can be unlearned; therefore, humans really do have choices as to their destiny and quality of life. Considerable importance falls upon those who have a direct influence on children, because it is they who will shape the attitudes of the future (Magill, Rodriguez, & Turner, 1996).

According to data presented above, one can conclude that learned helplessness must be rooted in the early childhood experiences. Hence, I believe that most of the subjects of

the present study who suffered from the state of learned helplessness have had it from the early stages of their psychological development.

2.2.4.4. Attributional Theories

When trying to make sense of human behaviour, one must be able to perceive behaviour accurately and understand its causes. Theories that describe ways in which one can make judgments about the causes of behaviour are called attribution theories (Magill, Rodriguez, & Turner, 1996).

This builds on the work of Heider (1958), who proposed that the concepts people have about causality affect their social behaviours. Attribution theory has grown into an important area of social psychological thought, research, and controversy. Weiner (1985) extended attribution theories to emotion, reasoning that how people explain their success and failures affects not only their behavioural commitment to achievement, but the feelings they experience in the wake of their efforts. Causal ascriptions play a key role. Weiner (1985) documented that in achievement-related contexts there are a few dominant causal perceptions. The most dominant of these causes are ability and effort. That is, success is ascribed to high ability and hard work, and failure is attributed to low ability and absence of trying. He also suggested that the structure of causal thinking shares three common properties, namely locus, stability, and controllability, with intentionality and globality as other possible causal structures.

Causal stability influences changes in goal anticipations, while the three causal dimensions determine the emotional experiences of anger, gratitude, guilt, hopelessness,

pity, pride, and shame. Weiner presumed that expectancy and affect direct motivated behaviour. The attributional theory therefore relates the structure of thinking to the dynamics of feeling and action. One can, for example, attribute success to external factors such as luck or the nature of the task, or to internal factors such as one's own effort or ability; these diverse attributions then influence the emotional reaction.

Recently, theorists and researchers have applied attribution formulations to the clinical symptoms of depression. One prominent attributional theory of depression (Abramson Seligman, & Teasdale, 1978), for example, proposes that individuals who characteristically make attributions that are internal, stable and global for their negative outcomes are prone to depression _that is, internal attributions following failure are thought to produce lowered self-esteem, and attributions to stable and global factors are thought to lead to the chronic and general motivational and performance deficits characteristic of the depressive syndrome. This theory has now been called 'learned helplessness'.

Janoff-Bulman (1979) has argued that only one type of internal attribution should be associated with depression. She distinguished between two types of internal attributions for negative outcomes: blame directed at one's character (e.g., ability) and blame directed at one's behaviour (e.g., effort). Since character is fixed and less controllable than behaviour, attributions to character-related factors should lead to helplessness and depression. Peterson, Schwartz, and Seligman (1981) concluded that attributions to character-related deficits may be a major concomitant of depression, but not a cause. Anderson (1983), on the basis of the possibility of modifying individuals' characteristic

attributional style, found that the behavioural attributions used by his subjects resulted in more expectation of success, higher levels of motivation, and better task performance when compared to subjects who made character-related attributions.

Harvey and Weary (1984) reviewed the general theoretical commentaries about attribution. They concluded that the field is alive with controversy and issues, and that this controversy reflects the lack of consensus about certain key concepts and about the most defensible theoretical interpretations for phenomena. It also reflects the fact that in certain domains of attribution work, the relevant evidence and the appropriate paradigms and procedures are in question. They suggested that there is no monolithic theory of attribution. The concept of attribution is a rich one, and is likely to remain viable in psychology for many years to come.

2.2.4.5. Locus of Control

The term 'locus of control' refers to a set of beliefs about the relationship between behaviour and the subsequent occurrence of rewards and punishments. The terminology used is *internal* versus *external* control of reinforcement (I-E). Whenever reinforcements (either positive or negative) are perceived by the individual as being the result of his or her own behaviour, efforts, or relatively permanent characteristics, it is an example of an internal belief. External beliefs, in contrast, involve perceptions that reinforcements occur as the result of luck, chance, fate, or the interventions of other powers, or else are simply unpredictable because of the complexity of events (Corsini, 1994).

The I-E concept was first outlined by Julian Rotter (1966). He not only defined the

concept but also described a social learning theory in which it could be incorporated. Rotter (1966) realized that I-E is not a concept which can be considered to be the only determinant of behaviour in a given situation; he therefore conceptualized it as only one variable in a larger social learning theory scheme. This theory described several variables which act in concert to produce a behaviour in a given situation: expectancies; reinforcement values; and the psychological situation. Any behaviour occurs because of expectancies that it will achieve the goal towards which it is directed and because of the value of that goal.

The specific situation influences both the magnitude of one's expectancies and the value of the goal. Rotter also suggested that there are three variables determining the expectancy that a specific behaviour will lead to a particular outcome. These are: (1) previous experience of the same situation; (2) experience generalized from related situations; and (3) numerous problem-solving generalized expectancies, of which I-E is but one example. These three variables all interact to determine one's expectancy for the success of the behaviour in question.

It is clear that I-E concerns how best to categorize situations that present the individual with a problem to be solved. By categorizing situations as fitting somewhere along the I-E dimension, the individual feels that he/she can better cope with them.

A series of studies (Wheaton, 1980; Krause & Stryker, 1984; Mirowsky & Ross, 1990) provides strong support for the hypotheses that the individual who has a strong belief that he can control his own destiny is likely to be more alert to those aspects of the

environment which provide useful information for his future behaviour, and more likely to take action when difficulties arise, and consequently be more able to surmount these obstacles. These studies indicated also that perceived control over both good and bad outcomes is associated with low levels of depression, and that the belief that the individual is responsible for his own successes and failures has large negative associations with depression. The general conclusion is that general maladjustment, as well as specific problems such as anxiety and depression, are mostly associated with an external orientation.

Perhaps the most serious gap in the locus of control literature is a systematic study of how I-E beliefs develop. However, some relationships have been noted in a broad fashion: for example, constancy of parental reinforcement, discipline, and standards are linked to the development of internality; low socio-economic status is associated with external beliefs; and racial and ethnic groups who have little access to power and mobility likewise show more external belief systems (Corsini, 1994). There is also some evidence suggesting that certain cultures teach external beliefs to different degrees (e.g., Eastern cultures are more collectivist than Western cultures, which tend to be individualistic); hence, if personal responsibility for one's own life is a Western value, its effect on psychological well-being may be different in Eastern cultures (Sastry & Ross, 1998).

2.2.4.6. Interpersonal Approach

Leary (1957) proposed an interpersonal model for understanding personality and maladaptive behaviour. Without deriving his model from ethological and biological work, he acknowledged the influence of Jung and other psychoanalysts, particularly

Sullivan and Karen Horney. Leary applied statistical procedures in order to derive two orthogonal constructs: *dominance-submission* and *love-hate* (the love-hate dimension may also be labelled in different ways, such as linking-distancing, approach-withdrawal, and friendliness-hostility). In this approach, proneness to depression is related to the dominance-submission dimension, rather than the love-hate dimension. On the basis of the two dimensions, this model suggests four basic classes of behaviour: *friendly dominance, friendly submission, hostile dominance,* and *hostile submission.* According to this model, different styles of interpersonal relationships are based on these four basic classes; interpersonal adjustment is provided through the different styles of interpersonal relationship.

Carson (1969) suggested that the dominance-submission and love-hate dimensions provide three options: *acceptance vs. rejection*, *self vs. other*, and *emotional vs. social.* For example, the cooperative behavioural style offers love to both self and other, but is rejecting towards hostile, status-seeking, or competitive responses in both self and other. The different styles have implications for both self and other in the three domains mentioned above.

The interpersonal approach emphasizes the role of (social) life events, the nature of significant relationships (mostly in the present, but with some consideration of early relationships), and the interpersonal tactics a person uses to gain and maintain relationships and resolve conflicts. The vast majority of people who have been exposed to severe life events and major crises develop symptoms of depression (Tennant, Bebbington, & Hurry, 1981; Ganzini, McFarland, & Cutler, 1990).

The interpersonal approach proposes various specific causes of depression, namely grief and loss, interpersonal role transitions, loss of sense of value, and social skills deficits. Coyne (1976a, 1976b) suggested that the depressed person is unattractive to others and therefore tends to elicit aversive responses. Coyne (1989) criticized the cognitive approach with respect to the idea that distorted cognitions cause depression, instead emphasizing the role of social environment. In agreement with this critique, Hooley and Teasdale (1989) reported that spouse criticism was associated with relapse. Furthermore, Vaughn and Leff (1985) demonstrated a relationship between depression and living with a non-supportive and unsympathetic spouse. Keitner and Miller (1990) found that women who have disputes with their husbands and then divorce have disputes with new husbands. However, they also reported that marriage may be less protective for women than men. This may be due to the dominance relationships in the marriage (i.e., women are more likely to be treated as subordinates).

These findings support the idea that the probability of becoming depressed in the presence of provoking agents is increased if a woman does not have, within her social network, a close, confiding relationship. Indeed, the importance of social and interpersonal variables to psychological well-being is well documented (Hooley & Teasdale, 1989; Beach, Sandeen, & O'Leary, 1990).

Moreover, it has been pointed out that the impact of life events in relation to social support is complex (Stokes & McKirnan, 1989). Hong, Wirt, Yellin, et al. (1979) maintained that individuals are not simply passive recipients of life events, but to some extent shape their environments. Andrews, Tennant, Hewson, et al. (1978) suggested that

coping and social supports influence the risk of psychological impairment, but they emphasized that coping and social support are independently related to neurosis and do not primarily exert their effects by 'detoxifying' high stress. In general, their data show that those who had good coping and support did have minimum stress. The risk of psychological impairment was five times as high among those who were under stress and had poor coping and support.

On the whole, this model emphasized the role of interpersonal relationships in maladjustment and readjustment (as well as in generating and treating pathological symptoms). In line with this assumption, Joiner, Brown, Felthous, et al. (1998) more recently showed that depressed subjects obtained lower scores on a social contact measure than non-depressed control subjects.

By reviewing the above theories it is clear that there exists a wide range of thoughts and speculations about the aetiology of depression. It seems that people are getting depressed through various causes and mechanisms; this can also be observed in the subjects of the present study _the causes of their depression are different and varied.

2.3. Culture

2.3.1. Definition of Culture

Culture has been defined as the accumulation of values, rules of behaviour, forms of expression, religious beliefs, occupational choices, and the like for a group of people who share a common language and environment (Triandis, 1994, cf. Bernstein,

Clarke-Stewart, Roy, et al., 1997). As such, culture is an organizing and stabilizing influence. It encourages or discourages particular behaviours and mental processes; it is also allows people to understand and anticipate the behaviour of others in that culture. It is a kind of group adaptation, passed by tradition and example rather than by genes from one generation to the next (Munroe & Munroe, 1994, cf. Bernstein, Clarke-Stewart, Roy, et al., 1997).

Psychologists as well as anthropologists have isolated many respects in which cultures differ (Berry, Poortinga, Segall, et al., 1992). One of the interesting ways of analysing these differences is by describing cultures as either individualist or collectivist. Individualist cultures tend to accept people who place personal goals ahead of the goals of the collective (such as the family or work group), whereas collectivist cultures tend to reject such people and to encourage subordination of personal goals to those of the collective (Guisinger & Blatt, 1994). Table 2.1, which was provided by Bernstein, Clarke-Stewart, Roy, et al. (1997), outlines these differences.

Table 2.1. Differences between individualist and collectivist cultures on several variables

Variables	Individualist	Collectivist
Personal identity	Separate from others	Connected to others
Major goals	Self-defined; be unique; realize your personal potential; compete with others	Defined by others; belong; occupy your proper place; meet your obligations to others; be like others
Criteria for self-esteem	Ability to express unique aspects of the self; be self-assured	Ability to restrain the self and be part of a social unit; be self-effacing
Source of success and failure	Success comes from personal efforts, failure from external factors	Success is due to help from others; failure is due to personal faults
Major frame of reference	Personal attitudes, traits, and goals	Family, work group

Culture is often associated with a particular country, but in fact most countries are multi-cultural; in other words, they host many sub-cultures within their borders. Often, these sub-cultures are formed by people of various ethnic groups (Oyserman, 1993).

2.3.2. Culture-Universal and Culture-Specific Frameworks: Emic and Etic

Each culture has its universal framework, which is shared with other cultures, and its specific framework, which belongs to the people of that culture and which is not shared with others from different cultures. This specificity gives each culture its own identity. These two terms ('universal' and 'specific') correspond to the cross-cultural specialist's terms 'emic' and 'etic' respectively. Jahoda (1983) indicated that the origins of the notions of emic and etic come from anthropology. From its inception in the 19th century

anthropology had a dual orientation, which generated conflict. On the one hand, the aim was to discover something about human nature in general as manifest in the numerous cultures around the globe; on the other hand, the aim was to understand particular cultures, with little or no concern for generalizations beyond their boundaries.

The latter approach gave rise to a debate as to how far it was possible to get 'inside the skin' of the people one was studying. This issue became more prominent with the advent of modern field methods in the 20th century. Thereafter the emphasis shifted increasingly towards comparisons between cultures, and then the problem of how to deal with all manner of variations presented itself. Jahoda (1983) suggested that ideally what was needed was a general theory of behaviour transcending as well as accounting for cultural variations.

Kenneth Pike (1954) (cf. Jahoda, 1983), an anthropological linguist, made an ambitious attempt to meet such a need. Although his design, for various reasons, did not meet with any success, he bequeathed to social science a pair of terms that has gained wide currency, namely emic and etic. One can argue that Pike may not have achieved major success in this theory because of the complexity and variability of the cultural issue.

The terms emic and etic refer to the two goals of cross-cultural research. One goal, the etic, is to establish theoretical frameworks useful in comparing human behaviour in various cultures. The term etic comes from phonetic analysis. In linguistics, a phonetic system is one that documents and analyses all meaningful sounds present in all languages and integrates them into a general framework. The other goal of cross-cultural research

is to document valid principles of behaviour within any one culture, with attention to what the people themselves value as important as well as what is familiar to them. Such analysis has to reject the importation and imposition of frameworks from outside the culture since, by definition, a researcher cannot gain insight into emics by using foreign tools; the tools must be indigenous. This type of analysis is called emic, which is a term from phonemics. In linguistics, a phonemic analysis documents sounds meaningful in a specific language (Corsini, 1994).

The metaphors of emic and etic for cross-cultural research, then, contain the elements referred to above: what is present and absent, what is meaningful, what has to be given special attention since it is common in one system but not another, and what can be systematized into integrative frameworks (Corsini, 1994). A useful summary of the global distinctions between the etic and emic approaches has been provided by Berry (1969) and is shown below in Table 2.2.

Table 2.2. The distinctions between the emic and the etic approaches

Emic approach	Etic approach
- Studies behaviour from within the system. - Examines only one culture. - Structure discovered by the analyst. - Criteria are relative to internal characteristics.	- Studies behaviour from a position outside the system. - Examines many cultures, comparing them. - Structure created by the analyst. - Criteria are considered absolute or universal.

Cross-cultural researchers have attempted to deal with both etics and emics in their research. For example, Brislin (1980) has proposed a system for cross-cultural research which represents such an attempt. The researcher starts by examining concepts that may

have cross-cultural validity, but keeps in mind that not all aspects of those concepts will be the same in all cultures under study. Aspects may be different both for cultures across nations and for various cultures or sub-cultures within a country.

Berry (1969) attempted to provoke discussion and argument on cross-cultural methodology by suggesting that cross-cultural psychologists adopt a three-step procedure to ensure the comparability of behaviour across cultures: (1) aspects of behaviour occurring in differing behaviour settings may be compared only when they can be shown to be functionally equivalent, which means that if similar activities have different functions in different societies, their parameters cannot be used for comparative purposes; (2) when aspects of behaviour occurring in differing behaviour settings are functionally equivalent, a comparative descriptive framework valid for both behaviour settings can be generated from an internal description of behaviour within each setting; (3) only when both these conditions are met may one attempt to construct and apply instruments to gauge behaviour in the two settings.

Berry (1969) suggested that this attempt must also satisfy the criterion that the instruments are conceptually equivalent to individuals in the two settings. In other words, care should be taken to ensure that material used to elicit responses possesses similar meaning to individuals in different cultures.

The purpose of the three-step procedure was summarized by Berry (1969, p. 124) as follows:

'It is obvious that our only entry into any system of behaviour must be by way of something external to that system. This can either be an emic from our own or some other system, or some assumed etic which we hope will be useful for our understanding of the new system of behaviour. The HRAF and ethnopsychiatric studies have entered with an assumed etic, while the cross-cultural psychologist has either done the same or attempted to impose an emic (usually one of Euro-American origin). Neither of these approaches is satisfactory because they are likely to be meaningless to the individual in the new behaviour system (conceptual non-equivalence); however, of necessity, they are the best that can be done. These attempts may be termed an imposed etic approach and are fatal to the aims of the analysis if they are imposed blindly, being closed to the possibility of modification from within the new system. Results from this sort of investigation can never produce anything more than anecdote study (in culture X, they score Y on test Z) and, of course, this can tell us nothing about the relationship between behaviour and cultural, social or ecological variables...modification of our external categories must then be made in the direction of the system under study, until we eventually achieve a truly emic description of behaviour within that culture. That is, an emic description can be made by progressively altering the imposed etic until it matches a purely emic point of view; if this can be done without entirely destroying or losing all of the etic character of the entry categories, then we can proceed to the next step...we can now set up a derived etic which is valid for making comparisons between two behaviour settings,...when all systems which may be compared (limited by the initial functional equivalence requirement) have been included, then we have achieved a universal for that particular behaviour'.

One can conclude that Bery's work on this theory has added more to our understanding of the concept that was invented by Kenneth Pike.

2.3.3. The Effect of Culture on Psychiatric Disorders and Diagnosis

The symptomatology of any illness is not only the expression of a pathological process in an individual, but depends upon many other factors, such as environment, and social and cultural background (Kleinman, 1978). Culture has been recognized as a pivotal factor in mental health diagnosis and treatment (Comas-Diaz & Griffith, 1988; Kleinman, 1978). Indeed, the American Psychiatric Association (APA) has formally acknowledged the significance of cultural issues in its diagnostic manual (DSM-IV). The same care has

been given to the cultural influence on mental health by the World Health Organization (WHO) in its diagnostic manual (ICD-10). Both manuals now include an introductory section placing cultural issues in a clinical context, and a sub-section in each diagnostic category with relevant cultural treatment issues. Furthermore, DSM-IV provides an appendix (appendix 1) that includes an outline for cultural formulations in diagnosis, along with a glossary of culture-bound syndromes recognized in other cultures that are not included in the main text (American Psychiatric Association, 1994).

The American Psychological Association has also paid attention to cultural and ethnic factors affecting mental health, developing guidelines for providers of psychological services to ethnically, linguistically, and culturally diverse populations. These guidelines recognize ethnicity and culture as significant parameters in understanding psychological processes, acknowledge that socio-economic and political factors have a significant impact on the psychosocial, political, and economic development of culturally diverse groups, recognize the need to help clients to understand, maintain, and resolve their ethno-cultural identification, and recognize the need to understand the interaction of culture, gender, and sexual orientation on behaviour (American Psychiatric Association, 1993).

The systematic examination of psychopathological manifestations in different cultures has yielded two general findings. One suggests that the same major disorders occur in a variety of different cultures. The other asserts that culture significantly influences the expression, course, and outcome of psychological disorders. The integration of these two types of finding strongly suggests that cultural variations in psychopathology occur

around a detectable core of universal features of psychological dysfunction (Draguns, 1985, cf. Comas-Diaz, 1996).

Kiev (1972) reported that the view that cultural factors condition the basic form and structure of psychiatric symptoms and illness has been in large part driven from reports of special transient forms of schizophrenia, along with a high frequency of hysterical disorders and a low frequency of depressive disorders, in developing societies. He indicated that while it is easy to see how culture can contribute to patterns of psychological deface, criteria for entry into the sick role, and attitudes towards specific symptoms, it is more difficult to understand how culture is able to affect the basic structure of psychiatric disorder. Kiev (1972) suggested that examination of the data will serve to clarify some of these issues, but it should be noted that these kind of studies do not prove that cultural factors produce illness, or even that some psychiatric entities occur only in specific cultures. Their importance is in demonstrating how culture may influence both the manifestations and the treatment of psychiatric illness, and how it determines the contents and the symbols that are associated with such illness.

Furthermore, Kleinman (1993) argued that culture affects the diagnostic patterns of clinicians as much as it influences the forms and patterns of disorder, individual coping mechanisms, and the strategies that families engage in to cope with the afflicted members (cf. Comas-Diaz, 1996).

Regarding the implications of Western categories of mental disorders in other cultures, Fernando (1995) argued that the dominant theme in Western culture, implemented

through psychiatry and psychology, is that problems to do with thinking, emotional reaction feelings, fears, anxieties, depression, etc. are conceptualized in terms of illness. Even family problems and social behaviour and hatred and jealousy are sometimes fitted into the illness model. He suggested that this Western way of conceptualizing mental health problems is alien to Asian and African cultural world views and, perhaps if we think about it, alien to what many people feel even in Western countries. Fernando (1995) concluded that the ideals of mental health implicit in the thinking that underlies training would naturally adhere to the values which are derived from Western culture, because cultures are seen hierarchically on the basis of racist assumptions about where they come from. Therefore, racism affects our perceptions of culture and these assumptions are incorporated into the training of professionals.

Bhugra (1993) emphasized that there is no doubt that culture affects individuals in the specific ways in which they see their environment and show their feelings, emotions, distress or conflict in behaviour, thought or action. He raised questions about the importance of cross-cultural psychiatry, stating that it may enable the clinician to understand the stress as well as the strengths that enable the individual to function better. Bhugra (1993) indicated that there should be a clear distinction between cross-cultural and ethnic psychiatry.

Fernando (1991) discussed the differences between race, culture, and ethnicity. He stated that these terms are interrelated in complex ways that depend on historical, political, and social factors. His summary of these differences and interactions is shown in Table 2.3.

Table 2.3. Race, culture, and ethnicity

	Characterised by	Determined by	Perceived by
Race	Physical appearance	Genetic ancestry	Permanent (genetic / biological
Culture	Behaviour Attitude	Upbringing Choice	Changeable (assimilation, acculturation)
Ethnicity	Sense of belonging Group identity	Social pressures Psychological need	Partially changeable

The view that culture can influence the basic structure of psychiatric disorders has been shown to be justified in numerous studies (e.g., Al-Issa, 1990; Mumford, 1993; Sue, Wagner, JA, et al., 1976; Anath, Engelsman, Ghadirian, et al., 1993).

2.3.4. The Effect of Culture on Emotional Expression

To understand the effect of culture on the emotional expression of people around the world, it is important first to know the nature of emotion. Duncan (1968), Andersen and Guerrero (1998), and Panlap (1998) have indicated that emotions originate in communication. Duncan (1968) suggested that we learn 'social feelings' through communication with others by observing their responses to us and learning what our acts mean to them, and subsequently to ourselves as we act out our roles in the community and culture.

Ekman and Friesen (1986) reported that there are at least six primary emotions (anger, fear, surprise, sadness, disgust, and happiness) which are usually considered to be

physiologically based and expressed similarly across cultures. On the other hand, information about secondary emotions was reported from the researches of Izard (1985) and Labouvie-Vief, Hakim-Larson, DeVoe, et al. (1989). They suggest that secondary emotions, such as pride, guilt, and shame, arise culturally through participation in the socio-cultural environment and tend to vary with age, gender, and culture.

Researchers have, over the course of decades, tried to determine whether the communication of emotional states is universal or culturally relative. Scherer and Wallbott (1994) reviewed the major controversy concerning psychological universality of differential emotion patterning versus cultural relativity of emotional experience. They reported that universalism posits that emotion, just like perception, cognition, or learning, is a basic mechanism of human functioning that is relatively invariant over races and cultures, while differentialism posits that emotions, as identified by different language labels, are differentiated with respect to psychological symptoms, expressive behaviour, motivation, and subjective feeling. The results of Scherer and Wallbott (1994) showed highly significant main effects and strong effect sizes for the response differences across seven major emotions (joy, fear, anger, sadness, disgust, shame, and guilt). Their empirical evidence supported the theories that postulate both a high degree of universality of differential emotional patterning and important cultural differences in emotion elicitation, regulation, symbolic representation, and social sharing.

Convincing research in the past 20 years has demonstrated both universal and culture-specific influences on the expression and perception of emotion (Matsumoto, 1991; Andersen & Guerrero, 1998). Cultures exert considerable influence over emotion.

What needs to be determined now is whether cultural dynamics affect the display of emotion and ultimately intercultural communication.

Porter and Samovar (1998) reviewed six diverse aspects of culture which affect emotion. These are: (1) display rules; (2) antecedent events; (3) individualism and collectivism; (4) context diversity; (5) non-verbal communication; and (6) language. They indicated that the cultural diversity of these aspects affects the expression of emotions in inter-cultural settings. These aspects are now discussed.

2.3.4.1. Display Rules

The term 'display rules' was coined by Ekman and Friesen (1975) to describe cultural influences on what people learn about the need to manage the appearance of particular emotions in various situations. Andersen and Guerrero (1998), Ekman (1978), and Shennum and Bugental (1982) (cf. Porter & Samovar, 1998) have suggested five culturally learned display rules: (1) simulation (showing non-existent feelings); (2) intensification (the appearance of more feelings than are actually felt); (3) neutralization or inhibition (giving the appearance of having no feelings when in reality you have a feeling); (4) deintensification (appearing to have fewer feelings than you actually possess); and (5) masking (covering one's true feeling by expressing a feeling that is not being felt). One can say that these display rules vary from one culture to another, if not within the same culture. It is obvious that culture imposes display rules when children are taught what they may and may not do, through unconscious observation, imitation of peers and adults, and through parental reinforcement (Andersen & Guerrero, 1998).

Porter and Samovar (1998) reviewed research which has shown the influence of culture on display rules. For example, Yun (1994) (cf. Porter and Samovar, 1998) found that in many Asian countries, such as China, Japan, Taiwan, and Korea, display rules are derived from Confucian principles and strong collective social relationships. Individuals in these counties attach great importance to the maintenance of proper social relationships, and it is improper to display emotions such as anger, disagreement, or contempt in public situations. Instead they encourage the individual to mask real feelings and to maintain appropriate social relationships. In the Middle East, when expressing anger or grief, the display rules prescribe loud, prolonged, and often anguishing behaviours.

Ekman and Friesen (1975) revealed that people only pause to think about display rules if they are in a strange or unique situation or if they are unable to interpret the social situation and need to determine their role and what is expected of them.

2.3.4.2. Antecedent Events

Mesquita and Frijda (1992) have suggested that emotions are elicited by antecedent events. Different individuals and groups may meet different kinds of events and be differently affected by them. The range of events an individual or group is emotionally sensitive to is an aspect of that individual's or group's characterization. These events are usually categorized in terms of event types that are recognized by the culture (event coding), which implies the recognition of a particular, culturally shared meaning.

Mesquita and Frijda (1992) assumed that these event-type schemata constitute one of the major pathways by which social perspectives and moral values enter the cognitive

structure that elicits emotional appraisal. Appraisal processes here can be conceived of as a series of checks with respect to a set of dimensions such as positive or negative valence, causation by someone else or the self, blameworthiness, outcome uncertainty, controllability, and modifiability. A series of such checks describes the emotional significance of an event (Frijda, 1986; Ortony, Clore, & Collins, 1988; Roseman, 1984; Scherer, 1984).

Mesquita and Frijda (1992) concluded that antecedent events, event coding, and appraisal are closely linked. Events are often coded in a particular way, and particular codings often entail particular means of appraisal. For instance, when an illness is coded as an outcome of witchcraft, it is necessarily understood as harmful, because of someone's agency, and difficult to control. Yet the components of event, coding, and appraisal are subject to separate sources of individual and cultural variation. Furthermore, cultural diversity in antecedent events and the effect it has on various emotional states may be seen by looking at the emotions of joy and happiness, sadness and grief, fear and anxiety, and anger and rage (Scherer & Wallbott, 1994).

It is very evident that antecedent events shared with other members of family or society will reinforce the emotional reaction of the individual, especially when it is culturally coded in a particular way.

2.3.4.3. Individualism and Collectivism

The influence of these cultural dynamics on emotions may be understood in terms of social roles and structures known as ingroups/outgroups. Matsumoto (1991) described

the self-ingroup relations as those which provide the safety and comfort requisite for free emotional expression and which tolerate a broad spectrum of emotional behaviour, while self-outgroup relationships are those which do not provide this flexibility and tolerance. People are more comfortable in expressing emotions to their families than to strangers in public, since the relationship with their families provides an environment in which emotions may be expressed in ways that could not be understood or perhaps tolerated by strangers.

Triandis, Botempo, Villareal, et al. (1988) indicated that the meanings of self-ingroup and self-outgroup relationships are culturally diverse and lead to cultural differences in emotional behaviour. Cultures with an individualistic orientation have more ingroups, and their societal survival is dependent in large measure upon an individual's efficiency and striving rather than upon groups within the society. In collective cultures, by contrast, people belong to outgroups, and their societal survival is much more dependent upon the effective functioning of groups than upon individual achievement (Matsumoto, 1991).

Because of these cultural differences in group relationships between individualism and collectivism, Matsumoto (1991) argued that collective cultures will foster emotional displays that maintain and facilitate group cohesion, harmony, and cooperation to a greater degree than individualistic cultures. He suggested also that the degree to which emotions are communicated in a culture varies according to how well they facilitate or hinder group cohesion. For example, Japanese people are more likely than Americans to suppress negative emotions because their collective culture demands a greater degree of harmony within its ingroups. Yet Japanese people would be more inclined than

Americans to express negative emotions if it would facilitate group cohesion.

Matsumoto (1991) found a wider variety of emotional behaviours within individualistic cultures than within collectivist cultures. Individualistic cultures valued this variety, while collectivist cultures discouraged it. He also found that the amount of emotional behaviour in individualistic cultures is larger than in collectivist cultures.

One can agree that people in collectivist cultures, such as the UAE's, are more comfortable in expressing and sharing their emotions with their families and other intimate relatives. Hence, there is much less emotional behaviour in these cultures than in the individualistic cultures.

2.3.4.4. Context Diversity

Context is the social and physical environment in which communication occurs, and includes the preceding and consequent facial expression, as well as body positions and movements, words and vocal tones, the nature of the setting, what has been happening previously, and who else is present (Ekman, Friesen, & Ellsworth, 1989, cf. Porter & Samovar, 1998).

Porter and Samovar (1998) provided a notion of context that has two dimensions. First, the social context influences the interpretation of emotions. This notion of context is reflected by the environment in which communication occurs; hence, the social environment helps to determine which emotions may be displayed, and aids in the interpretation of those emotions. The second dimension of the context is expressed by the

term 'high- and low-context cultures' (Hall, 1976; cf. Porter & Samovar, 1998); Hall categorized cultures as being either high- or low-context, depending on how much meaning their members attach to settings. The high- and low-context of cultures affects the types of messages that are created within those cultures. Therefore, contextual differences lead to cultural diversity in expression. In high-context cultures relatively little information is actually contained in verbal messages or facial expression. These cultures enjoy a consistency of messages that produces consistent responses to the environment, and, because of tradition and history, these cultures change very little over time.

In low-context cultures, by contrast, most of the information is contained in the verbal message or in facial and bodily movements. Participants lack a large pool of common experiences, which means that whenever they interact with others they need detailed background information (Hall & Hall, 1990, cf. Porter & Samovar, 1998).

One can conclude that this point is relevant to the present study because the context of our communication varies widely between different high- and low-context cultures.

2.3.4.5. Non-verbal Communication

It is well established that culture can affect non-verbal communication (Porter & Samovar, 1998). Tsunoda (1979) has shown how cultures transform simple behaviours into many different messages. He indicated that in our interactions with people from different cultures, we encounter non-verbal displays with meanings unique to their culture or sub-culture. Erickson (1979) studied, through slow-motion analysis of film,

characteristic ways of speaking and listening among Blacks and Whites in an interview situation, and found that their styles of listening and speaking are quite different. This, he said, may be related to cultural differences between Blacks and Whites in the timing of kinesic activity (e.g., head nods, eye contact) and speech that reflects understanding and paying attention.

Rosenthall, Hall, Archer, et al. (1979) developed an instrument designed to measure differential sensitivity to various channels of non-verbal communication (the Profile of Nonverbal Sensitivity Test, PONS). They found that a number of groups (e.g., cross-cultural, psychopathological, by sex, and by age) showed differential ability in interpreting information transmitted through the different non-verbal channels measured by the PONS. Hall (1979) summarized the effect of culture on such non-verbal communication, and indicated that it is evident that culture, for the most part, has been oriented towards the past and has had as one of its principal functions the provision of models that allow the members of a given culture to have clear-cut ways of relating to each other. He revealed that no culture has developed special skills in relating to outsiders in any terms other than its own.

2.3.4.6. Language

The impact of culture on emotional expression can be seen in its determination of how such feelings as happiness, sadness, and anger should be expressed (McConatha, Lightner, & Deaner, 1994). Matsumoto and Assar (1992) have indicated that all languages derive from and represent the cultures from which they originate. To see the connection between language and culture they compared the American English culture

and language to the Japanese culture and language. They found that the American culture is less structured, places little emphasis on social positions, and permits significant individual variation in adhering to the rules of the culture. Concomitantly, their language is a relatively complex one that involves rules of grammar and syntax but contains many exceptions to these rules. Thus American English tends to be relatively independent of social context and varies little even when differences exist in the social positions of the persons interacting.

Japanese culture and society, on the other hand, are bound by rigid rules that govern social relationships and social status in all aspects of life. Their language is rigid and highly structured, and also employs rules of grammar and syntax B but allows very few exceptions to those rules. The Japanese language differs substantially in various social situations; for example, if a Japanese person is speaking to someone of lower social position, he or she is permitted to speak in a particular way.

Russell (1991) reviewed ethnographic and cross-cultural studies on emotion lexicons. He found that these studies hint that different languages provide different categories for the emotions; at the same time, other evidence revealed similarity in emotion categories across different cultures and languages. In a further step, Russell (1991) examined evidence and hypotheses relating to how emotions are categorized in different languages and cultures. He concluded that people of different cultures and languages categorize the emotions somewhat differently. The boundaries around the domain appear to vary, as do divisions within the domain. Thus, neither the word *emotion* nor words for even allegedly basic emotions, such as anger and sadness, are universal. Russell (1991) emphasized that

the presence of differences between cultures in categorizing emotions does not mean that these categories do not exist within particular cultures, but that both similarities and differences in how the emotions are categorized exist in different languages and cultures.

Fernando (1991) reviewed the emotions and their expressions. He indicated that complicated personal, cultural and social meaning complexes may fashion the way in which emotion is expressed through behaviour, and that the socio-cultural context in which an emotion is felt and expressed may affect the outcome. He added that emotions may be suppressed, distorted or exaggerated for psychological, social or cultural reasons; some feelings, or the way they are expressed, may be designated as illness. Fernando (1991) went on to state that feelings may be expressed in terms of idioms that have become imbued with meaning through usage underscored by symbolic associations. Inevitably, such idioms of feeling states are heavily determined by habits and traditions arising from culture as well as contextual factors and personal inclinations. The validity of these idioms stems from their usefulness as forms of expression and/or adaptation for the individual. Thus, the socio-cultural dimensions of emotional expression are varied and complex.

In studying the idiomatic expression of psychosocial distress, Nichter (1981), an anthropologist, proposed that the judgment of a particular idiom of distress as normal or abnormal, or adaptive or maladaptive, should not be made until the following have been considered: an individual's socio-cultural constraints on and opportunities for expression, alternative modes of expression, personal and cultural meaning and social ramifications of employing modes, and a person's past experience and familiarity with alternative

modes.

Fernando (1991) has argued that the question of communication and rapport between patient and physician is fundamental to the idioms used for the expression of distress. In situations where both participants in an interaction have similar understanding of the idioms, communication is easy and the idioms of expression that are *natural* to both can be usefully employed. But if there is a cultural gulf between them, problems arise. Fernando believes that such a gulf can be overcome by knowledge, which can be obtained from the patient, but this may be blocked if the interaction takes place in a context where the physician is influenced, consciously or unconsciously, by racist value judgements of the patient or his/her culture.

It is clear that the literature on the linguistic diversities and the cultural dynamic that affect emotional expressions shows that the effect of culture on linguistic diversities appears in the following: (1) the judgements of emotion; (2) the categories of emotion; and (3) the framing of communicative behaviour. This is because different cultures and languages provide different categories, frames and judgements, although there are some similarities as well.

2.3.5. The Effect of Culture on the Concept of Depression

Marsella, Sartorius, Jablensky, et al. (1985) have indicated that popular conceptions of depression are similar to the medical description. The current medical conception of depression asserts that it is a psychiatric syndrome characterized by specific affective,

cognitive, behavioural, and somatic symptoms. Indo-European languages have many words that refer to depressive experiences. Marsella and his colleagues (1985) stated that this view may be unique to European and North American cultures since equivalent concepts of depression are not found among many non-European groups.

Thus Marsella and his colleagues discussed a definition of culture that not only involves an *external* variable involving artefacts and practices of particular ethnic groups, but also an *internal* variable represented in knowledge, beliefs, attitudes, cognitive styles, self-referent systems, and other varieties of subjective experience relevant to depression. They argued that cultural factors constitute an important context for all aspects of depressive experience and disorder which must be considered if an accurate understanding of depression is to be achieved. They added that a definitive answer would require a careful appraisal of the *emic* conceptualization of depression. They reviewed many studies concerning the concept of depression among different cultural groups such as Nigerians, Chinese, Canadian Eskimos, Japanese, and Malaysians. They concluded that the fact that no conceptually equivalent terms for depression exist in many non-European cultures does not mean that depressive disorders do not exist. Rather, it is possible that the subjective experience of depression, its behavioural manifestations, and the social responses to it may vary across cultures.

Several investigators have conducted empirical studies regarding the conceptualization of depression across cultures. For example, Leff (1973) reported that developed (Western) countries show a greater differentiation of emotional states (e.g., depression and anxiety) than developing countries. He also reported that data from a US/UK project

indicated that a group of Black American patients showed significantly less emotional differentiation than a matched group of White American patients.

In 1974 Leff expanded his research to explore any possible differences between psychiatrists from the various cultures in the way in which they perceived patients' verbal expression of emotion. He found that psychiatrists from developed centres agreed with psychiatrists from developing centres in their perception of the degree of emotional differentiation shown by patients from developed centres. However, their ratings of patients from developing centres indicated a significant disagreement. Psychiatrists from developing centres saw these patients as exhibiting a relatively low degree of emotional differentiation, whereas their colleagues from developed centres rated them significantly higher in this respect. Leff (1974) concluded that the assessment by the developing centre psychiatrists was more likely to be accurate.

Later on, Leff (1977) indicated that the local cultural meaning of *being depressed* varies widely both with patient's language family and with differentiation of emotional terminology. Hence Leff's works strongly support the contention that the diagnosis of depression is influenced by the perceptions of both patients and psychiatrists.

Gada (1982), in his study of 100 depressed patients from western India, reported that there are significant differences in the symptomatology of depression between western Indian and north Indian depressed patients, and between western Indian and south Indian depressed patients. Gada (1982) indicated that some of these differences are likely to have been determined by differences in the numbers of endogenous and neurotic

depressed patients in the samples; others are likely to have been a reflection of background cultural factors, as India is a country where socio-cultural and religious practices differ significantly from region to region. Gada (1982) also found that, relative to British depressed patients, somatic symptoms, hypochondriasis, anxiety, and agitation presented in a significantly larger percentage of Indian depressed patients, while guilt feelings and obsessional and paranoid symptoms were significantly less frequent.

So it is clear that the concept of depression is affected by the patient's language family as well the perceptions of the psychiatrists and the reflection of other background cultural factors.

Furnham and Malik (1994) compared native Britons' and Asian-Britons' (from the Indian sub-continent) beliefs about the causes and cures of depression. They found that middle-aged Asian migrants significantly differed from the middle-aged British and young Asian samples in their beliefs about depression and anti-depressive behaviour. Furnham and Malik (1994) concluded that perceptions of the causes and symptoms of depression and appropriate anti-depressive behaviour were mediated by cultural values and beliefs that the individual was exposed to in their formative years, which subsequently affect their tendency to recognize, report and seek help for depression.

Furthermore, various writers, including Chang (1985, 1988), Fernando (1988), Furnham and Kuyken (1991), Leff (1988), and Prince (1990), have pointed out that culture establishes not only what constitutes an illness, but also the appropriate response to that illness. Thus, culture affects the way in which biological changes in the body and

psychological factors are perceived and acted on or not acted on, depending on expectations, taboos and current knowledge of cause and effect in that culture (Rack, 1982, cf. Furnham & Malik, 1994). Hence, it can be argued that the experience of symptoms is, in part, determined by culture, which in turn affects the account of the illness given to the professional (Furnham & Bochner, 1990, cf. Furnham & Malik, 1994). In other words, non-Western populations do experience depression but they respond to it differently.

Yet another approach to understanding the conceptualization of depression across cultures has been the study of indigenous categories of mental disorder. Marsella (1980) reviewed a number of these studies (e.g., Resner & Hartog, 1970, in Malaysia; Schmidt, 1964, in Borneo; Prince, 1964, Edgerton, 1966, and Orley, 1970, in Africa; and Boyer, 1964, among American Indians). He found that in all these studies there were no concepts that represented depression as either a disease symptom or a syndrome. Marsella (1980) claimed that this fact should not be taken lightly, since it points to a possible bias among many Western-oriented investigations that pay little heed to indigenous conceptions of disorder in arriving at conclusions regarding the distribution and expression of depression. He noticed that it becomes apparent in the various reports regarding the conceptions of depression is that the term is not well represented among the lexicons of non-Western people. He indicated that this does not mean that depression, as it is defined in the West, is absent in cultures that do not have conceptually equivalent terms, but that it is conceptualized differently and may be experienced differently.

Marsella (1980) argued that although individuals from different cultural groups may have

similar psychological states, the recognition, interpretation, and behavioural representation of problems may vary across cultures, and the social response to the behavioural representation may also differ. He therefore concluded that depression would be embedded in an entirely different context and assume an entirely different meaning across different cultures.

In contrast, Bebbington (1993), from his transcultural point of view, indicated that the concepts of depressive disorder were developed within a Western intellectual culture, and that the utility of these concepts would be enhanced if their applicability extended beyond their culture of origin. He argued that there is no doubt that some cultures use conceptualizations of the form of dysphoria which differ from the syndromes employed by Western scientists. However, it can likewise be argued that this fact, while of intrinsic interest, is not necessarily relevant to the cross-cultural identification of those syndromes. In other words, the fact that some cultures organize their concepts of dysphoria in a different way does not mean that Western syndromes cannot be applied within those cultures. All this requires is that most of the symptoms that constitute the syndromes can be recognized.

Bebbington (1993) provided many examples to emphasize his point of view. For instance, he discussed the findings of Binitie (1975), indicating that although Binitie found that suicidal ideation and guilt were less common in Nigerian than English subjects, depression could certainly be recognized in the former by the presence of depressed mood, somatic symptoms and motor retardation. Bebbington concluded that these differences were matters of degree and in any case were not large. He emphasized

that the transcultural perspective illuminates the essentially Western psychiatric conceptualizations of depression. However, the virtues of regarding diseases as heuristic categories affording a framework for clinical investigation are twofold: the validity of other conceptualizations is readily acknowledged, but, by the same token, their existence does not invalidate the use of the disease categories themselves. It is clear that although Bebbington tried to emphasize the transcultural aspects of depression, he could not ignore its cross-cultural aspects.

Going beyond these observed cultural correlates of depression, a number of elaborate theories have been proposed to account for both the origin of and the variation in depression. Fundamentally, these theories have assumed either psychodynamic or social-psychological conceptual frameworks (Berry, Poortinga, Segall, et al., 1992). Marsella (1980) discussed these theories in terms of the following variables emphasized by the theorists.

(1) *Family structure.* Extended families provide more elaborate social support, close mother-child relationships, and reduced risk of loss of loved ones.

(2) *The conforming personality.* Depression is more likely to occur among highly socialized individuals who tend to conform to societal and parental pressures. Marsella (1980) indicated that this hypothesis failed to confirm the notion, and the cross-cultural evidence also conflicts with the conformity hypothesis, since depression rates appear to be much lower in those cultural milieus that stress conformity rather than individuality.

(3) *Social cohesion*. Depression rates would be higher among women, members of highly traditionalized and tightly knit social groupings. These ideas received some support from many of the studies cited by Marsella (1980). Yet the *social cohesion* idea is in conflict with many epidemiological studies of traditional societies, which have shown that depression rates are extremely low. Marsella explained that it may be due to the fact that the social cohesion concept is part of a much larger and more complicated equation of variables that must be used to predict depression rates.

(4) *Psychological defences*. Depression may be low in certain non-Western cultures because of the reliance on psychological defences that are socially sanctioned.

(5) *Mourning rituals*. Low rates of depression may result from ritualized and overt expressions of grief.

(6) *The expression of aggression.* Cultures providing outlets for aggression will experience low levels of depression.

(7) *Self-structure.* Patterns of symptom expression found among different ethnocultural groups may be related to the nature of the self-structure, which is conditioned in such a way that if a culture conditions a view of self as somatic functioning, somatic symptoms will dominate the picture. In contrast, if a culture conditions a view of self as an existential process, existential complaints will dominate.

Marsella's (1980) own theory involves a cultural dimension of *epistemic orientations*

(that is, objective versus subjective orientation). In the relatively *objective* type of culture there is an abstract language and individuated self-structure; by contrast, in *subjective* types of culture there is a metaphorical language and more communal structure. According to Marsella, depression takes a primarily affective and cognitive form in cultures with objective orientation and is experienced as a sense of isolation, while it takes a primarily somatic form in cultures with subjective orientations.

In general, depression appears to be related to both the quantity and quality of stresses presented in a culture, especially during the critical period of childhood, when object attachments are being formed. There is no doubt that there are strong theoretical grounds for expecting differences in the frequency and manifestation of depression across different cultures. Marsella (1980) indicated that most theoretical interpretations are based on psychodynamic and/or social-psychological precepts. However, there is an absence of systematic empirical studies based on these concepts.

Hence, one is faced with the challenges of devising ways or inventing research instruments to test the validity of these psychodynamic and social-psychological theoretical interpretations of depression.

2.4. Coping Strategies

2.4.1. The Concept of Coping

The concept of coping has been important in psychology for over 40 years (Lazarus & Folkman, 1984). It is currently the focus of an array of psychotherapies and educational

programmes which have as their goal the development of coping skills. The subject of coping has also received widespread lay attention, but despite the rich history and popularity of the concept, there is little coherence in theory, research, and understanding _it is at best confused (Lazarus & Folkman, 1984, 1991).

The concept of coping has been managed with different approaches. It will therefore be useful to clarify these approaches in order to describe the conceptualization of coping more fully.

2.4.2. The Traditional Approaches

Traditional approaches to coping emerged from two separate and distinct literatures: animal experimentation and psychoanalytic ego psychology. Lazarus and Folkman (1984, 1991) stated that within the animal model, coping is frequently defined as acts that control aversive environmental conditions, thereby lowering psycho-physiological disturbance. The central theme of the animal model, they indicated, is the unidimensional concept of drive or arousal, and research centres largely on avoidance and escape behaviour. Lazarus and Folkman argued that what could be learned from this model about human coping, which includes cognitive coping and defence, is modest.

In the psychoanalytic ego psychology model, coping is defined as realistic and flexible thoughts and acts that solve problems and thereby reduce stress. Lazarus and Folkman (1984, 1991) found that the main difference between the treatment of coping in this model and that of the animal model is the focus on ways of perceiving and thinking about

the person's relationship with the environment. This means that the psychoanalytic ego psychology model is centrally concerned with cognition. Lazarus and Folkman also revealed some other differences between these two models. They indicated that the psychoanalytic ego psychology approach differentiates a number of processes that people use to manage troubled relationships. They concluded that systems of coping based on the ego psychology model generally conceive of a hierarchy of strategies that progress from immature or primitive mechanisms, which distort reality, to mature mechanisms.

According to Lazarus and Folkman (1984, 1991), psychoanalytic ego psychology approaches have dominated coping theory, and have also dominated coping measurement. Measurement approaches in this model have tended to assess coping traits (i.e., properties of persons that dispose them to react in certain ways) and styles (i.e., broad ways of relating to particular types of people or situations, similar to traits but differing in degree), rather than processes. For example, the *Type A* behaviour pattern can be thought of as a coping style that includes behavioural, motivational, and cognitive properties.

Lazarus and Folkman (1984, 1991) have criticized these approaches, arguing that the trait and style approach to coping is inevitably incomplete. Measures of coping traits and styles are not good predictors of actual coping processes. Lazarus and Folkman indicated that this approach underestimates both the complexity and the variability of the ways in which people actually cope. They also criticized the application of the concept of automatized adaptive behaviour in the traditional approaches to coping. They indicated that coping implies effort, whereas automatized adaptive behaviours do not. They added

that many behaviours are originally effortful, but become automatized through learning processes.

Lazarus and Folkman (1984, 1991) stated that coping must be viewed as efforts to manage stressful demands regardless of outcomes, since the psychoanalytic model considers the unsuccessful or less successful efforts to deal with stress as defence. They therefore emphasized that no strategy should be considered inherently better or worse than any other judgements as to the adaptiveness of a strategy must be made contextually.

Furthermore, Lazarus and Folkman stated that coping should not be equated with mastery over the environment, because many sources of stress cannot be mastered, and effective coping under these conditions is whatever allows the person to tolerate, minimize, accept, or ignore what cannot be mastered.

2.4.3. Coping Processes Approach

This approach has been developed by Lazarus and his colleagues (e.g., Folkman, Schaefer, & Lazarus, 1979; Coyne & Lazarus, 1980; Lazarus & Folkman, 1984, 1991). In order to understand the coping processes approach, it is important to emphasize that it is based on the cognitively oriented theory of stress and coping developed by Lazarus and his colleagues. This theory posits two processes, which will now be discussed.

2.4.3.1. Cognitive Appraisal

In order to understand how one can deal with stress, it is necessary to know the significance or the meaning of the event to the individual (e.g., Averill, 1973; Bulman & Wortman, 1977; Thompson, 1981). Within the theoretical formulation offered by Lazarus and his colleagues, the meaning of an event is determined by cognitive appraisal processes.

Lazarus and Folkman (1984, 1991) have described two forms of appraisal. *Primary appraisal* is appraisal of the situational demands and how they interfere with goals; in other words, what is at stake for the individual concerned. This includes an appraisal of whether the situation involves harm/loss, threat or challenge, the degree of permanence, costs, etc. *Secondary appraisal* is appraisal of one's own coping resources, of what personal and social resources one can draw upon, as well as what can be done.

Lazarus and Folkman (1984, 1991) argued that neither of these two forms of appraisal should be assumed to occur before the other, or to be the more important. The two processes can occur simultaneously and will influence each other. For example, if an individual, in his or her secondary appraisal, does not have the resources available to deal with the stress, it may cause the primary appraisal to perceive a greater threat than might otherwise be the case. Lazarus and Folkman also asserted that appraisals are not static and are not made only at one point in time, influencing all future behaviours. There is a continuous process of appraisal and reappraisal.

2.4.3.2. Coping

Lazarus and Folkman (1984) defined coping as constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person. They argued that these cognitive and behavioural efforts are constantly changing as a function of continuous appraisals and reappraisals of the person-environment relationship, which is also changing.

Lazarus and Folkman (1984) and Folkman (1984) have indicated that there are three main features of this definition of coping. First, it is *process oriented*, meaning that it focuses on what the person actually thinks and does in a specific stressful encounter, and on how this changes as the encounter unfolds. Second, this definition views coping as *contextual*: it is influenced by the person's appraisal of the actual demands in the encounter and the resources for managing them. Folkman (1984) stated that the emphasis on context means that particular personal and situational variables together shape coping efforts. Third, coping is *changeable*: it is a shifting process in which a person must, at certain times, rely more heavily on one form of coping, and at other times on another form. Thus, there are no *a priori* assumptions about what constitutes good or bad coping.

2.4.3.2.1. Functions of Coping

Coping has two main functions: the regulation of emotion or distress (emotion-focused coping) and the management of the problem that is causing the distress (problem-focused coping) (Lazarus & Folkman, 1984). Support for the existence of these two functions comes from numerous investigators (e.g., Kahn, Wolfe, Quinn, et al., 1964; Mechanic, 1962) and they have long been implicitly recognized by clinicians (e.g., Hay & Oken,

1972; Goldstein, 1980). Folkman and Lazarus (1980) have shown that both forms of coping are used in most stressful encounters and that the relative proportions of the two forms vary according to how the encounter is appraised. For example, emotion-focused forms of coping are more likely to occur when there has been an appraisal that nothing can be done to modify harmful, threatening, or challenging environmental conditions. Problem-focused forms of coping, on the other hand, are more probable when such conditions are appraised as amenable to change.

Lazarus and Folkman (1984) reviewed the literature regarding coping functions and found a wide range of coping strategies which consist in one or other form of coping function. For instance, in the *emotion-focused* forms, they found two groups of processes. First, cognitive forms of emotion-focused coping lead to a change in the way an encounter is construed without changing the objective situation. These strategies are equivalent to *reappraisal*. One large group of these forms consists of cognitive processes directed at *lessening emotional distress,* and includes strategies such as avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from negative events. A smaller group of cognitive strategies is directed at *increasing emotional distress*. Lazarus and Folkman (1984) suggest that some individuals need to feel worse before they can feel better; in other words, in order to get relief they first need to experience their distress, and to this end engage in self-blame or some other form of self-punishment.

Secondly, emotion-focused coping strategies do not change the meaning of an event

directly; the meaning of an encounter can remain the same even if some of its aspects are screened out, or if thoughts about the encounter are put aside temporarily. This form of coping includes behavioural strategies such as engaging in physical exercise to get one's mind off a problem, meditating, having a drink, venting anger, or seeking emotional support. These strategies can lead to reappraisals but are not themselves reappraisals.

In *problem-focused* forms of coping, strategies are similar to those used for problem solving. Problem-focused efforts are often directed at defining the problem, generating alternative solutions, weighing the alternatives in terms of their costs and benefits, choosing among them, and acting. Lazarus and Folkman (1984), according to Kahn, Wolfe, Quinn, et al. (1964), have discussed two major groups of problem-oriented strategies: first, those directed at the environment, which include strategies for altering environmental pressures, barriers, resources, procedures, and the like; second, those directed at the self, which include strategies that are directed at motivational or cognitive changes such as shifting the level of aspiration, reducing ego involvement, finding alternative channels of gratification, developing new standards of behaviour, or learning new skills and procedures.

Lazarus and Folkman (1984) realized that the number of problem-focused forms of coping that are applicable across diverse situations seems relatively limited when compared with the vast array of emotion-focused strategies discussed in the literature. They also indicated that the definition of problem-focused coping strategies is to a certain extent dependent on the types of problems being dealt with, and that trans-situational comparisons of problem-focused coping strategies are more difficult than trans-

situational comparisons of emotion-focused strategies.

The above theory of functions of coping can be applied to any culture. In developing cultures it seems that the emotion-focused coping strategies are more applicable than other coping strategies.

2.4.3.2.2. Sources of Coping

Lazarus and Folkman (1984) indicated that the ways in which people actually cope depend heavily on the resources that are available to them and the constraints that inhibit use of these resources in the context of the specific encounters. These resources include: health and energy; existential beliefs (e.g., about God), or general beliefs about control; commitments, which have a motivational property that can help to sustain coping; problem-solving skills; social skills; social support; and material resources.

Lazarus and Folkman (1984) also suggested that coping may be determined by constraints that mitigate against the use of resources. These constraints are: (1) *personal constraints*, which are internalized cultural values and beliefs that proscribe certain types of action or feeling, and psychological deficits that are a product of the person's unique development (for example, people may have at their disposal many forms of social support in a crisis but be unable to use them because of how they construe this support); (2) *environmental constraints*, which include demands that compete for the same resources, and agencies or institutions that are needed for coping efforts.

Along with resources and constraints, the level of threat that the person experiences plays

a role in determining coping. The extent to which a person feels threatened is in part a function of his or her evaluation of coping resources with respect to internal and external demands in a particular situation, as well as the constraints inhibiting their use. Level of threat, in turn, influences the extent to which available resources can be used for coping. For instance, the greater the threat, the more primitive, desperate, or regressive emotion-focused forms of coping tend to be, and the more limited the range of problem-focused forms of coping tends to be.

2.4.3.2.3. Control or Coping

One of the primary appraisal processes that has received the most attention in research on coping has been that of control. Intuitively, it would seem that to cope with a situation is to attempt to control it, whether by altering the environment, changing the meaning of the situation, and/or managing one's emotions and behaviours.

The cognitive-transactional view of coping suggests that coping strategies will have beneficial effects only when they fit the situation. For example, Lazarus and Folkman (1984) suggested that practical coping will be beneficial only when a situation is within the individual's control. If it is not within the individual's control, emotion-focused coping will be more beneficial. Folkman (1984) argued that the distinction between, on the one hand, control of sense or beliefs in general and control appraisal, and, on the other hand, control as coping, is essential if there is to be clarity about these important concepts in stress and coping theory and research.

Many investigators have tried to clarify these distinctions. For instance, Rothbaum,

Weisz, and Snyder (1982) suggested a two-category taxonomy of control: *primary control*, denoting attempts to change the environment; and *secondary control*, denoting attempts to fit in with the environment or flow with the current. Lazarus and Folkman (1984) discussed this work and realized that the key word in their distinction between the two forms of control is *attempt*, which places these concepts in the category of coping rather than belief or appraisal, although they actually seem to be speaking of a kind of appraisal. Averill (1973) also implicated efforts in his discussion of control. He distinguished between three forms of control: *behavioural control* (direct action on the environment which needs effort); *cognitive control* (the way a potentially harmful event is interpreted); and *decisional control* (the range of choice available to the individual).

Folkman (1984) indicated that it may be difficult to separate control as an appraisal process and control as a form of coping. Therefore, in disaggregating the concept of control with respect to its appraisal and coping functions, it is better to define the pathways through which control affects the outcomes of stressful encounters and short- and long-term adaptational outcomes (Lazarus & Folkman, 1984).

In my view it is more favourable to define the effect of control by the outcomes of the stressful encounters, as well as by the short- and long-term adaptational outcomes.

2.4.4. Coping and Depression

Depression as an emotional aspect of human behaviour has received a great deal of attention with regard to its aetiologies, symptoms, courses, and treatment. But the relationship between, on the one hand, coping and depression or emotion in general, and

how depressed people cope, and, on the other hand, the mediating effects of coping on depression, have not been widely investigated. Folkman and Lazarus (1991) attempted to study the relation between emotion and coping. They tried to evaluate the idea that coping is a response to emotion, and to offer a broader view based on cognitive and relational principles concerning the processes of emotion and coping. They indicated that, in order to understand the relationship between emotion and coping, it is essential to view them from the standpoint of processes, which means refering to the changing character of what the person thinks and does during the unfolding of specific person-environment encounters and across encounters.

Folkman and Lazarus (1991) concluded that two principles must be taken into account when studying the relationship between emotion and coping. The first is that every encounter, even the most simple, is usually complex and contains multiple facets and implications for well-being that either exist side by side or arise sequentially. In order to understand the emotion process, each emotion must be linked analytically to the cognitive appraisal that influences it. The second principle concerns the temporal and unfolding quality of emotion and coping processes. Having reviewed the social literature, especially that dealing with disaster, Folkman and Lazarus (1991) found that encounters involving harm or benefit often have three or more stages: anticipation, confrontation, and post-confrontation. They placed coping within these stages and indicated that coping in anticipation offers an important opportunity to influence what happens at the point of confrontation by preventing or ameliorating harm or facilitating benefit. After confrontation, coping must be aimed at managing the consequences and their implications for the future.

Accordingly, emotions constantly shift throughout this process according to the changing status of the person-environment relationship. These two principles highlight the complex and dynamic nature of emotions and coping in social encounters and point the way for researchers to investigate empirically the precise mechanisms through which coping mediates the emotional response (Folkman & Lazarus, 1991)

Depression researchers who have investigated how depressed people cope with everyday difficulties have borrowed a common strategy from the stress literatures. For example, Coyne (1982) has suggested that one will not achieve an adequate model of depression without an understanding of the depressed person=s ecological niche, typical responses, and resulting feedback. Coyne, Aldwin, and Lazarus (1981) studied depression and coping from the standpoint of existing cognitive models of depression in a number of significant ways. First, they elaborated on the role of coping, and recognized that it has an emotion-regulating function as well as a problem-focused function. Second, their focus on a person-environment unit suggests that the persistence of depression does not require a cognitive structure, schema, or style that moves from one situation to another without regard to feedback. Instead, they indicated that the depressed person may face situations that are intractable to, or even maintained by, the particular ways of coping that are chosen.

Coyne, Aldwin, and Lazarus (1981) thought that theorists overestimated the consistency of the behaviour and cognitions of depressed persons. They argued that this consistency is a feature of a cycle in which depressed persons tend to appraise situations as concerning loss and threat of further loss, cope ineffectively, face distressing

circumstances, and, in turn, approach new situations burdened by this. Coyne (1982) indicated that the problems of depressed persons are not based solely in their cognition or perceptions of their circumstances, but in their transactions with their environments.

On this basis of the interpersonal dimension of depression emphasized by Coyne (1976a, 1976b), Coyne, Aldwin, and Lazarus (1981) found that the coping of depressed persons was characterized by seeking emotional and informational support and by wishful thinking, and that they did not differ from non-depressed persons in the amount of problem-focused coping or self-blame. Consistent with these results, Billings and Moos (1984) noted that coping responses directed toward problem solving and affective regulation were associated with less severe dysfunction, whereas emotional discharge responses, more frequently used by women, were linked to greater dysfunction.

Mitchell, Cronkite, and Moos (1983) also found that greater levels of events and strains, and less family support, which provoke higher levels of depression, are accompanied by lower proportions of problem-focused coping. Depressed patients in Parker and Brown's (1982) sample reported socializing less and engaging in fewer distracting activities, and they rated themselves as more passive.

Coyne and Downey (1991) concluded that the findings of studies on coping and depression indicate that persons with chronic depressive symptoms do more wishful thinking, escape-avoidance, confrontation, and support-seeking. They also indicated that the results from coping studies have not yet been particularly informative. Such studies offer little advice as to improving the coping of persons vulnerable to depression or other

forms of psychopathology. Some findings have suggested that particular coping patterns are positively related to symptoms or to the probability of being depressed. Coyne and Downey (1991) argued that this positive correlation may reflect nothing more than the fact that the respondents were already distressed when they began coping with a specific incident; he added that it may indicate that coping efforts become more intense but unfocused when things are not going well.

Coyne and Downey (1991) also discussed the differences in how people report that they cope. They suggested that these differences may reflect differences in their circumstances, and that these may not readily be eliminated by matching or statistical controls. Coyne and Downey found that studies designed to identify the competencies that buffer individuals from the effects of stress almost inevitably confound competency both with level of upset at the time of the episode and with situational factors such as the quality of relationships with other persons involved in the incident.

Coyne and Downey concluded that studies of coping need to give more attention to how people manage their close relationships. They suggested that the basic dimensions of problem- and emotion-focused coping will need to be supplemented by considerations of *relationship-focused* coping: how people in distress deal with those with whom they have enduring relationships, with others who offer advice, or who can influence the situation, or with those who to some degree share their fate, despite disagreements and even hostility.

One can conclude from the literature reviewed here that research to date is unable to

determine whether the way in which one copes can reduce the potential for distress or depressive disorder. This is because there is no single convincing theory to be adopted as a determinant of our coping strategies, and because of the wide diversities in cultural dimensions like religious beliefs, rearing pattern, and traditional trends of education, as well as the weather and other environmental factors. Coping is most likely to be multifactorial in nature.

Chapter 3

United Arab Emirates (UAE)-Dubai

3.1. Introduction

In this chapter an attempt will be made to describe the culture of the United Arab Emirates (UAE), where this project took place. The core of the chapter consists of a discussion of the geographical and historical background of the UAE, of the modern UAE, and of how the discovery of oil affected different aspects of life, with special consideration given to education and health care (including mental health) services. Later in this chapter, the traditional role of women in the UAE and the current position of women will be discussed from the standpoint of legal protection, and marriage and family. The chapter ends with a consideration of some of the effects of social change upon women's mental health.

3.2. Geographical Background

The UAE lies on the eastern side of the Arabian peninsula, with coastlines along the Arabian Gulf and the Gulf of Oman. Its total area, including 200 islands, is 83,300 square kilometres, and it is inhabited by 2.38 million people. Most of its terrain consists of mountains or deserts; this was the main cause for its people living in the coastal cities or some inland oases like Al Ain, Al Dhaid, and Liwa. The people of the UAE are Arabs, whose history and culture date back at least 6,600 years. The UAE is one of the fastest

growing countries in the world and is the major economic force in the region (Dubai Municipality, 1995).

3.3. Historical Background

Before independence and federalization in December 1971, the UAE was known as the *Trucial States*, a loosely defined affiliation of the seven main emirates of the peninsula (Abu Dhabi, Dubai, Sharjah, Ajman, Umm al Qaiwan, Ras al Khaimah, Fujairah). Earlier it was designated the *Pirate Coast*, and much earlier, around 5,000 years ago, the land which is known as the UAE was part of *Magan*, bordering the Bitter Sea (Arabian Gulf) along with the neighbouring civilization of Dilmun (Bahrain) (Vine & Casey, 1992).

Earlier still, the region was inhabited by Stone Age man. During this period, perhaps 8,000 years ago, the less arid region supported diverse wildlife, upon which man depended for food. Hundreds of stone tumuli, scattered along the foothills of Jebel Hafit near Al Ain in the Emirate of Abu Dhabi and dating from the end of the fourth millennium BC, provide one of the first indications of an organized settled society, who buried their dead with some ceremony; items found in their graves indicate links with Mesopotamia (Vine & Casey, 1992).

However, early in the second millennium BC, for a number of reasons, all mention of *Magan* disappears from the written record. Vine and Casey (1992), in their work exploring the foundations and heritage of the UAE and its people, argued that it is possible that a shift to a more arid climate, accompanied by the encroachment of desert

sands, rendered living conditions rather arduous in southern Arabia, and forced the inhabitants into a more nomadic lifestyle. However, excavations have provided evidence that many important cities existed around some oases and on both Gulf coasts during the Hellenistic period, and that these were flourishing in the late first millennium BC as a result of their position on important trading routes.

In 200 BC, the Persians extended their influence right along the western side of the Gulf, from Oman to Kuwait. Major population migrations into the territory of the lower Gulf continued to establish settlement patterns for hundreds of years to come. From the second century AD, the Azdites, a tribal group of Qahtani extraction, moved from their homes in Yemen, dominating the south-western and western slopes of the Hajar mountain range by the sixth century. From then on, the predominant population flow into south-east Arabia was from the north. Some of these migrants shared the Azdite (Qahtani) ancestry, others sprang from the Adnanian half of Arab genealogy. Although these major migrant groups dispersed in smaller units throughout the region, connections persisted between related family groups (Vine & Casey, 1992).

Persian influence continued in one form or another until 600 AD, when the Prophet Mohammed despatched couriers to local tribes, seeking their support for his pan-Arab mission. The conversion of the local sun- and fire-worshipping population to Islam was rapid and constituted the most profound and enduring spiritual and social revolution ever to have affected this area. Following the Prophet Mohammed's death, a revolt in the region led to a major confrontation in 632 AD between local tribes and the Muslim army. This battle ended in a tremendous victory for the Mecca-based army, and from then on,

the lower Gulf was firmly part of the Muslim world (Vine & Casey, 1992).

The meagre economic resources of the area were a fundamental problem as population increased with immigration and the radiation of the tribes across the entire region. Each individual tribal group was therefore faced with the task of effective and efficient utilization of its particular share of very limited resources. In this situation, the indigenous people were required to develop a high level of versatility in order to exploit all the economic resources available, and this factor did not change significantly over the centuries. The way in which these limited economic opportunities were utilized seems to have predetermined the intensely tribal structure of society, existing in its purest form right up until the discovery of oil in the region (Vine & Casey, 1992).

Europe, too, made its impact on the lives of the indigenous population. This impact began with the Portuguese in the 15th century; they maintained a repressive presence in the region until 1653. The British interest in the region grew steadily as internecine rivalry weakened the power of the tribal leaders. After an attack led by the British on Ras al Khaimah, a treaty was signed in January 1820 between the British and the shaikhly rulers (Vine & Casey, 1992).

The 19th century was a period of prosperity for some as the market for pearls expanded dramatically, leading to a marked increase in the settled population. But this relative flow of wealth was to dry up as the artificially cultured pearl gradually came to dominate an ever-diminishing market. By the 1950s, population estimates in the Trucial States showed a decrease in numbers for almost every tribe and coastal settlement. Emigration to find

work in the oil industries of neighbouring countries played a major role in this pattern. However, the country's indigenous population increased dramatically thereafter (Vine & Casey, 1992).

In December 1971, following the British announcement of its plans for a rapid withdrawal, six emirates, Abu Dhabi, Dubai, Sharjah, Ajman, Umm al Qaiwan, and Fujairah, were united by a provisional federal constitution into an internationally recognized political entity under the presidency of His Highness Sheikh Zayed bin Sultan al Nahyan, ruler of Abu Dhabi. The six were subsequently joined, early in 1972, by Ras al Khaimah. The rulers of all seven emirates form the Supreme Council, the foremost decision-making body of the federation. Whilst the individual emirates retain full sovereignty over their national resources, the central government has exclusive legislative and executive powers, not only in key areas such as foreign affairs and defence but also in education, health, and electricity (Vine & Casey, 1992).

Like all new states, the UAE has had its teething problems, but the stability and permanence of the federal structure has been reinforced by relative financial security and a gradual change of emphasis from regional to central administration. In the following sections, the effect of this rapid social change, and especially its effect on the women of the UAE, will be discussed.

3.4. The Modern UAE

The discovery of oil in the region in the 1960s changed the Emirates radically, and the stable society which had prevailed for a long time and isolated the UAE's society from the outside world was affected drastically.

The oil boom has brought enormous benefit to the UAE, but petroleum and gas exports are by no means the sole factors behind the country's advancement. The rush of oil was accompanied by a flurry of construction. Industrial plants sprang up around the country, high technology arrived in various forms, and the biggest dry docks in the world were built at Dubai, using the most modern methods available. At the same time, the UAE has undergone monumental changes in agriculture, education, and health care, with hospitals and clinics, schools and universities sprouting up around the country, like the wheat now growing across previously barren desert plains. Similarly, electricity has reached all corners of the Emirates, providing the power to maintain progress (Vine & Casey, 1992).

One can state also that one of the best aspects of the modern UAE is that, despite its impressive achievements, its people have not abandoned their traditional Arab values. In a world where the influences of urbanization are eroding family life and spiritual and social traditions, the people of the Emirates hold these traditions in high esteem. The presence of Islam remains strong, and the religious habits of the people have remained unchanged. The UAE and its people have taken all the changes accompanied by the oil boom in their stride, ever mindful of the need to move with the times, but equally vigilant in ensuring that their past is not forgotten. Their centuries-old culture has been guarded as eagerly as any priceless heritage.

It is not simply the achievements of the UAE which impress, but also the short time-scale in which progress has taken place in different aspects of people's lives. One example is illiteracy, which was a feature of the population when the British departed _ today the UAE is on the verge of achieving a completely literate population, a remarkable achievement in less than 30 years. As education has been a priority of the UAE since its inception, formal education in schools, colleges, and universities has grown at an equally impressive rate. In 1985-1986, there were over 250,000 pupils enrolled in State institutions or private schools, including the Universities; over 375 State schools were in operation throughout the country, with 10,777 teachers employed.

The State schools were augmented by about 150 private schools, attended by 90,000 students. In addition, several thousand students attend special schools run by the Ministry of Defence, and at least 6,000 students attend the Emirates University at Al Ain. Over half of the students at the University, which was opened in 1977, are girls; they study the same curriculum as their male counterparts but attend separate lectures. Within the field of adult education, the efforts of the UAE Women's Federation in providing literacy classes for women have been of considerable significance. Today, the UAE boasts a fully integrated educational system catering for more than half a million pupils and students (Vine & Casey, 1992).

Another example of the impressive progress of the modern UAE is the health care services. As recently as 1971, the vast majority of the Emirates had no health service; yet today every population centre in the country, however small or remote, is covered by the national health service. Concurrent with this development, efforts to prevent illness have

been stepped up and programmes for the eradication of malaria and other diseases have met with considerable success. Progress in the field of educational and training programmes for nurses and doctors has also received a boost from the establishment of medical colleges associated with the national university. As part of the national health service efforts to encourage international cooperation in the medical field, regular seminars are held in the country, bringing in experts from all parts of the world.

A sustained programme of hospital and clinic construction throughout the federation has greatly improved health care facilities for UAE residents. Private medical centres also provide many specialist services.

Mental health services, on the other hand, have not received the same attention or resources as other health services. They have so far been given a very low priority. Ghubash (1992) provides a brief description of mental health services in the UAE. Ghubash states that before the establishment of any professional clinic or hospital for mental illness in the UAE, general practitioners were able to give some help to those suffering from mild disorders, but tended to treat major psychoses with small and ineffective doses of a variety of psychotropic drugs. Violent and excited patients were harboured in a ten-bed asylum at Hor El-Anz, in Dubai, under the medical care of police physicians, where they were given small doses of psychotropic drugs. Ghubash (1992) indicated that until 20 years ago, prisoners suffering from mental disorders were dealt with by the prison authority with physical restraint. She added that the Hor El-Anz centre is still used for some chronically ill and very excited and aggressive patients, but it has been modified and upgraded.

In 1975, the Department of Health and Medical Services in Dubai began to provide facilities for specialized psychiatric services. Ghubash (1992) has argued that although there are 12 large, modern, and well-equipped general hospitals in the UAE, only two have psychiatric in-patient units (Rashid Hospital in Dubai and Central Al Jazeira Hospital in Abu Dhabi). At Al-Jimi Hospital in Al Ain and Saif Bin Ghubash Hospital in Ras al Khaimah, psychiatrists have regular use of beds in the medical wards (about 20 at Al-Jimi, and around five to seven in Ras al Khaimah). The other eight general hospitals have no attached psychiatrists and no psychiatric facilities.

In 1981, a specialized hospital for psychiatry and drug dependence opened in Dubai. Regarding child psychiatry, there is only one unit available in Dubai, which was opened in 1982 and is attached to the adult psychiatry department in Rashid Hospital. Geriatric psychiatric services are very limited, with only a few beds in each department. In 1994, the New Psychiatric Hospital opened in Abu Dhabi. This hospital has the latest equipment and includes a department for training the national mental health staff.

Although the Ministry of Health in the UAE is taking considerable effort to increase the number of mental health staff, in general the psychiatric services share with all other medical specialities the problem of a shortage of trained, Arabic-speaking nursing staff. Furthermore, the psychiatric services have the problem of a shortage of well-trained psychologists, social workers, and expert psychiatrists.

The improvement in mental health services in the UAE is still at its beginning, and prejudice against mentally ill patients and ignorance about the effectiveness of modern

psychiatric and psychological treatments are widespread not only among the general public but also among some of the administrators of the UAE's hospitals. For instance, some of the psychiatric hospitals and departments in the UAE are still using ICD-9 diagnostic criteria rather than ICD-10. Statistical data concerning psychiatric patients are still not well organized. According to Ghubash (1992), the only elementary and non-standardized statistics collected by the staff of existing psychiatric units concern the number and type of patients treated. Computerized systems for recording routine data are as yet unavailable in the psychiatric services, although such systems are operational in the general hospitals.

In conclusion, one can state that, as with any attempt at change and improvement, the provision of adequate mental health services will be accompanied by a lot of problems. The overall aim of improving services for the people will not be achieved without criticizing and changing the systems which are found not to be useful.

Faith healers, as well as psychiatrists, provide a great deal of treatment for mental illness. Since people in the UAE and all Arab countries use for madness the Arabic word *jinoon,* which is derived from *jinn* (demons), the mentally disordered patient is considered to be possessed by supernatural beings which control his behaviour, thoughts, and desires. Thus, the causes of madness are regarded as exterior to the person and are often considered to result from persecution and sorcery (Al-Issa, 1990). The 'evil eye' is considered a means of sanction against anybody who exceeds the limits imposed by the community on positive attributes such as wealth, health, beauty, and happiness. It is often motivated by envy, jealousy or even admiration by an enemy or a friend (Al-Issa, 1990).

People of the UAE, as strong followers of Islam, may seek treatment from faith healers because their practices are more related to the Muslim religion than is Western psychiatry. Healers may recite phrases from the Koran or give the patient an amulet (*herz*) to carry around, or soak a paper with religious writings in water for the patient to drink. According to Baasher (1975) (cf., Al-Issa, 1990), traditional healers in Muslim countries can be classified either as Islamic healers or as non-religious healers, who utilize magico-religious practices. Al-Issa (1990) discussed the practices of the latter type of healers in Algeria, and indicated that they specialized in dealing with sexual and emotional problems such as impotence, frigidity, sterility, and contraception.

Traditional therapy, especially when it deals with magic, is illegal in most Arab countries, including the UAE. Al-Issa (1990) has argued that this is mainly the result of the association of native therapy with underdevelopment and the desire for modernization. He realized that despite this therapy being illegal it is on the increase. Al-Issa (1990), citing Bensmail (1984), suggested that acculturation and social change have made the new generation of educated young people so insecure that they revert to traditional therapists and indigenous remedies. However, the use of native healers may be due in part to the limited availability of psychiatric services.

3.5. The Role of Women in the UAE

The rapid and comprehensive development of the UAE's society over the last 20 years has radically changed people's lives. The flow of male labourers into the newly established country unbalanced the sex ratio of the population. Education and the new

systems of communication (e.g., mass media and modern forms of transportation) have provided the people of UAE with a new-found awareness of the world around them; this in particular has had significant effects _positive and negative_ on the UAE's people. In order to understand the advantages of these changes for women, it is important to examine briefly the role of the UAE's women in the past.

3.5.1. Women's Traditional Roles

One can see that through the long history of the UAE women have played an important part in its social life. Al Qasmi (1993) discussed women's role in the UAE in terms of three levels of social status comprising the society in the pre-petroleum era. First, among those who were living in the coastal cities and whose economic life depended on the sea (through, for example, fishing or diving for pearls), which required the absence of the men from their homes for at least 3-4 months, women were provided with opportunities to take responsibility for their families, such as taking care of their children, taking decisions about some family matters, and sometimes working in tailoring or in making baskets and mats in order to survive until the return of their husbands.

Second, the women among those who were living by oases and were dependent on agriculture, in addition to carrying out their domestic work, shared with their husbands and families the agricultural, watering, and harvesting work. Furthermore, they were involved in breeding livestock, dairy work, and manufacture (mainly of food products).

The third social tier was the upper class (e.g., ruler families and merchants). Although the material needs of the women of this class were always fulfilled, they were regarded as

second-class citizens, and had to obey their families if they were single, or entertain their husbands if married. They were veiled from outsiders, and were probably fearful that their rich husbands would remarry.

Although women therefore shared with men many of the responsibilities inside the house and in wider society, they were always deprived of even basic rights, such as choosing a spouse. In conclusion, one can state that, traditionally, women were to obey their fathers when still single, their husbands when married, and their sons when widowed. Wives could be divorced for any reason, such as failing to bear sons or failing to obey and serve parents-in-law. Hence, it has been widely acknowledged that, while life was hard for all ordinary people in the pre-petroleum UAE, it was considerably more difficult for women of all classes, because, throughout society, men outranked women.

3.5.2. The Current Position of Women in the UAE

What follows is not intended to be an exhaustive analysis of the present situation of women in the UAE, but to give the reader a sense of the conditions in which the government and women themselves have attempted to construct the narrative structure of their lives. The situation of women in the present UAE must be seen in the context of a world which is rapidly changing in outward signs of prosperity and way of life, but one in which people affected by these changes naturally seek to protect the strong cultural foundations which form the very basis of their society.

The changing role of women, and changes in the structure of the family, raised questions not only for men who wished to build a strong and healthy national community, but for

women conscious of their position as women. Women constitute nearly half of the national indigenous population of the UAE, but less than one-third of the total population including foreigners (Dubai Municipality, 1995). As a consequence, it was important for the modern UAE to pay attention to the needs of the UAE's women in this rapidly developing country. This point helped to formulate a comprehensive view of the woman in society, seeing her as a child, student, wife, and mother, and as an important member of the national work-force, either in a professional role or as a valued worker in a wide range of other fields.

This belief in the importance of the woman's role has led to a progressive policy of female education and training and to employment of women in many economic, health, social, information, education, and military fields. These changes were taking place, however, within a legal and ethical framework which still largely upheld the primacy of the male.

3.5.2.1. Legal Protection

The UAE's temporary constitution includes many articles emphasizing women's rights in different spheres of life, such as the economic, cultural, and social spheres, including family life. But, like many things in the UAE's temporary constitution, this is a statement of intent rather than a guarantee of rights. It does not take into account the profound conservatism of many of the male population who wield authority in the public and personal spheres of life. In an effort to guarantee women their basic rights, the government has emphasized women's rights for education, work, and their choice of spouse.

However, traditional Islamic and tribal values are dominant in the UAE, as in most of the Arab countries, and *shari'a* (the rules developed from verses of the Koran and from the decisions of the Prophet Mohammed and his early companions into a complex system of legal opinions and judgements) remains the legal system governing all aspects of life.

Hourani (1992) has argued that in these types of society even when laws have changed, social customs have not necessarily changed with them. New laws could not always be enforced, particularly when they came up against deeply rooted social customs which asserted and preserved the domination of the male.

3.5.2.2. Marriage and Family

In the UAE's society, generally, girls marry early, and their marriages are mostly arranged by the family, although these aspects are changing nowadays owing to women's education and participation in the work-force. Nonetheless, a large number of women still accept the system in principle, but try to obtain for themselves a better position within it by more or less subtle manipulation of their menfolk (Hourani, 1992).

Laws pertaining to marriage, divorce, inheritance and child custody in the Gulf region, including the UAE, are governed by Islamic law. In the case of marriage, for example, the *shari'a* does not specify an age limit _it is left to the father or the nearest male relative to decide when to sign the marriage contract. However, such types of marriage are more common in villages and remote areas where girls get married early. The practice is still recognized as legally valid because of the absence of a minimum age of marriage (Fakhro, 1996).

Polygamy continues to arouse strong resentment among women at all social levels. Islamic law allows men to have up to four wives at any one time. Thus, the threat of polygamy affects all women. As for divorce, the right of women to dissolve their marriage is denied to them in most Muslim countries, including the UAE. The power of divorce lies completely in the hands of the husband. It is left to his will and conscience to decide on divorce. Divorce procedures can be conducted orally: a husband can be divorced from his wife if he utters three times in succession, 'you are divorced', and he compensates his wife with whatever remains unpaid of the dowry. At present, divorce rates are high in the majority of the Gulf states (Fakhro, 1996). The government of the UAE, in an attempt to reduce the stresses on the divorced woman, has decided that each divorcee must receive a monthly allowance in addition to the grant of a house.

One of the important aspects of the family system in most Muslim countries is the custody of children. Divorced or widowed mothers retain the custody of their children for a limited period, after which custody passes to the father or the nearest male relative on the father's side. However, during the mother's period of custody, which lasts until a daughter is nine years old or a son is seven, the father remains a guardian of the child. If the mother remarries, however, she loses her right of custody. Fakhro (1996) has discussed this point and indicated that such laws do not allow much consideration for a divorced woman, whose role as wife and mother may be taken away, although she is given no say in the divorce action.

Fakhro (1996) argued that there is a pressing need for a progressive family law which would regulate marital patterns and relations, view marriage as a partnership with shared

duties and obligations, and in the event of a divorce grant full parental rights and duties to the parent who is responsible for the care and rearing of the child.

Abu Shehab (1992) reviewed marriage and family and their relationship to modernity from the Islamic point of view. She indicated that the basic values of the family were fiercely defended, and that Islam has been able to raise an effective barrier between itself and the new culture and undermine any attempt to modernize the family. In Muslim societies, the impact of Western culture generally stops at the threshold of the house. As a consequence, Abu Shehab indicated, Muslim women have to bear a heavy burden, as these conditions impose on them the role of representative of the values of the past and preserver of the cultural distinctiveness of the Muslim *ummah*. The pressure on a Muslim woman to keep herself within the strict limits of her culture is enormous, and it seems that the great majority of Muslim women accept this role as the guardian of tradition, since there is no other alternative.

However, there are an increasing number of women who do not accept the system and are claiming the right to define their own identity and bring about changes in their social status. Hourani (1992) has argued that they are not yet in a position of power. The advent of women ministers or members of parliament in many Muslim countries was little more than a token change. Women's views are better expressed through women's organizations and the press.

For example, the Moroccan author Mernissi (1985), in *Beyond the Veil*, argued that sexual inequality is based upon, or at least justified by, a particular Islamic view of

women as having a dangerous power which must be contained; this, she suggested, was a view which was incompatible with the needs of an independent nation in the modern world.

Besides the women's movement demanding a new Islamic view of their situation, Fakhro (1996) has indicated that there are a growing number of Islamic reformists who claim the right to *ijtihad* (interpretation or self-exertion in understanding and interpreting the *shari'a*) and *ijma* (the consensus of the community) and to reject *taqlid* (a blind following of the past). Although the conflict between the forces of conservatism and modernism has continued, these reformists seek to interpret and apply Islamic principles and requirements to modern life in order to develop appropriate Islamic responses for modern Muslim societies. This trend has helped to establish a growing network of scholars and social scientists from all regions of the Arab Muslim world.

In conclusion, one can say that the UAE is a part of Islamic society, and is a modern developing country affected by great socio-economic and cultural changes. Although its constitution emphasizes the rights of women in many spheres of life, and although efforts are going on to educate women and to offer them chances to participate in the work-force, there is still a need to revise and reform family law, especially the articles relating to the women. However, no reform of Islamic law in the region can be achieved without the effort and will of all Muslim countries to work together to find a formula that combines modernity and the essence of Islamic teachings, and this will be achieved by the revivification and implementation of *ijtihad* and *ijma*.

3.6. The Effects of Social Changes upon Women's Mental Health in the UAE

It is generally agreed that the changes over the last two decades have been so great that their extent is yet to be properly recognized. All human beings have experienced massive changes, and any specific changes affecting women have also affected men. Man and woman are interdependent, and each affects the balance and movement of the other (Shainess, 1974). However, there are some changes that appear to be specific to women. Looking to the psychological context of women's health, some consider that it includes the effects of multiple roles, personal and social role expectations, relationships, personal and work environments, inequality, discrimination, poverty, and violence, as well as individual psychological makeup (Stewart, 1996).

Women's lives, world-wide, have changed radically in the latter half of the 20th century; besides having domestic and child care responsibilities, most women, including many mothers, work outside the home. In performing multiple jobs, women experience 'double shifts' in their roles as wage earners, homemakers, and family caregivers to children, partner, and aging parents. Regardless of the increasing participation of women in the work force, society still expects women to be compliant, unassertive, nurturing, and unselfish, while at the same time competing in the marketplace. There is also discrimination at work, and women are still paid less than men for the same work. It is no wonder that many women feel stressed and tired (Stewart, 1998).

Turning to more changes specifically affecting women in the UAE, the contrast with the

picture of even two decades ago is great. Traditional stereotypes of the passive, in some ways delicate, woman, preoccupied with her double role as wife and mother, taking on all of the gender tasks assigned to her (cooking, cleaning, caring for her children, serving her husband in a multitude of ways), are all passing. Fostered by social and technological changes, including the high level of education, communication with the outside world, and women=s consideration of their positions, a new woman is emerging. She rejects the traditional roles described, demanding individual satisfaction and success. Large families are essentially a thing of the past, and the number of small families is growing. The divorce rate and the age of marriage are rising; both result in women spending longer periods of their lives alone.

During rapid socio-technical development, many sectors of society will suffer psychologically or emotionally in trying to adjust to the social and cultural changes. Women, children, and the elderly are the most exposed during these changes. In particular, women are under great pressure to adjust and adapt to the changes in their social life.

Harpham (1994) indicated that urbanization in developing countries involves changes in social support and life events which have been shown to affect mental health, mainly causing depression and anxiety, particularly among low-income women. The UAE is one such developing country. Beside its urbanization and social changes, the situation of women in this traditional society has some special aspects. Women are expected to play a dual role: on one side, the modern UAE expects women to take part in the development of the country by participating in the different areas of the work-force; on the other side,

it is expected that women will represent the values of the past, in order to preserve the cultural distinctiveness of Islam. If women start to demand rights, it will be regarded as a disaster for the traditions, and as Islam having lost its final hold on society because of the disobedience of women. As a consequence, many women demonstrate their readiness to pay the price of remaining apart from the international march of women who have said farewell to their old cultures. Abu Shehab (1992) has argued that it is not surprising to find this attitude among such women, since the improvements in their conditions brought about by the modernized ruling elites are not at all impressive, especially where Western values are combined with the traditional conceptions used to control them.

One can state that such confusion over which particular values which should be forsaken and which upheld may play a pivotal role in provoking psychological disturbance among women.

Ghubash (1992) investigated the effect of these socio-cultural changes on the epidemiology of mental illness among women in Dubai. She calculated a psychiatric morbidity rate of 22.7% among her subjects (n=300), and found that the most common psychiatric disorder was depression, which was estimated to affect around 13% of subjects; the prevalence of anxiety was 7%. Psychiatric disorders were found to be significantly associated with post-marital status, especially among women as single parents raising children and among women living in polygamous marriages. Regarding the relationship between socio-cultural changes and psychiatric morbidity, Ghubash found it to be complex. She suggested that conflict of beliefs is a potential psychopathological influence rather than traditional or modern behaviour *per se*. She

realized that psychiatric disorders are commoner at the two extremes of the continuum than in subjects who had moved partly towards more Western attitudes and behaviours.

Summarizing, one can conclude that the UAE still remains a patriarchal, male-dominated society. Despite the educational and professional achievement of urban women, they still retain their traditional subservient role in order to avoid any external pressure from male society. However, they experience internal pressure resulting from the conflicts between their traditional role and the natural need of any human being to improve, and feel guilty where they may be deemed to have abandoned the old traditions. Women in the UAE face the two extremes of modernity and traditional values; they need to bring about a synthesis of these two extremes.

Reviewing the previous and the present chapters, it is considered that reports on the language of emotion suggest that the concept of depression among diverse groups may vary. Many non-Western groups do not appear to have emotional terms equivalent to the English word 'depression' (Brandt & Boucher, 1986). As Marsella (1980) (cf. Brandt & Boucher, 1986) noted, what appears to be needed is emically derived depression categories relevant to specific, particularly non-Western, cultures. Similarly, because of the differences in cultural dimensions between the local community and Western norms, an attempt will be made in this study to respond to the needs outlined by the reviews of cross-cultural studies. This study was therefore designed to discover the symptom profile of depression in women in Dubai, the concept of depression among the native people in Dubai (that is, how depression is represented in the native language of the UAE), and how much antidepressive behaviour the people in Dubai report.

Within this general framework, a number of specific questions were asked:

1. What is the symptom profile of depression in women in Dubai, and how does it vary with socio-demographic status?

2. How are psychological illnesses, in particular depression, handled by native people in contemporary Dubai?

3. What kinds of ideas, norms and beliefs operate in native people in Dubai concerning depression?

4. What are the symptoms of depression as conceived by the native people of Dubai?

5. What is the interface between the conception of depression in Dubai people and the conception in the West?

6. What is the 'pan-cultural' feature of the everyday understanding of depression in the indigenous language of the people of Dubai?

7. Are certain coping strategies used by women in Dubai to deal with depressed feelings?

Chapter 4

Description of the Project

4.1. Aims

As can be seen from the questions raised in the previous chapter, this project has four primary aims:

(a) To investigate depression in women in Dubai, and to explore its association with socio-demographic variables such as age and marital, educational, occupational, and socio-economic status.

(b) To assess the symptom profile of depression in this population and compare it with profiles already reported from the industrialized countries.

(c) To explore the following: the concept of depression among the native people of Dubai through the language used to express feelings of sadness/depression; the way they handle feelings of depression; and the ideas, norms, and beliefs concerning depression which exist among them.

(d) To explore the coping strategies that women in Dubai have for dealing with depression, and how helpful they find these strategies.

The secondary aims of the project include:

(a) The development of an instrument for measuring depression in the indigenous language of Dubai (Arabic).

(b) An examination of the association between this instrument and a previously standardized and established measure.

4.2. Hypotheses

The project had several major hypotheses, derived both from the research questions and from the aims. The following hypotheses were formulated:

H1. Among women in Dubai, the prevalence and severity of depression are associated with socio-demographic variables such as age and marital, educational, occupational, and socio-economic status. More specifically:

H1a. Depression is associated with age; those most affected by the rapid socio-economic changes mentioned above _ those in the 20-40 age range _ will show severer depressive symptoms than others.

H1b. Depression is associated with marital status; married women will show severer depression than single women.

H1c. Depression is associated with educational status; low educational status will be associated with severer depression than high educational status.

H1d. Depression is associated with occupational status; housewives will show severer depression than working women.

H1e. Depression is associated with socio-economic status; those in low-income groups will show severer depression than those in the middle and higher ranges.

H2. The symptom profile of depression in women in Dubai will be characterized by the presence of many somatic symptoms.

H3. There will be differences in the coping strategies of women in Dubai when compared with those of depressed women in the West. The former will be more likely to turn to alternatives like faith healing and social activities, and see them as more appropriate strategies for dealing with depression than medical treatment.

H4. There will be differences between the concept of depression of the people of Dubai and the Western psychiatric views of depression (as described in ICD-10 and DSM-IV), regarding clinical presentation and the details of symptomatology.

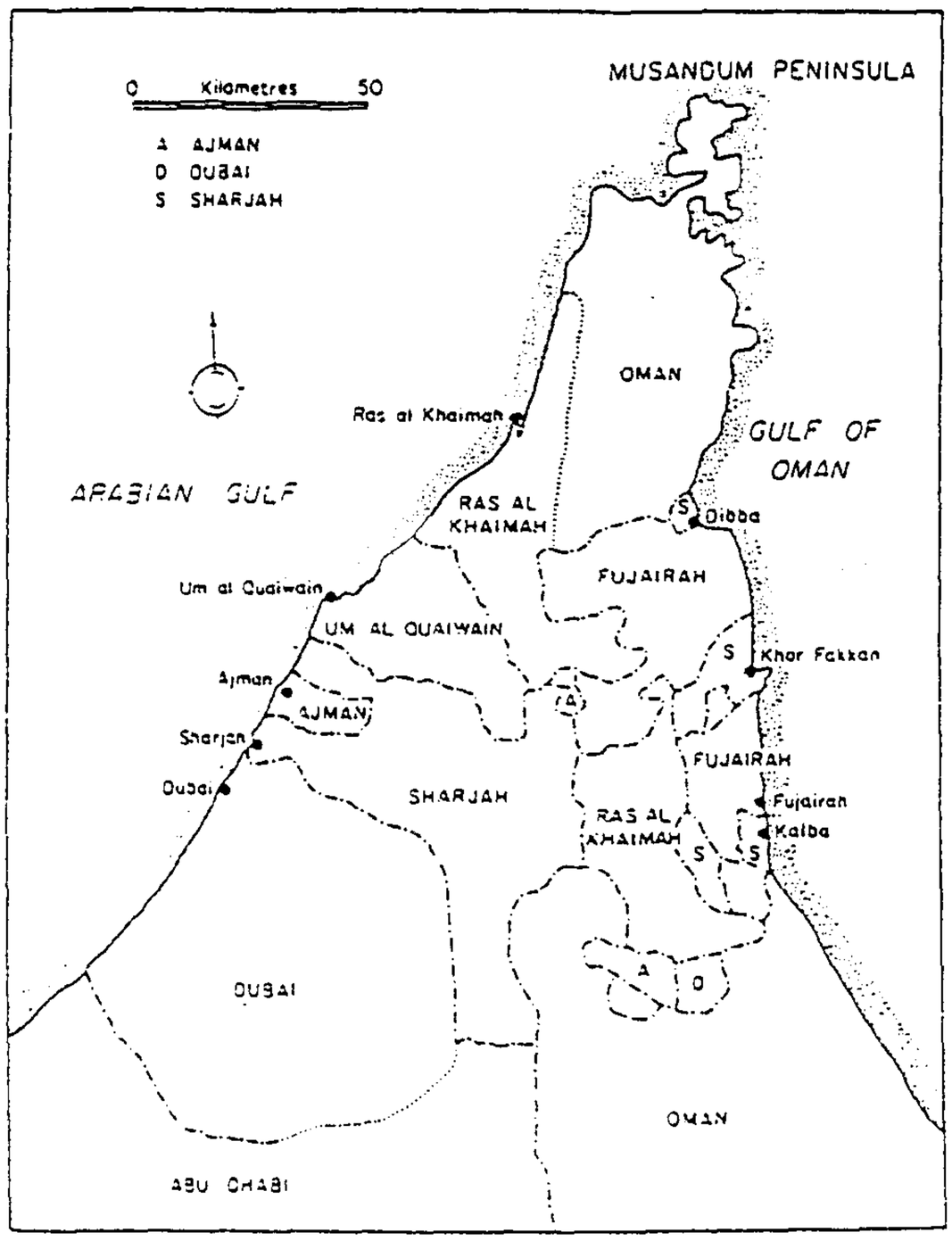
Chapter 5

Design and Methodology

5.1. StudyArea and Period

The study was performed in the Emirate of Dubai, the second biggest emirate of the United Arab Emirates (UAE), which comprises seven semi-autonomous emirates: Abu-Dhabi, Dubai, Sharjah, Ajman, Um-al-Qaywain, Ras-al-Khaima and Fujairah. (These are shown in Figure 5.1.) The UAE was established as a state on 2 December 1971. The study period covered the 24 months taking from the period between April 1994 and March 1998.

Figure 5.1. The map of the United Arab Emirates



5.2. Sample

5.2.1. Population

Dubai is a multicultural state in which customs, habits, and social structure vary markedly between the different racial and ethnic groups. The ratio of nationals to non-nationals is 1:6 (Dubai Municipality, 1995). The last census estimate of the general population of Dubai (1995) gave a total population of 610,926. Out of these, nationals numbered approximately 104,720 individuals. The non-nationals represent various ethnic groups, namely other Arabs, Asians, Africans, and Europeans. The socio-demographic characteristics of the population of Dubai – sex and age, and marital, educational, and occupational status – are shown in Figures 5.2, 5.3, 5.4, and 5.5.

Figure 5.2.

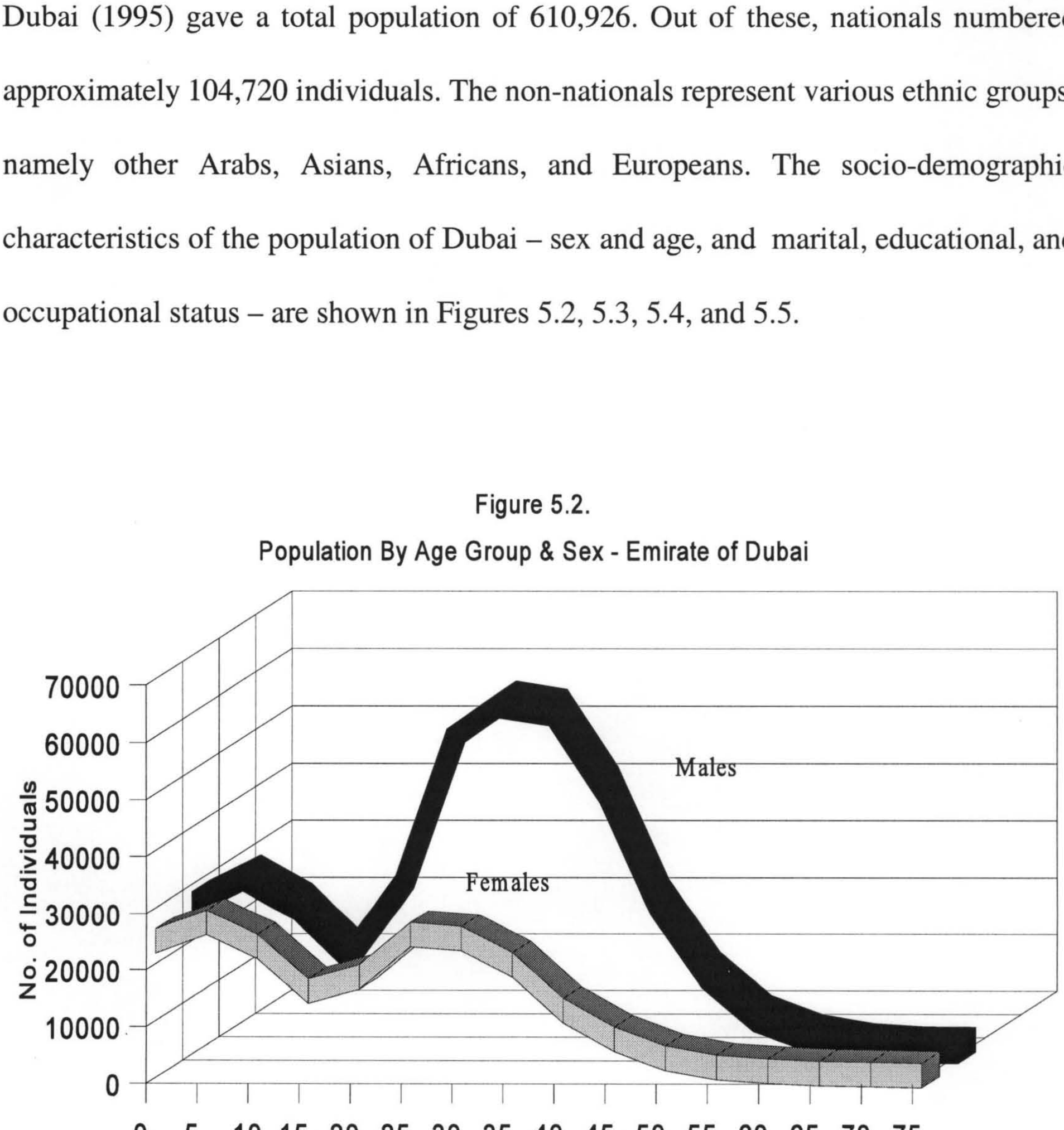


Figure 5.3.

Relative Distribution of Population (15+) by Marital Status - Emirate of Dubai

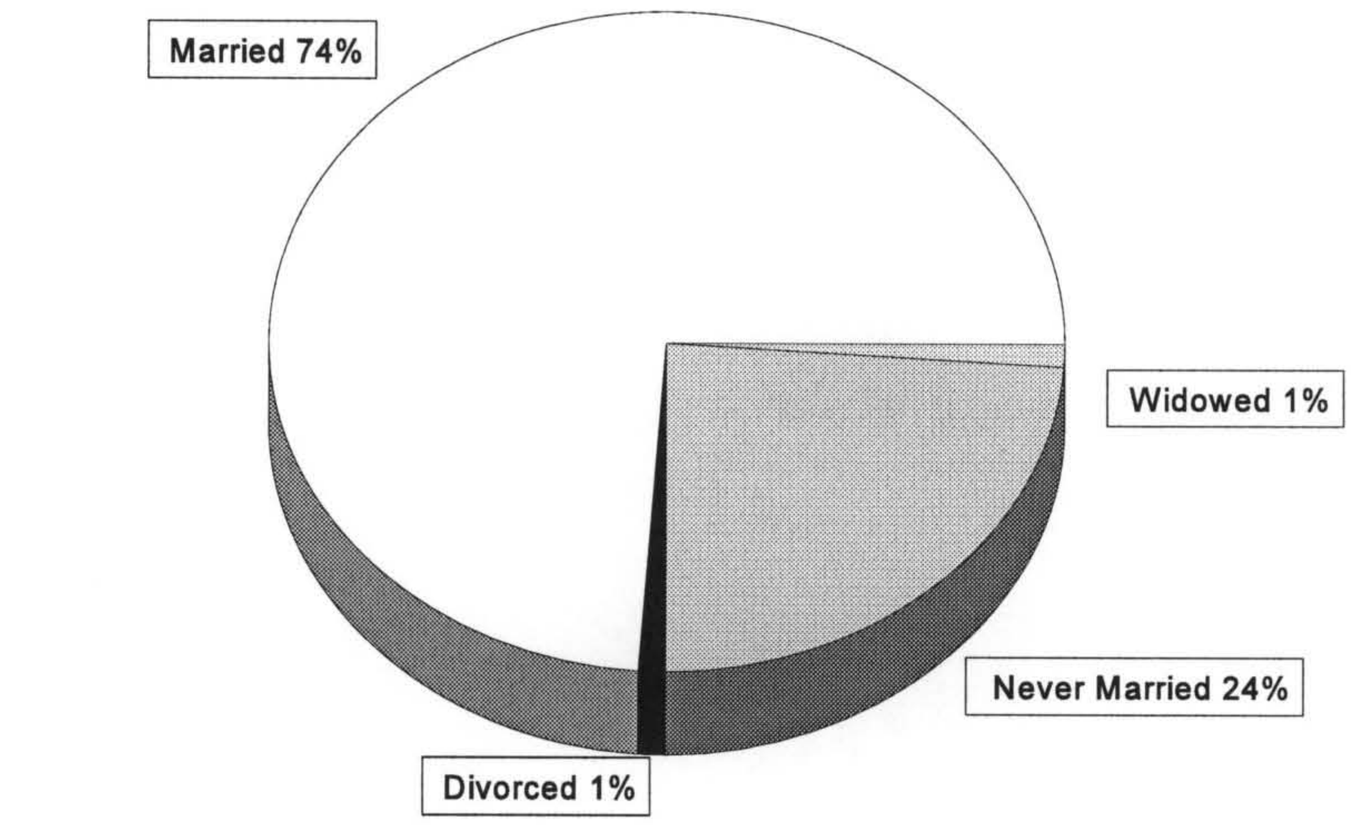


Figure 5.4.

Relative Distribution of Population by Educational Status - Emirate of Dubai

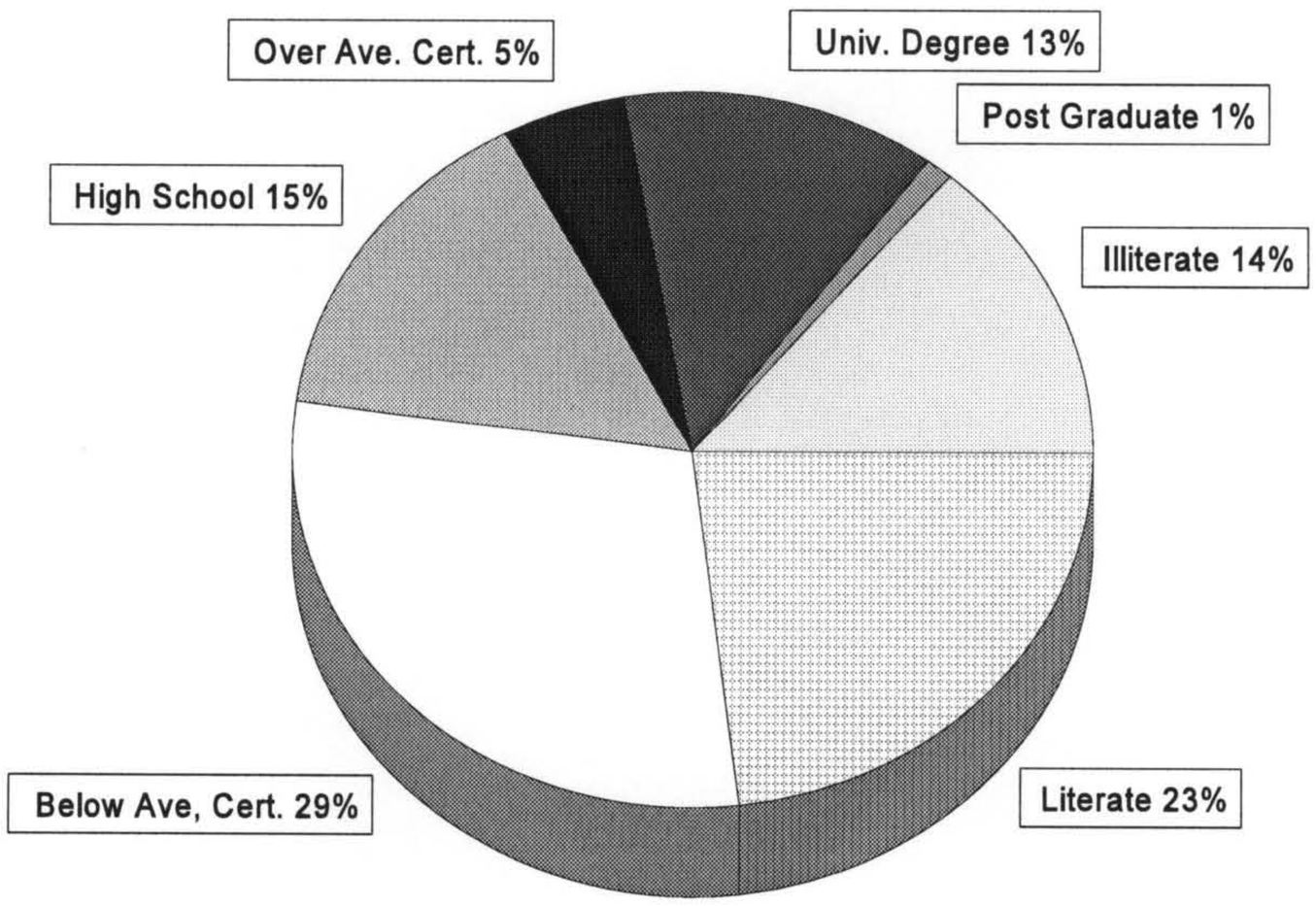
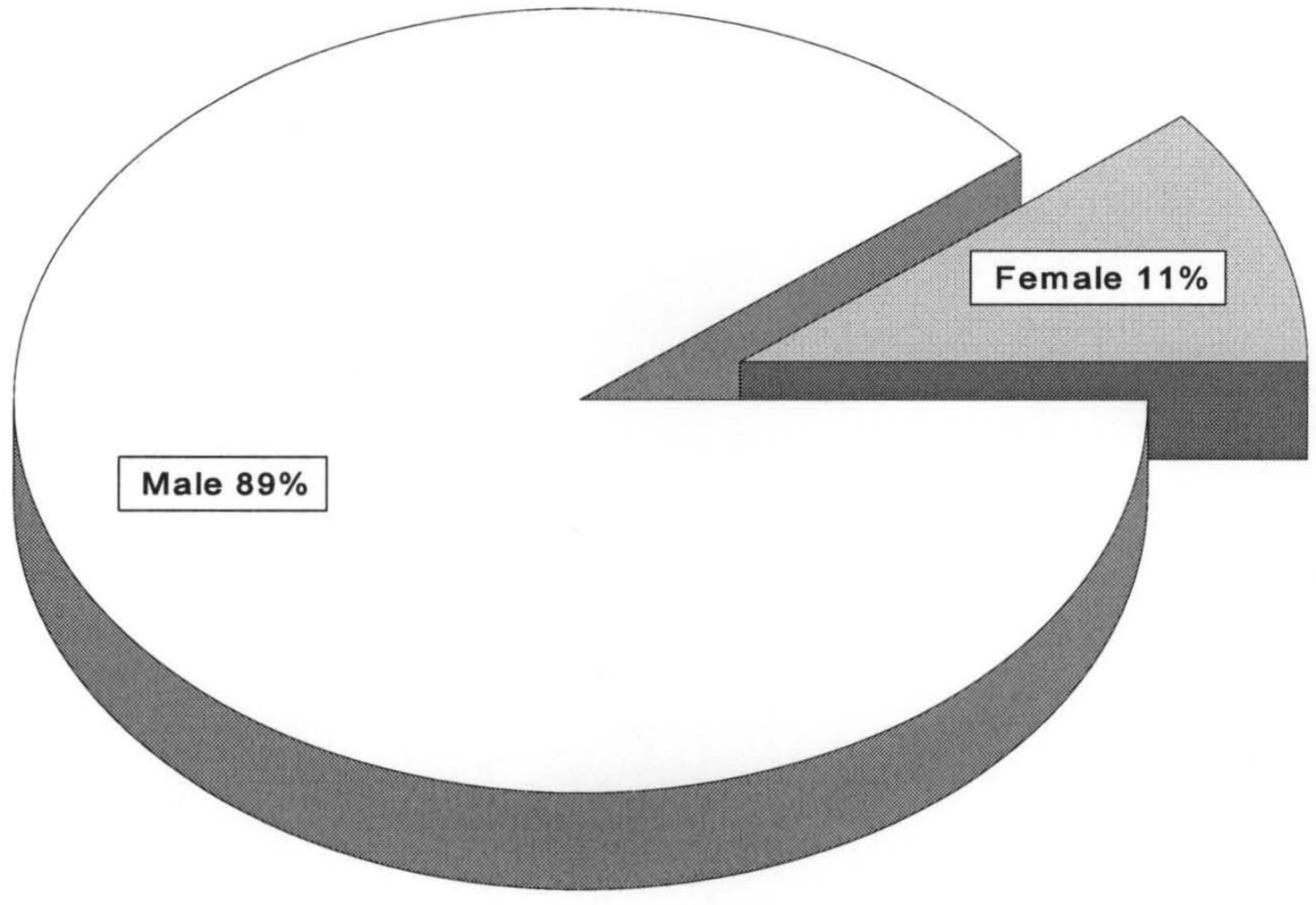


Figure 5.5.

Employed population by sex - Emirate of Dubai



This project focused on the nationals of Dubai, excluding the non-nationals, who make up the majority of the population. Subjects were eligible for the study if they were nationals by parentage and birth, or by marriage and residence if they were born in the neighbouring Gulf states (Oman, Qatar, Bahrain, and Saudi Arabia), since these states have very similar social and political organizations, culture, traditions, and language, and were also affected by the oil boom during the 1960s and 70s, so the effects of modernization on these societies were much the same as in the UAE.

The sample, which was selected for the present study retrospectively, was distributed across the age range 18-60 years. This age range was chosen with reference to the Dubai census of 1995, which indicated that the majority of the Dubai population (73.3%) are 15-60 years old. Furthermore, age 18 is considered in Dubai as the point of transition to adulthood. Subjects with overt psychotic symptoms, organic brain syndromes, or mental retardation were excluded from the study.

5.2.2. Sampling Frame

In the UAE there simply does not exist an appropriate resource from which one can derive a sample. There is no comprehensive list of residents' names and addresses available through an electoral register or other form of registration. Cities are not completely divided into wards with a numbering system. It was therefore important to find a sampling frame which provided enough relevant information about the potential sampling units to select the necessary sample.

Since this study used a dual approach to research – using both quantitative and qualitative methods – the sampling frames for the two methods were different:

(a) Quantitative sampling: Three types of sampling frame were adopted for this purpose:

(1) For the clinical sample, required for two of the studies (I and IV) of this project, purposive selection from the psychiatric department at Rashid Hospital in Dubai was used. Operationally, since this study was an investigation of depression in women in Dubai, only local female patients who met the inclusion criterion of depression according to the criteria for depressive episode in ICD-10 were recruited. Patients with psychotic symptoms, organic brain syndromes, or mental retardation were excluded.

(2) For the non-clinical samples, required for Studies II, III and IV, random selection techniques were used to recruit the subjects from the community population. Lists of native members or employees attending the associations (e.g., the Ministry of Education, the Social Developmental Association for Women in Dubai and the Dubai Police Headquarters) contacted were used, and the subjects were randomly selected according

to their identification numbers (for example, those subjects who had a digital number were selected).

(3) Snowball sampling was also used in making initial contact with potential participants; this entails beginning with one subject and asking him or her to put the researcher in touch with others. It was used for the further recruitment of subjects for Studies II, III, and IV.

***(b) Qualitative sampling*:** Rather than attempt to draw a random sample of the population, it was decided to concentrate on individuals whose social position brought them into contact with a large number of people (such as individuals who occupy a position of trust and respect within the community), who could be called community leaders. This meant that their perceptions and responses were based on a wide experience of events and problems in the community. Operationally, the subjects were defined as (1) nationals from the UAE who spoke fluent native Arabic, who had (2) lived within the study area for not less than five years, who had (3) work or other duties which brought them into regular contact with many members of the community, and who were (4) willing and able to cooperate.

5.2.3. Sample Size

To calculate the number of randomly chosen female non-clinical subjects needed for Studies II, III, and IV, the statistical tool STATCALC Epi-Info-6 was used with an assumption of 80% power (that is, an 80% probability of getting significant results if a particular effect size is assumed for the population), and a 5% significance level. The

numbers entered were:

(a) the native population size of the Emirate of Dubai, which is nearly 104,720 according to the statistical survey carried out by the Dubai Municipality (1995);

(b) the expected prevalence of non-psychiatric females with depressive symptoms in Dubai, which was 13% according to the results of Ghubash (1992);

(c) an initial assumption for the lowest expected prevalence of depression, which was 4%. According to this procedure, a sample of 100 randomly selected subjects would be sufficient to represent the total population of Dubai. The decision was therefore taken to choose 100 subjects for the non-clinical study.

It was not possible to have a predetermined sample size for the clinical sample, as the numbers depended on the availability of cases in the relevant time periods.

5.3. Instruments

As outlined earlier in this chapter, this study aims to explore different aspects of the phenomenon under study (symptoms, concepts, coping strategies). In order to achieve this, it was important to select a set of instruments capable of generating data that would answer the research questions. Instruments were selected on the basis of several considerations: (1) our ontological position, which suggests that people's conceptions, interpretations and experiences are meaningful properties of the social reality which our questions are designed to explore; (2) our epistemological position, which suggests that a legitimate means to generate data on these ontological properties is to interact with people, to talk to and listen to them, and to gain access to their accounts and articulations;

(3) pragmatic considerations – the data which are needed are not available in any other form, so the technique of interviewing subjects was the only way to get the relevant answers for the research questions.

In the following sections, more details of the instruments used in this investigation are given.

5.3.1. The Depression Scale of the Minnesota Multiphasic Personality Inventory (MMPI-D)

The MMPI consists of 556 self-reference statements which are divided into four validity scales (cannot say (?) scale, L scale, F scale, and K scale) and ten basic clinical or personality scales (hypochondriasis, depression, hysteria, psychopathic deviate, masculinity-femininity, paranoia, psychaesthenia, schizophrenia, hypomania, and social introversion). People taking the test respond to each statement as true as applied to them, as false as applied to them, or as not applying to them. The relatively unambiguous stimuli and the structured response format qualify the use of the MMPI for classification as an objective technique of personality assessment.

One appealing feature of the MMPI is that, although it takes an experienced clinician to interpret it, it can be administered easily to individual subjects or groups of subjects by non-professional examiners. The MMPI's manual indicates that individuals aged 16 years or more with at least six years of schooling should be able to complete the MMPI satisfactorily. Experience suggests that if they are properly motivated and carefully supervised, and if appropriate forms of the test are employed, even people with less than

six years of education may be able to take the test.

Because the length of time required to complete the MMPI is sometimes prohibitive, numerous efforts have been made to develop short or abbreviated forms of the test. For the current project, which investigated depression, the decision was taken to use Scale 2 (MMPI-D), which was originally developed to assess symptomatic depression. The primary characteristics of symptomatic depression are poor morale, lack of hope for the future, and a general dissatisfaction with one's own life situation. Many of the 60 items in the scale deal with various aspects of depression such as denial of happiness and personal worth, psychomotor retardation and withdrawal, and lack of interest in one's surroundings. Other items in the scale cover a variety of other symptoms and behaviours, including physical complaints, worry or tension, denial of impulses, difficulty in controlling one's own thought processes, and religious fervour. Scale 2 seems to be an excellent index of subjects' discomfort and dissatisfaction with their life situations.

After administration of the test, an individual's responses are scored in a standard way. The scoring procedures yield scores for validity scales and the basic clinical scales. The raw scores from the standard validity and clinical scales are transformed into linear T-scores (mean=50, SD=10). Whereas very elevated scores on Scale 2 may be suggestive of clinical depression (particularly if T-scores exceed 80), more moderate scores tend to be indicative of a general attitude or life style characterized by poor morale and lack of involvement (Graham, 1987; Hathaway & McKinley, 1989).

Hathaway and McKinley (1989) suggested that an MMPI-D T-score of 40 or below is

indicative of low depression, 41-55 is indicative of modal depression, 56-65 is indicative of moderate depression, 66-75 is indicative of high depression and 76 or above is indicative of very high depression.

An Arabic version of the MMPI-D was used in the current project. This version has been translated into classic Arabic and was validated by Al-Haj to the Saudi Arabian Society, which is very close in language and culture to society in the UAE (Al-Haj, 1981).

5.3.2. Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI) is a 21-item instrument designed to assess the severity of depression in adolescents and adults. During the last 25 years, the BDI has become one of the most widely accepted instruments in clinical psychology and psychiatry for assessing the severity of depression in psychiatric patients and for detecting possible depression in normal populations (Steer, Beck, & Garrison, 1985, cited by Beck & Steer, 1993).

The 21 symptoms and attitudes assessed by the original BDI include: (1) mood; (2) pessimism; (3) sense of failure; (4) self-dissatisfaction; (5) guilt; (6) punishment; (7) self-dislike; (8) self-accusation; (9) suicidal ideas; (10) crying; (11) irritability; (12) social withdrawal; (13) indecisiveness; (14) body image change; (15) work difficulty; (16) insomnia; (17) fatigability; (18) loss of appetite; (19) weight loss; (20) somatic preoccupation; (21) loss of libido.

These items cover both cognitive symptoms (items 1-13) and somatic symptoms (items

14-21) (Lustman, Clouse, &, Griffith, 1992). The BDI requires approximately 5-10 minutes when self-administered, and may take 15 minutes for oral administration. Each BDI item is rated on a 4-point scale ranging from 0 to 3. The maximum total score is 63; the higher scores reflect greater severity of depressive symptomatology. Beck and his colleagues (Beck & Steer, 1993) have suggested the following classification of severity for depressed patients: a score of 0-9 is considered within the normal range (asymptomatic); scores of 10-18 indicate mild-moderate depression; scores of 19-29 indicate moderate-severe depression; and scores of 30-63 indicate extremely severe depression. Hence, 10 may be used as a cut-off point for depression.

If the BDI is used to screen for possible cases of depression, the cut-off score should be raised in order to reduce the number of false positives. Since the present project aims to screen for possible cases of depression among non-psychiatric women, and for comparison purposes between psychiatric and non-psychiatric subjects, the decision was made to raise the cut-off scores in order to reduce the number of false positives. The cut-off scores adopted were those used by Ghareeb (1990) with a sample of non-psychiatric subjects in the UAE. A score of 0-15 was considered normal; scores of 16-33 indicated mild depression; scores of 34-45 indicated moderate depression; and scores of 46-63 indicated severe depression.

This instrument was translated into Arabic and validated in the UAE in 1988 by Ghareeb (Ghareeb, 1990).

5.3.3. General Health Questionnaire, 28-item version (GHQ-28)

The General Health Questionnaire (GHQ) was designed as a self-administered screening test for detecting psychiatric disorders among respondents in community settings and in non-psychiatric clinical settings, such as primary care or among general medical out-patients. The questionnaire was designed to be easy to administer, acceptable to respondents, fairly short, and objective in the sense that it did not require the person administering it to make subjective assessments about the respondent. The aim was to detect those forms of psychiatric disorder which may have relevance to a patient's presence in a medical clinic, so its focus must be on psychological components of ill-health.

The GHQ-28 has now been used in 38 languages, and over 50 validity studies have been published (Goldberg & Williams, 1988). The questionnaire concerns itself with two major classes of phenomena: inability to continue to carry out one's normal healthy functions; and the appearance of new phenomena of a distressing nature. It should be noted that the GHQ is sensitive to very transient disorders, which may remit without treatment.

The purpose of using the GHQ-28 in this study was to detect the presence of psychiatric symptoms, in particular depressive symptoms, in women in the Dubai community who considered themselves to be healthy. An Arabic form of the GHQ-28 was produced by El-Islam (1986), who modified the form and style of the English test before it could be applied to Arabs; for example, a less condensed layout of alternatives facilitated the choice of answers, and items which did not translate well were rephrased in order to

convey the meaning in Arabic.

The GHQ-28 has four seven-item scales: somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. The answer to each question is chosen from four alternatives, related to the present state of health. Scores of 0, 0, 1, 1 were used for the A, B, C, and D alternatives respectively; the range of possible scores therefore extended from 0 to 28.

Goldberg and Williams (1988) presented a table of the threshold score for 72 validity studies which showed that for the GHQ-28 and GHQ-30 there is a very wide range of best thresholds quoted by various authors. They indicated that if the purpose of using the GHQ is to discriminate between cases and non-cases, the threshold must be raised to obtain optimal results. For the current study, therefore, the threshold used was a score of 9/10: that is, scores of 9 and below were taken to indicate non-cases, and scores of 10 and above to indicate cases.

5.3.4. The Antidepressive Activity Questionnaire (AAQ)

This instrument was developed by Rippere (1974). It was derived from data gathered by the researcher in a study which aimed to determine objectively whether the existence of a consensus of opinion regarding 'the thing to do when you are feeling depressed' could be demonstrated; and, if so, to establish empirically which behaviours are therefore commonly supposed to be antidepressive, and to find what people actually do when they feel depressed and how helpful they find it. These aims tested a hypothesis which took the form of a general proposition: that there is in our culture (the UAE culture) a body of

conventional wisdom regarding the thing to do when feeling depressed. The AAQ consists of 100 items which describe the antidepressive behaviour which might be used by people when they are feeling depressed. These items cover: (1) activity and work; (2) self-care and maintenance; (3) pharmacological interventions; (4) cognitive and affective experience; (5) aesthetics, entertainment, contemplation; (6) help and comfort-seeking; (7) avoidance.

The Arabic version of the AAQ was produced by the present researcher with the help of a bilingual (in English and Arabic) psychiatrist who was also knowledgeable about the study area, and who was aware of the intent of each item and of the scale as a whole. After the translation into Arabic was done, two bilingual graduates who are not psychologists or psychiatrists and who were working in the Researches and Studies Centre at the Dubai Police Headquarters as translators were asked to translate the new version back into English. The meaning of the back-translated version was similar to that of the original. The reliability and validity of the translated form were not assessed, since the items of the scale were not testing a particular psychological or emotional disturbance, but covered general activities which could be used by the respondents universally. However, it was necessary to modify the Arabic form before it could be applied to Arabs; for example, items which did not suit the UAE culture were changed into suitable ones (e.g. 'go for a drive or bicycle ride', was changed to 'go for a drive', and 'go to church or chapel' was changed to 'go to mosque', and so on).

In case there were any omissions from the list of 100 activities, an extra question was used at the end of this questionnaire: it asked subjects to list any activities that they did

that were not included in the main part of the questionnaire.

The subjects were required to indicate not only which of the 100 items described their own antidepressive behaviours but also how frequently they used them (on a 3-point scale: rarely, sometimes, quite often) and how helpful they found them (on a 3-point scale: not very, moderately, very).

5.3.5. Open-ended Inquiry

This was the qualitative approach; data collection methods used in qualitative research differ from those used in quantitative research designs (Nachmias & Nachmias, 1992). After the identification of the topic of interest and of research questions, an optimal beginning was a generative approach, since the goal was to discover theoretical relationships driven directly from the focus group interviews of participants within the community setting under study.

There were insufficient data in existence about the concepts and words related to depressed feelings among the people of Dubai when the study began; it was therefore premature to engage in verification research at this stage of the project. Accordingly, as a qualitative approach, it was decided to begin with an open-ended question to elicit as much descriptive information as possible about the concept and words related to depressive feelings which were used by the native people of Dubai.

Open-ended questions are not followed by any kind of specified choice, and the respondents' answers are recorded in full. The virtue of the open-ended question is that

it does not force the respondent to adapt to preconceived answers; having understood the intent of the question, one can express thoughts and feelings freely, spontaneously, in one's own language. If the answers to open-ended questions are unclear, the interviewer may probe by asking the respondent to explain further or to give a rationale for something stated earlier. However, open-ended questions are difficult to answer and even more difficult to analyse (Nachmias & Nachmias, 1992).

Open-ended questionnaires are mostly used by ethnographers to pursue fieldwork when there is a lack in knowledge about any phenomenon, or during the discovery phases of research. The decision was taken to use this approach in the current investigation for Study III, which aimed to study the concept of depression among people in a specific culture (Dubai). Culture is the broadest ethnographic concept. Definitions of culture typically espouse either a materialist or an ideational perspective (see Chapter 2). For this particular part of the study, the ideational perspective was adopted. The most popular ideational definition of culture comprises the ideas, beliefs, and knowledge that characterize a particular group of people (Fetterman, 1989).

Although there is general agreement that an adequate ethnography of cultural knowledge of mental disorder must begin with close attention to culture-specific modes of conceptualizing and talking about illness, there is far less agreement about the appropriate methodology for accomplishing this objective, or even about the feasibility of developing an analytic framework for genuinely comparative research. Some of the major developments in ethnographic approaches to medical knowledge have come from paying close attention to the language used to describe and talk about illness. It is an important

insight of cultural research that much of our implicit everyday knowledge about the world is reflected in ordinary language which encodes and expresses that knowledge (Marsella, 1980).

The open-ended inquiry used in this study consisted of one open-ended question asking the respondents to list all the words they could think of which indicated emotion, such as 'anger', 'disgust', 'fear', 'happiness', 'sadness', and 'surprise', and which completed the frame 'I feel...' in their own native language, Arabic. The frame was modified according to the grammatical structure of the UAE's native language. The respondents were free to list as many terms as possible; no upper or lower limit was set.

5.4. Procedure

The investigation of the symptoms of depression, of the concept and words related to depression among the native people of Dubai, and of the coping strategies used by women in Dubai to deal with depression was carried out in four inter-related studies. Each study had its own design and methods; they are summarized in Figure 5.6.

Figure 5.6. Summary of the four inter-related studies

Study I

Aims:

1. Estimating the association of depression by socio-demographic variables (age, and marital, educational, occupational, and socio-economic status).
2. Assessing the symptom profile of depression in women in Dubai.

Hypotheses:

H1. Among women in Dubai, the prevalence and degree of depression are associated with socio-demographic variables such as age and marital, educational, occupational and socio-economic status. More specifically:

H1a. Depression is associated with age; those most affected by the rapid socio-economic changes _those aged 20-40_ will show severer depressive symptoms than the others.

H1b. Depression is associated with marital status; married women will show severer depression than single women.

H1c. Depression is associated with educational status; low educational status will be associated with severer depression than high educational status.

H1d. Depression is associated with occupational status; housewives will show severer depression than working women.

H1e. Depression is associated with socio-economic status; those in low-income groups will show severer depression than those in the middle and higher ranges.

H2. The symptom profile of depression in women in Dubai will be characterised by the presence of many somatic symptoms.

Sample:

Fifty-six native female patients from the psychiatric department at Rashid Hospital in Dubai took part in this study.

Instruments:

1. MMPI-D scale.
2. BDI.
3. ICD-10 criterion for depressive episode.

Statistical analyses:

1. Pearson coefficient analysis.
2. One-way analysis of variance (ANOVA).
3. Multivariate analysis of variance (MANOVA).
4. Bivariate contingency analyses (chi-squared analyses).

Results:

The findings of this study partially supported the first hypothesis (H1c and H1e), and supported the second hypothesis. It also provoked many questions:

(1) Will non-psychiatric women with depressed symptoms have the same symptom profile of depression as the patients? (2) Will association of depression with socio-demographic variables be different in the non-psychiatric women? (3) If the psychiatric patients seek help from professionals, how do women from the community cope with their depressed feelings? Hence, the further intention was to answer these questions by using the same procedure with a larger community sample.

Study II

Aims:

Beside the two aims of Study I, this study also aims to explore the coping strategies which women from the community use to deal with their depressed feelings and how helpful they find them.

Hypotheses:

This study tested hypotheses H1 and H2 (which were tested in Study I), in a larger sample, and hypothesis H3, which predicted that:

There will be differences between the coping strategies of women in Dubai and those of depressed women in the West. The former are more likely to turn to alternatives like faith healing and social activities as more appropriate strategies for depression than psychiatric treatment.

Sample:

One hundred native females from the community, representing different demographic statuses, took part in this study.

Instruments:

1. BDI
2. GHQ-28
3. AAQ

Statistical analyses:

1. STATCALC Epi-Info.
2. Pearson coefficient analysis.
3. One-way analysis of variance (ANOVA).
4. Multivariate analysis of variance (MANOVA).
5. Bivariate contingency analyses (chi-squared analyses).
6. Independent *t*-test.

Results:

The findings of this study partially supported hypotheses H1, H2, and H3. The field observation revealed that women in Dubai were using some indigenous expressions which were not included in the standardized questionnaires, which were used in this study, to illustrate their symptoms.

Study III

Aims:

1. To investigate the concepts and words related to depression among the native people of Dubai.
2. To develop a checklist of depression-related words and expressions from the indigenous language of Dubai.

Hypotheses:

The hypothesis of this study is that there will be differences between the concept of depression in the people of Dubai and the Western psychiatric views of depression (ICD-10 and DSM-IV) in clinical presentation and the details of the symptomatology.

Sample:

1. Forty native subjects (20 females and 20 males) were recruited for four focus-group sessions.
2. Two hundred native subjects (100 females and 100 males) were selected from the community for the open-ended inquiry.

Instruments:

1. Open-ended inquiry.

Statistical analyses:

Since this study used a qualitative approach, no statistical tests were used; a descriptive method was used to present the findings.

Results:

A checklist of words related to depression in the indigenous language of Dubai (Arabic) was produced. It was important then to assess whether this checklist is applicable as a culturally sensitive scale for measuring depression in women in Dubai.

Study IV

Aims:

1. To develop a culturally sensitive and cross-culturally comparable self-report scale for measuring the severity of depression in women in Dubai (the Dubai Depression Inventory, DDI).
2. To pilot this inventory.

Hypotheses:

It was predicted that the instrument developed would be more sensitive in measuring the severity of depression in the specific culture of Dubai than the standardized measure BDI.

Sample:

1. Fifteen native female patients were recruited for this study from the psychiatric department at Rashid Hospital.
2. One hundred native females, representing different demographic statuses, were selected from the community.

Instruments:

1. BDI.
2. DDI.

Statistical analyses:

1. Reliability analysis-scale split half.
2. Cronbach alpha.
3. Correlation similarity coefficient.
4. Pearson correlation coefficient.
5. Factor analysis (principal component analysis with varimax orthogonal rotation).
6. Receiver Operating Characteristic (ROC) curve.
7. One-way analysis of variance (ANOVA).
8. Multivariate analysis of variance (MANOVA).
9. Bivariate contingency analyses (chi-squared analyses).

Results:

The findings of this study showed that the new instrument was sensitive as a measure of depressive symptoms among the clinical and community samples and was easily understood by subjects. These findings proved that native expressions of depression exist, and can be and should be used by mental health professionals.

In the following sections, the four studies will be reported separately.

5.4.1. Study I (Pilot Study)

5.4.1.1. Introduction and Aims

Until recently, there was no adequate information, either quantitative or qualitative, in Dubai about the nature of depressive symptomatology in the female native population or about whether there are any differences in its manifestation between women in Dubai and women in other cultures.

The present study was designed to:

(a) estimate the association of depression with socio-demographic variables: age, and marital, educational, occupational, and socio-economic status.

(b) assess the symptom profile of depression in women in Dubai.

5.4.1.2. Hypotheses

The present study tested two hypotheses. The first hypothesis concerns the prevalence of depression among women in Dubai and its association with various socio-demographic variables – age, and marital, educational, occupational and socio-economic status. The second hypothesis postulates that the symptom profile of depression in women in Dubai will be characterized by the presence of many somatic symptoms.

5.4.1.3. Sample

5.4.1.3.1. Population of Depressed Patients

According to statistics regarding the psychiatric patients who visited the psychiatric clinic at Rashid Hospital, which were provided by the Department of Health and Medical Services, approximately 3,785 depressed patients (according to ICD-9 diagnoses) were admitted to or visited the psychiatric clinic between 1 January 1991 and 14 May 1994. This psychiatric population encompassed all age groups, both genders, and various nationalities (Tables 5.1 and 5.2).

Of the native female patients who attended the psychiatric clinic during this period, 971,869 were diagnosed as ICD-9 disease code 296 (affective psychoses), and 102 were diagnosed as ICD-9 disease code 311 (depressive disorder not elsewhere classified).

Table 5.1. Depressed patients diagnosed as ICD-9 disease code 296 who visited the psychiatric clinic at Rashid Hospital in Dubai between 1/7/1991 and 14/5/1994 categorized by age, sex, and nationality

	UAE		Others		Unspecified		Total		
Age group	M	F	M	F	M	F	M	F	Group total
5 - 14	3	11	11	0	0	0	14	11	25
15 - 44	440	587	617	810	7	8	1064	1405	2469
45 - 59	95	195	125	169	1	4	221	368	589
60 +	105	76	29	61	0	0	134	137	271
Total	643	869	782	1040	8	12	1433	1921	3354

Table 5.2. Depressed patients diagnosed as ICD-9 disease code 311 who visited the psychiatric clinic at Rashid Hospital in Dubai between 1/7/1991 and 14/5/1994 categorized by age, sex, and nationality

	UAE		Others		Unspecified		Total		
Age group	M	F	M	F	M	F	M	F	Group total
5 - 14	1	0	1	2	0	0	2	2	4
15 - 44	70	75	71	106	0	0	141	181	322
45 - 59	10	22	17	22	2	0	29	46	75
60 +	11	5	1	13	0	0	12	18	30
Total	92	102	90	143	2	0	184	247	431

Reviewing these statistics, it can be seen that most of the patients who were assessed and treated were diagnosed under the heading of affective psychosis derived from ICD-9.

It is unfortunate that the psychiatric department in the Department of Health and Medical Services in Dubai was still using this classification despite the implementation of ICD-10 a decade earlier. For this reason, it was decided to adopt ICD-10 as the instrument for investigating the symptoms of depression in the present study.

5.4.1.3.2. Sampling Frame

This study used a quantitative method, and since it had been decided to select the subjects from the psychiatric department at Rashid Hospital in Dubai, the sampling frame adopted was purposive selection. Only native female patients who had been diagnosed by a psychiatrist or psychiatrists as having clinical depression according to ICD-9 criteria were included. Patients with overt psychotic symptoms, organic brain syndromes, or mental retardation were excluded from the study.

5.4.1.3.3. Sample size

The subjects were drawn from the psychiatric population of native adult females who attended the psychiatric clinic at Rashid Hospital between 1 April 1994 and 31 October 1994, and who had been diagnosed as ICD-9 disease codes 296 and 311. The average duration of their depressive disorders was two years. All the patients were taking medication for their depressive disorders.

In all, the study included 60 consecutive first-time attenders. Three patients did not complete the investigation, and one patient refused to take part in the study. Hence the study comprised 56 local female patients. All of the subjects were classified as natives of the UAE: that is, they were born in and received their education in the UAE, and were primarily from Muslim backgrounds.

5.4.1.4. Instruments

The questionnaires used in this study were as follows:

(a) the Depression Scale of the Minnesota Multiphasic Personality Inventory (MMPI-D);

(b) the Beck Depression Inventory (BDI)

(details on these two instruments were given earlier in this chapter, in sections 5.3.1 and 5.3.2);

(c) The ICD-10 criterion for the diagnosis of depressive episode with its specification as mild, moderate, and severe, rechecked in all cases (including single episodes) of

depressive reaction, psychogenic depression, and reactive depression. The files of all the patients were studied carefully.

5.4.1.5. Procedure

The study was conducted at the psychiatric clinic of Rashid Hospital, a large general hospital that also serves as a community health centre. Permission was obtained from the hospital administration to interview the patients, and individual consent to participate in the study was obtained from each patient.

Patients were mostly referred to the psychiatric clinic after being examined and investigated in other medical departments and found to suffer from no organic disorders that could account for their symptoms. Patients' evaluations and diagnoses were typically carried out by an initial interviewer (a psychiatrist). The initial interviewer then presented the cases to the researcher, who conducted a complementary interview. Each patient was given a brief explanation of the study, and the confidentiality of all information was emphasized. Then, separately for each of the tests, each patient was given instructions on how to complete the questionnaire. For illiterate patients, the researcher read the questionnaire items slowly and carefully, and filled in the questionnaires together with the patient.

The questionnaires took an average of 45 minutes to complete (range 35-65 minutes). All the patients answered the questionnaires at the hospital. Socio-demographic data were collected via additional questions on the questionnaires.

5.4.1.6. Statistical Analysis

To assess the relationship between the BDI and the MMPI-D, Pearson coefficient analysis was used.

Group mean differences were assessed by analysis of variance (ANOVA) to determine whether the variables age and marital, educational, occupational, and socio-economic status were independent of, or associated with, the severity of depression.

To assess whether there were any interaction effects or main effects between these variables and the severity of depression, multivariate analysis of variance (MANOVA) (regression approach) was performed.

Bivariate contingency analyses (chi-squared analyses) were also used to examine the differences between the symptoms of depression for the female patients of Dubai and the patients in the USA presented by Beck and Steer (1993). Because of the preliminary nature of this study, a significance level $P<0.05$ was set.

5.4.1.7. Results

5.4.1.7.1. Social and Demographic Features of Patients

Fifty-six female patients were recruited from consecutive referrals to the psychiatric out-patient services. The mean age of the patients was 32.3 years (range 20-40). The basic data are shown in Table 5.3.

5.4.1.7.2. Clinical Characteristics of Patients as Measured by the BDI and MMPI-D

Of the 56 patients who took part in the present study, 25 (45%) were diagnosed according to ICD-9, which is still used in the psychiatric department of Rashid Hospital, as disease code 296, and 31 (55%) patients were diagnosed as disease code 311. Five (9%) were in-patients, the rest (91%) were out-patients.

On the BDI, 30 patients (54%) had severe depression, 14 (25%) had moderate depression, and 12 (21%) had mild depression. The mean score for depression on the BDI was 27.6 (SD=11.89).

On the MMPI-D, 13 (23%) had very high depression, 10 (18%) had high depression, 15 (27%) had moderate depression, 16 (28%) had modal depression and two (4%) had low depression. The mean score for depression on the MMPI-D scale was 30.08 (SD=7.27). The data are presented in Tables 5.3 and 5.4.

Table 5.3. The level of depression on the BDI and socio-demographic variables for the 56 patients comprising the study sample

Demographic variables	BDI Mild	Moderate	sever	Total
Age				
20-24	3 (43)	-- -- --	4 (57)	7 (12)
25-29	1 (09)	4 (36)	6 (55)	11 (20)
30-34	3 (24)	5 (38)	5 (38)	13 (23)
35-40	5 (20)	5 (20)	15 (60)	25 (45)
Marital status				
Married	6 (18)	7 (21)	20 (60)	33 (59)
Unmarried	6 (35)	5 (30)	6 (35)	17 (30)
Divorced	-- -- --	2 (50)	2 (50)	4 (07)
Widowed	-- -- --	-- -- --	2 (100)	2 (04)
Educational status				
Illiterate	-- -- --	-- -- --	7 (100)	7 (12)
Non-graduate	5 (24)	4 (19)	12 (57)	21 (38)
Graduate or higher	7 (25)	10 (36)	11 (39)	28 (50)
Occupational status				
Housewife	5 (15)	6 (18)	22 (67)	33 (59)
Employed	6 (29)	8 (38)	7 (33)	21 (38)
Student	1 (50)	-- -- --	1 (50)	2 (04)
Socioe-conomic class				
Low	-- -- --	2 (17)	10 (83)	12 (21)
Middle	6 (21)	8 (27)	15 (52)	29 (52)
High	6 (40)	4 (27)	5 (33)	15 (27)

NOTE: values in parentheses are percentages.

Table 5.4. The level of depression on the MMPI-D and socio-demographic variables for the 56 patients comprising the study sample

Demographic variables	MMPI-D Low	Modal	Moderate	High	V. high	Total
Age						
20-24	1 (14)	2 (29)	1 (14)	1 (14)	2 (29)	7 (12)
25-29	1 (09)	3 (27)	3 (27)	3 (27)	1 (09)	11 (20)
30-34	-- -- --	7 (54)	3 (23)	1 (08)	2 (15)	13 (23)
35-40	-- -- --	4 (16)	8 (32)	5 (20)	8 (32)	25 (45)
Marital status						
Married	1 (03)	8 (24)	10 (30)	6 (18)	8 (24)	33 (59)
Unmarried	1 (06)	7 (41)	4 (23)	3 (18)	2 (12)	17 (30)
Divorced	-- -- --	1 (25)	1 (25)	-- -- --	2 (50)	4 (07)
Widowed	-- -- --	-- -- --	-- -- --	1 (50)	1 (50)	2 (04)
Educational status						
Illiterate	-- -- --	-- -- --	2 (29)	1 (14)	4 (57)	7 (12)
Non-graduate	-- -- --	6 (29)	7 (33)	3 (14)	5 (24)	21 (38)
Graduate or higher	2 (07)	10 (36)	6 (21)	6 (21)	4 (14)	28 (50)
Occupational status						
Housewife	1 (03)	6 (18)	11 (33)	7 (21)	8 (24)	33 (59)
Employed	1 (05)	9 (43)	4 (19)	3 (14)	4 (19)	21 (38)
Student	-- -- --	1 (50)	-- -- --	-- -- --	1 (50)	2 (04)
Socio-economic class						
Low	-- -- --	1 (08)	6 (50)	3 (25)	2 (17)	12 (21)
Middle	1 (03)	10 (35)	5 (17)	3 (10)	10 (35)	29 (52)
High	1 (07)	5 (33)	4 (26)	4 (26)	1 (07)	15 (27)

NOTE: values in parentheses are percentages.

Pearson coefficient analysis was used to assess the relationship between the BDI and the MMPI-D. The result indicate that the scores were significantly correlated (r=0.67, P<0.001) in the sample of 56 patients at Rashid Hospital.

5.4.1.7.3. Analyses of Severity of Depression with Demographic Variables

One-way analysis of variance (ANOVA) was performed to determine whether age and marital, educational, occupational, and socio-economic status were independent of, or associated with, the severity of depression. As shown in Tables 5.5 and 5.6, there was no significant relation between age, marital status or occupation status and severity of depression score on either the BDI or the MMPI-D. There was however a significant

relation between educational status and severity of depression on the BDI ($F_{2,53}$=3.52, P=0.037): illiterate patients scored higher than the two groups of educated patients. On the MMPI-D ($F_{2,53}$=2.66, P=0.079), however, the significance was below 0.05, but the trend is close to significance.

There was also a significant relationship between socio-economic group and severity of depression on the BDI ($F_{2,53}$=4.25, P=0.019); patients from the low-income group scored higher than those in the middle- and high-income groups. By contrast, results obtained on this variable from the MMPI-D did not show any significant differences. According to the results of the BDI, whenever the level of education or the socio-economic group is low, depressive symptoms appear more severe.

Table 5.5. One-way analyses of variance of socio-demographic variables and depression on the BDI for the 56 patients comprising the study sample

			BDI ANOVA		
Demographic variables	Mean	SD	F	df	P
Age					
20-24	30.43	17.14			
25-29	26.82	10.25	0.27	2,53	0.849
30-34	25.69	11.24			
35-40	28.16	11.78			
Marital status					
Married	28.21	12.17			
Unmarried	25.24	12.33	0.49	2,53	0.691
Divorced	29.25	10.05			
Widowed	34.50	9.19			
Educational status					
Illiterate	37.86	6.91			
Non-graduate	27.52	11.35	3.52	2,53	0.037
Graduate or higher	25.11	12.18			
Occupational status					
Housewife	29.24	11.90			
Employed	25.05	11.73	0.79	2,53	0.457
Student	27.50	16.26			
Socioe-conomic groups					
Low	34.17	6.93			
Middle	28.03	11.26	4.25	2,53	0.019
High	21.53	13.68			

Table 5.6. One-way analyses of variance of socio-demographic variables and depression on the MMPI-D for total of the 56 patients comprising the study sample

Demographic variables	MMPI-D Mean	SD	ANOVA F	df	P
Age					
20-24	30.00	10.50			
25-29	28.82	6.43	1.12	2,53	0.350
30-34	27.69	7.66			
35-40	31.92	6.29			
Marital status					
Married	30.39	7.17			
Unmarried	28.35	7.65	0.99	2,53	0.402
Divorced	31.50	6.81			
Widowed	37.00	5.66			
Educational status					
Illiterate	35.43	4.96			
Non-graduate	30.33	7.52	2.66	2,53	0.079
Graduate or higher	28.57	7.11			
Occupational status					
Housewife	30.55	6.59			
Employed	28.90	7.72	0.79	2,53	0.457
Student	35.00	15.56			
Socioe-conomic groups					
Low	31.08	4.94			
Middle	31.00	8.17	1.28	2,53	0.286
High	27.53	6.74			

The relationship between all the socio-demographic variables and severity of depression was examined by multivariate analysis of variance for both the BDI and the MMPI-D. There were no significant effects found for any variables on the severity of depression with either instrument.

5.4.1.7.4. Analyses of Symptoms of Depression

The differences between the symptoms of depression for the 56 female patients of Dubai and 248 patients from the USA (Beck & Steer, 1993) were also examined by bivariate

contingency analyses (chi-squared analyses). Each of the 21 items on the BDI were analysed in order to determine precisely which symptoms of depression reflected differences as a function of the patient's culture. Significant or near significant differences were found on 13 of the 21 BDI items. With the strongest effects listed first, significant differences were found on self-dislike, feeling of punishment, loss of appetite, weight loss, body image change, fatigability, suicidal ideas, somatic preoccupation, indecisiveness, insomnia, and self-accusations; values of chi-squared were respectively 39.22, 26.68, 22.93, 11.67, 9.67, 6.95, 5.86, 5.74, 4.66, 3.92, and 3.91; values of *P* ranged from <0.001 to <0.05. Irritability and social withdrawal were nearly significant (chi-squared 3.41 and 3.35 respectively, $P<0.10$).

Pair-wise comparisons of the results of the 13 items revealed the following: on nine items (feeling of punishment, loss of appetite, weight loss, body image change, fatigability, somatic preoccupation, insomnia, irritability, and social withdrawal) Dubai patients scored higher on the depressive symptoms than US patients. On the self-dislike, suicidal ideas, indecisiveness, and self-accusation items, US patients scored higher than Dubai patients. The data are presented in Table 5.7.

Table 5.7. Chi-square analyses of depressive symptoms and ethnicity (56 patients from Dubai and 248 patients from the USA) on each of the 21 items of the BDI

Items	Chi-square	Significance	Dubai patients % response	USA patients % response
1- Sadness	2.15	.142	89%	81%
2- Pessimism	.76	.383	77%	82%
3- Sense of failure	.55	.458	73%	68%
4- Dissatisfaction	.41	.522	89%	92%
5- Guilt	.40	.526	63%	67%
6- Punishment	26.68	.001	71%	34%
7- Self-dislike	39.22	.001	63%	93%
8- Self-accusation	3.91	.047	82%	91%
9- Suicidal ideas	5.86	.015	41%	59%
10- Crying	1.32	.250	79%	71%
11- Irritability	3.41	.065	93%	83%
12- Social-withdrawal	3.35	.067	86%	74%
13- Indecisiveness	4.66	.031	61%	75%
14-Body image change	9.67	.001	79%	56%
15- Work difficulty	1.08	.296	80%	86%
16- Insomnia	3.92	.047	84%	71%
17- Fatigability	6.95	.008	95%	80%
18- Loss of appetite	22.93	.001	79%	43%
19- Weight loss	11.67	.001	43%	21%
20- Somatic preoccupation	5.74	.017	70%	52%
21- Loss of libido	.99	.320	66%	59%

In conclusion, the findings of this study support hypothesis H1c, which predicted that low educational status will be associated with more severe depression than high educational status, and hypothesis H1e, which predicted that those in the low-income group will show severer depression than those in the middle and higher ranges. The hypotheses regarding age and marital and occupational status were not supported.

The results of this study also showed that the symptom profile of depression in women in Dubai was characterized by somatic factors. This finding confirmed the second hypothesis.

Overall, the findings of this study, since they resulted from a clinical sample, provoked many questions. (1) Do non-psychiatric women with depressed symptoms have the same symptom profile of depression as the patients? (2) Is the association of depression with socio-demographic variables different in non-psychiatric women? (3) If psychiatric patients seek help from professionals, how do women from the community cope with their depressed feelings? The further intention was therefore to answer these questions by using the same procedure with a larger community sample.

5.4.2. Study II

5.4.2.1. Introduction and Aims

The patients in Study I cannot be regarded as representative of the spectrum of depressive conditions in the UAE culture. Nevertheless, their standardized and systematic description by means of the instruments used in this study provides useful information about the features of depressive patients treated at in-patient and out-patient psychiatric facilities in Dubai. Hence, the second study sought to:

(a) detect the presence of psychiatric symptoms and in particular depressive symptoms in a female community sample in Dubai;

(b) estimate the association of stresses and depression with socio-demographic variables;

(c) reveal the coping strategies used to deal with depressed feelings and to discover how helpful these were.

The results of Study I showed that the MMPI-D had some limitations when used for investigating the symptoms of depression among psychiatric patients. These limitations were that some of the questions had no relation to the cultural aspects of patients in Dubai, so the sensitivity of the instrument was affected. The BDI proved more relevant and sensitive for measuring the severity of depression in this sample. The decision was therefore made to eliminate the MMPI-D from further investigations.

While Study I concerned the symptoms of depression among depressed patients, Study

II aimed to detect depressive symptoms among women from the community. Accordingly, it was of interest to detect cases of hidden psychiatric illness in women who considered themselves to be psychologically healthy, and then to determine the nature of these hidden psychiatric illnesses. The self-report GHQ was therefore used alongside the BDI to differentiate cases from non-cases, as it allows investigation of four dimensions (psychosomatic symptoms, anxiety, dysfunction, and depression).

5.4.2.2. Hypotheses

This study tested hypotheses H1 and H2 from Study I (see Study I), but in a larger, community sample. In addition, it tested hypothesis H3, which postulated that there will be differences in coping strategies between women in Dubai and depressed women in the West, and that the former will be more likely to turn to alternatives like faith healing and social activities as more appropriate strategies for depression than psychiatric treatment.

5.4.2.3. Sample

5.4.2.3.1. Sampling Frame

Since this study was looking for quantitative data in community subjects, the following two sampling frames were adopted.

First: a random selection technique was used to select the subjects from the community in the different parts of the study area. The Ministry of Education, the Social

Developmental Association for Women in Dubai and the Dubai Police Headquarters were visited, because the majority of the staff at these places are native, and because they are from different levels of socio-demographic status.

Second: snowball sampling was used, whereby one subject was asked to put us in touch with others. The subjects who were eligible for the study were asked whether they knew any others who were interested in taking part in the research.

5.4.2.3.2. Sample Size

Of 120 native females who were selected at random and through the snowball selection technique from the community population in the different parts of the study area, six did not return the inventories and 14 were discarded because they did not answer the majority of the items in the two inventories. Hence, only 100 women were recruited. Table 5.8 shows the number of subjects selected from each area.

Table 5.8. Description of the community sample in different parts of the study area

Study area	Number of subjects
Social Developmental Association for Women in Dubai	48
Ministry of Education	27
Researches & Studies Centre of Police Headquarters	10
Subjects in homes (snowball subjects)	15
Total	100

5.4.2.4. Instruments

The following instruments were used in this study:

1. The Beck Depression Inventory (BDI).

2. The General Health Questionnaire, 28-item version (GHQ-28).

3. The Antidepressive Activity Questionnaire (AAQ).

Details of these instruments were given earlier in this chapter (see sections 5.3.2, 5.3.3, and 5.3.4).

5.4.2.5. Procedure

Permission to carry out the study was obtained from the administration of the Social Developmental Association for Women in Dubai, the Ministry of Education, and the Dubai Police Headquarters. Individual consent was obtained from each subject.

The majority of the subjects (85 of 100) were seen at the Social Developmental Association for Women in Dubai (48 subjects), or at the Ministry of Education (27 subjects), or at the Researches and Studies Centre in the Dubai Police Headquarters (10 subjects). These subjects were seen in group settings. The other 15 subjects were seen individually in their homes.

Before administration of the questionnaires, the main aims of the research were explained to the subjects by the researcher as follows:

that we were interested in their attitudes to themselves and in how they respond to

difficult or stressful events in their lives (for example, there are lots of ways to deal with stress; these questionnaires ask you to indicate what you generally feel and do when you experience stressful events).

It was also explained to the subjects that all the information would be confidential and that no-one would be identified by name.

Subjects were asked to answer honestly and independently and were reminded that there were no right and wrong answers. They were also asked to fill in the questionnaires as fully as possible. Before administering the questionnaires, the instructions for each were read out to the subjects.

After completing each questionnaire, the forms were collected and the next form distributed. The questionnaires were given in following order: BDI, GHQ-28, AAQ. Incomplete forms were discarded from the study.

The BDI and the GHQ-28 were scored according to the standard instructions. The AAQ was scored to yield two kinds of data: frequency data and helpfulness data (see below, section 5.4.2.7.5).

Socio-demographic data were collected on a separate sheet of paper. This work was carried out between January 1996 and May 1996.

5.4.2.6. Statistical Analysis

The Statistical tool STATCALC Epi-Info-6 was used to calculate the sample size required for this study (see section 5.2.3). In order to test the relationship between the BDI and GHQ-28, Pearson correlation coefficients were computed between the total scores of the two instruments.

To compare the means of demographic sub-groups, one-way analysis of variance with the Scheffe test was used to test for significant differences.

To explore differences among the socio-demographic variables (age, and marital, educational, occupational, and socio-economic status) in order to determine whether they were independent of, or associated with, the severity of depression, and to assess whether there were any interactions or main effects between these variables and the severity of depression, a multivariate analysis of variance (MANOVA) (regression approach) was performed.

In order to compare the frequencies of responses to items on the BDI between depressed patients from Study I and normal women with depressive symptoms from this study, bivariate contingent analysis (chi-squared analysis) was performed.

In order to examine the differences between the varying levels of depressed mood and coping style, independent *t*-tests were conducted on the number of subjects in each group endorsing AAQ items.

In order to determine whether coping activities were related to the demographic variables, or whether there were any interactions between these variables and the coping activities, multivariate analysis of variance was performed.

5.4.2.7. Results

5.4.2.7.1. Social and Demographic Features of Subjects

All of the subjects were classified as natives of the UAE, in that they were born in and received their education in the United Arab Emirates, and were primarily from Muslim backgrounds. The mean age of the subjects was 28.06 years (range 18-43). Sixty per cent of the women were single (43% were non-married, 10% were divorced, and 7% were widowed), and 40% were married. All of the subjects had some kind of educational qualification. The basic data are shown in Table 5.9.

5.4.2.7.2. Clinical Characteristics of Subjects as Measured by the BDI and GHQ-28

Of the 100 native women who completed the BDI, five had severe depression, six had moderate depression, 23 had mild depression, and 66 were without any appreciable symptoms. The mean score for depression on the BDI was 10.41 (SD=8.94). The relevant data are presented in Table 5.9.

Table 5.9. The level of depression on the BDI and socio-demographic variables for the 100 non-psychiatric females comprising the community sample

	BDI				
Demographic variables	Normal	Mild	Moderate	Severe	Total
Age groups					
18 - 19	5 (46)	3 (27)	1 (09)	2 (18)	11
20 - 29	36 (74)	11 (22)	0 (---)	2 (04)	49
30 - 39	17 (57)	9 (30)	4 (13)	0 (----)	30
40 - 49	8 (80)	0 (----)	1 (10)	1 (10)	10
Marital status					
Single	40 (67)	15 (25)	3 (05)	2 (03)	60
Married	26 (65)	8 (20)	3 (7.5)	3 (7.5)	40
Educational status					
Literate	15 (60)	6 (24)	3 (12)	1 (04)	25
Preparatory school	14 (61)	6 (26)	1 (04)	2 (09)	23
High school	14 (54)	9 (34)	2 (08)	1 (04)	26
Graduate or higher	23 (88)	2 (08)	0 (----)	1 (04)	26
Occupational status					
Housewife	39 (58)	19 (28)	5 (07)	5 (07)	68
Working	27 (84)	4 (13)	1 (03)	0 (----)	32
Socio-economic group					
Low	12 (44)	8 (30)	3 (11)	4 (15)	27
Middle	31 (66)	13 (28)	2 (04)	1 (02)	47
High	23 (88)	2 (08)	1 (04)	0 (----)	26

NOTE: values in parentheses are percentages.

On the GHQ-28, 33 subjects showed appreciable symptoms while 67 did not show any noticeable symptoms, and the mean score for the GHQ-28 was 7.67 (SD=5.43). The relevant data are presented in Table 5.10.

Table 5.10. The level of depression on GHQ-28 and socio-demographic variables for the 100 non-psychiatric females comprising the community sample

	GHQ-28		
Demographic variables	Normal	Cases	Total
Age groups			
18 - 19	5 (08)	6 (18)	11
20 - 29	39 (58)	10 (30)	49
30 - 39	16 (24)	14 (43)	30
40 - 49	7 (10)	3 (09)	10
Marital status			
Single	39 (58)	21 (64)	60
Married	28 (42)	12 (36)	40
Educational status			
Literate	13 (19)	12 (36)	25
Preparatory school	14 (21)	9 (28)	23
High school	18 (27)	8 (24)	26
Graduate or higher	22 (33)	4 (12)	26
Occupational status			
Housewife	41 (61)	27 (82)	68
Working	26 (39)	6 (18)	32
Socio-economic group			
Low	10 (15)	17 (52)	27
Middle	34 (51)	13 (39)	47
High	23 (34)	3 (09)	26

NOTE: values in parentheses are percentages.

Pearson coefficient analysis was used to test the relationship between BDI and GHQ-28 scores. The results indicated that BDI score was significantly correlated with GHQ-28 score (r=0.92; P<0.000) in the sample of 100 non-psychiatric women, which indicates that the 'case' screening using the BDI was closely related to that using the GHQ-28.

5.4.2.7.3. Analyses of Severity of Depression with Demographic Variables as Measured by the BDI

The effect of each socio-demographic variable on the severity of depression was examined by conducting one-way analyses of variance on the means of the BDI. Significant associations were found between severity of depression and occupational status ($F_{1,98}$=8.47, P=0.005); the highest rate of depression was found among the housewives, whose rate was just over twice that of the working women.

There was also a significant association between severity of depression and socio-economic status ($F_{2,97}$=11.51, P=0.001): the low-income group appeared to have higher rates of depression than the middle- and high-income groups.

Analyses of age, marital status, and educational status showed that there were no significant relationships between these variables and severity of depression on the BDI. The results of these analyses are presented in Table 5.11.

Table 5.11. One-way analysis of variance of socio-demographic variables and depression on BDI for total of 100 females from the community sample

Demographic variables	BDI Mean	SD	ANOVA F	df	P
Age					
18-19	14.82	12.87			
20-29	8.43	7.82	2.003	3,96	0.119
30-39	11.73	7.53			
40-49	11.30	11.62			
Marital status					
Single	9.52	8.25			
Married	11.75	9.85	1.50	1,98	0 .223
Educational status					
Literate	11.76	10.01			
Preparatory school	12.00	9.84			
High school	11.08	7.93	1.75	3,96	0.162
Graduate or higher	7.04	7.48			
Occupational status					
Housewife	12.13	9.76			
Working	6.75	5.43	8.47	1,98	0.005
Socio-economic groups					
Low	16.11	11.16			
Middle	9.85	7.23	11.51	2,97	0.001
High	5.50	5.52			

The relationship between all the socio-demographic variables and severity of depression was examined next by multivariate analysis of variance on BDI scores. No significant effects were found for any variables; therefore, to determine the interactions between the variables, it was decided to covary the age group and the education variables. The results indicated that the BDI score for depression was associated with socio-economic status ($F_{2,86}$=3.58, P=0.032) and occupational status ($F_{1,86}$=7.36, P=0.008), while age, marital status, and educational status did not predict any association with depression, and interaction between these variables had no significant effects on the severity of depression. Results of these analyses are provided in Table 5.12.

Table 5.12. Regression analysis for the socio-demographic variables and the severity of depression on the BDI

Demographic variables	SS	DF	MS	F	Sig
Within residual	5525.40	86	64.25		
Regression	133.55	2	66.77	1.04	.358
Marital status	.64	1	.64	.01	.921
Occupational status	472.77	1	472.77	7.36	.008
Socio-economic status	459.59	2	229.80	3.58	.032
Marital by occupational status	71.47	1	71.47	1.11	.295
Marital by socio-economic status	61.83	2	30.92	.48	.620
Occupational by socio-economic status	69.42	2	34.71	.54	.585
Marital by occupational by socio-economic status	95.53	2	47.76	.74	.479

In general, it emerged that occupational and socio-economic status each had a separate effect on the severity of depression (as determined by the BDI) in both analyses (one-way ANOVA and multivariate analysis).

5.4.2.7.4. Analyses of GHQ-28 Scores with Demographic Variables

The effects of the demographic variables on GHQ-28 scores were examined by conducting one-way analyses of variance on the mean scores of the GHQ-28. A significant effect of age on GHQ-28 scores was found ($F_{3,96}$=3.044, P=0.033): the highest scores (10 and above, which indicate stress) on the GHQ-28 were found amongst those aged 18-19 and 30-39 years.

Another significant effect on GHQ-28 scores was found to be occupational status ($F_{1,98}$=3.92, P=0.051); the highest scores were found among those women who were not working.

Analysis of socio-economic status showed a strong effect of this demographic variable on GHQ-28 scores ($F_{2,97}$=11.78, P=0.001); the low-income group appeared to have higher scores on the GHQ-28 than the middle- and high-income groups. The results also showed that there was no significant effect of marital and educational status on GHQ-28 scores. The results are presented in Table 5.13.

Table 5.13. One-way analyses of variance of socio-demographic variables and depression on the GHQ-28 for the 100 females from the community sample

			GHQ-28 ANOVA		
Demographic variables	Mean	SD	F	df	P
Age					
18-19	9.73	7.44			
20-29	6.08	4.68	3.044	3,96	0.033
30-39	9.30	4.89			
40-49	8.30	5.89			
Marital status					
Single	7.47	5.08			
Married	7.98	5.97	0.208	1,98	0.649
Educational status					
Literate	9.48	5.79			
Preparatory school	7.83	6.22			
High school	7.38	5.09	1.74	3,96	0.164
Graduate or higher	6.08	4.32			
Occupational status					
Housewife	8.39	5.86			
Working	6.13	4.04	3.92	1,98	0.050
Socio-economic group					
Low	11.37	6.53			
Middle	7.00	4.51	11.78	2,97	0.001
High	5.04	3.49			

The relationship between all the socio-demographic variables and their effects on GHQ-28 scores were examined next by multivariate analysis of variance. The procedures which were used for the analysis of BDI scores were also used for the analysis of GHQ-28 scores: the analysis was conducted first on all variables, but no significant

effects were found for any; therefore, to determine the interactions between the variables, it was decided to covary the age group and the education variables. The results revealed that only socio-economic status was associated with the higher GHQ-28 scores ($F_{2,83}$=4.17, P=0.019); the other four demographic variables – age, and marital, educational, and occupational status – were not significantly associated with high GHQ-28 scores and were not significantly inter-related. Results of this analysis are provided in Table 5.14.

Table 5.14. Regression analysis for socio-demographic variables and severity of depression on the GHQ-28

Demographic variables	SS	DF	MS	F	Sig
Within residual	1920.61	83	23.14		
Regression	62.59	2	31.30	1.35	.264
Socio-economic status	192.93	2	96.47	4.17	.019
Marital status	46.55	1	46.55	2.01	.160
Occupational status	105.92	2	52.96	2.29	.108
socio-economic by marital status	37.05	2	18.52	.80	.453
socio-economic by occupational status	156.38	4	39.09	1.69	.160
Marital by occupational status	4.81	1	4.81	.21	.650
socio-economic by marital by occupational status	10.22	2	5.11	.22	.802

Overall, it can be concluded that the only demographic variable significantly associated with higher rates on the GHQ-28 in multivariate analysis was socio-economic status, while in one-way ANOVAs, age, socio-economic status, and occupational status each had a separate effect on GHQ-28 scores.

5.4.2.7.5. Analyses of Symptoms of Depression on the BDI

The major depression symptoms were studied using two approaches. The first was by calculating the percentage of subjects in the total sample who endorsed depression on the BDI items as indicating major signs of depression symptoms. Table 5.15 shows the results of this approach. This approach was not used in Study I, since the sample of Study I was a clinical one, and it was expected that they would endorse all the symptoms of depression.

Table 5.15. Percentage of subjects who endorsed BDI item choices greater than 0 (n = 100)

BDI items	Endorsed by
1- Sadness *	60%
2- Pessimism	18%
3- Sense of failure	13%
4- Dissatisfaction *	53%
5- Guilt	18%
6- Punishment	41%
7- Self-dislike	13%
8- Self-accusation *	53%
9- Suicidal ideas	6%
10- Crying	27%
11- Irritability *	65%
12- Social-withdrawal	47%
13- Indecisiveness	35%
14- Body image change	38%
15- Work-difficulty	26%
16- Insomnia	46%
17- Fatigability *	62%
18- Loss of appetite	41%
19- Weight loss	24%
20- Somatic preoccupation	27%
21- Loss of libido	18%

*** Items endorsed by 50% or more.**

Table 5.15 shows that the five major components of depressive symptoms in the total sample studied, endorsed by more than 50% of the subjects, are as follows: sadness, dissatisfaction, self-accusation, irritability, fatigability. These five items were chosen to be the major cultural components of depression symptoms in the total sample.

The second approach used in studying the major components of depression in the sample was identifying the depressed subjects in the sample and then calculating the items endorsed by 50% or more of these subjects. For this purpose, a depressed subject was defined as one whose score on the BDI exceeded 15. Thus, scores of 16-33 on the BDI indicated mild depression, scores of 34-45 indicated moderate depression, and scores of 46-63 indicated severe depression. Thirty-four subjects met this criterion for depression (23 mild, six moderate, and five severe). The major components of depression for the depressed subjects are shown in Table 5.16.

Table 5.16. Percentage of depressed subjects who endorsed BDI item choices greater than 0 (n = 34)

BDI items	Endorsed by
1- Sadness *	82%
2- Pessimism *	53%
3- Sense of failure	38%
4- Dissatisfaction *	88%
5- Guilt *	50%
6- Punishment *	71%
7- Self-dislike	38%
8- Self-accusation *	74%
9- Suicidal ideas	18%
10- Crying	47%
11- Irritability *	79%
12- Social-withdrawal *	74%
13- Indecisiveness *	76%
14- Body image change *	74%
15- Work-difficulty *	62%
16- Insomnia *	65%
17- Fatigability *	91%
18- Loss of appetite *	62%
19- Weight loss	38%
20- Somatic preoccupation *	50%
21- Loss of libido	47%

*** Items endorsed by 50% or more.**

It can be seen from Table 5.16 that 15 out of the 21 items constituting the BDI were endorsed by more than 50% of the depressed subjects. Considering the five items in Table 5.15 endorsed by more than 50% of the total sample as signs of depression, it can be seen that these items also appear as major items in Table 5.16, endorsed by the depressed subjects. These five items could be considered as the major cultural components of depression in this study's sample.

For comparative purposes, bivariate contingency analyses (chi-squared) were conducted on the each of the 21 items of the BDI in order to determine the differences among the symptoms of depression for the 56 female patients from Study I and the 34 females with depressed symptoms from this study. Significant or near significant differences were found between the patients and the community sample with depressed symptoms on 11 of the 21 BDI items. With the strongest differences listed first, the differences were found for sense of failure, crying, pessimism, suicidal ideas, self-dislike, and insomnia (chi-squared 10.79, 9.45, 5.50, 5.32, 5.00, and 4.37 respectively, values of *P* ranged from <0.001 to <0.05). Work difficulty, irritability, somatic preoccupation, loss of libido, and loss of appetite were nearly significant (chi-squared 3.74, 3.56, 3.47, 3.16, and 2.98 respectively, $P<0.10$).

Pair comparison of the results of the 11 items revealed that the patient sample scored higher on these 11 items than the depressed community sample. The relevant data are presented in Table 5.17. These data indicate that patients had higher levels of severity than the community sample.

Table 5.17. Chi-squared analysis of depressive symptoms between 56 depressed patients and 34 females with depressed symptoms on each of 21 items of the BDI

BDI items	Chi-squared	Significance	56 Patients % responses	34 depressed females % responses
1- Sadness	.88	.348	89%	82%
2- Pessimism	5.50	.019*	77%	53%
3- Sense of failure	10.79	.001*	73%	38%
4- Dissatisfaction	.024	.877	89%	88%
5- Guilt	1.36	.244	63%	50%
6- Punishment	.007	.932	71%	71%
7- Self-dislike	5.00	.025*	63%	38%
8- Self-accusation	.942	.332	82%	74%
9- Suicidal ideas	5.32	.021*	41%	18%
10- Crying	9.45	.002*	79%	47%
11- Irritability	3.56	.059*	93%	79%
12- Social-withdrawal	2.05	.152	86%	74%
13- Indecisiveness	2.36	.124	61%	76%
14- Body image change	.301	.583	79%	74%
15- Work-difficulty	3.74	.053*	80%	62%
16- Insomnia	4.37	.037*	84%	65%
17- Fatigability	.41	.523	95%	91%
18- Loss of appetite	2.98	.084	79%	62%
19- Weight loss	.187	.666	43%	38%
20- Somatic preoccupation	3.47	.062	70%	50%
21- Loss of libido	3.159	.076	66%	47%

5.4.2.7.6. Analysis of the Antidepressive Activity Questionnaire (AAQ)

Data scoring for the AAQ was carried out as follows: each questionnaire was scored to yield two kinds of data: (a) *frequency data* on a three-point scale (rarely, sometimes, quite often); (b) *helpfulness data* on a three-point scale (not very, moderately, very). In order to determine the activities frequently used by the subjects and those that they rated as helpful, it was decided to choose only the activities rated as being done often and found very helpful. The other two categories, rarely/not very and sometimes/moderately, were considered only in determining the number of items ticked by the subjects and the number of times that each item was ticked. In order to determine the average number of items ticked and the average number of items rated helpful, it was decided to consider only those items which were endorsed by 50% or more of the subjects.

The 100 activities of the AAQ were placed into seven categories according to their components (see Appendix 5): (1) items 1-32 were labelled as 'activity and work'; (2) items 33-40 were labelled as 'self-care and maintenance'; (3) items 41-50 were labelled as 'pharmacological'; (4) items 51-61 were labelled as 'cognitive and affective experience'; (5) items 62-76 were labelled as 'aesthetics, entertainment, and contemplation'; (6) items 77-96 were labelled as 'help and comfort seeking'; (7) items 97-100 were labelled as 'avoidance'.

All 100 AAQ items were ticked at least once; the highest number of ticks for one item was 75. Each subject ticked at least four items; the highest number of items ticked by one subject was 97. Table 5.18 shows that only 19 of the 100 items were endorsed by more than 50% of the subjects.

Table 5.18. Antidepressive Activity Questionnaire items endorsed, often done, or very helpful, as mentioned by a sample of 100 subjects

AAQ items	Endorsed	Often done	Very helpful
1- Keep busy.	69	17 (25)	18 (26)
2- Do something I enjoy.	60	36 (60)	24 (40)
3- Give myself a treat.	54	18 (33)	30 (56)
4- Do something to take my mind off it.	60	21 (35)	15 (25)
5- Do something I can get engrossed in.	51	18 (35)	15 (29)
6- Stick to my normal routine.	66	42 (64)	30 (45)
10- Go for walk.	51	12 (24)	21 (41)
18- Do housework.	66	42 (64)	36 (55)
19- Cleaning or tidying.	63	39 (62)	39 (62)
20- Cooking or baking.	57	18 (32)	15 (26)
23- Go shopping.	63	12 (19)	9 (14)
28- Take a rest.	54	15 (28)	21 (39)
31- Play with children or watch them playing.	51	18 (35)	30 (59)
33- Have a bath.	51	33 (65)	36 (71)
37- Go to bed.	57	18 (32)	18 (32)
77- See a friend or friends.	51	24 (47)	30(59)
78- Ring someone up.	60	21 (35)	24(40)
92- Take comfort in my religion.	60	36 (60)	36(60)
94- Pray.	75	48 (64)	60(80)

NOTE: Values in parentheses are percentages.

In view of the probably quite non-specific effects of behaviours such as keep busy, stick to my normal routine, go shopping, do something to take my mind off it, do something I enjoy, ring someone up, cooking or baking, go to bed, take a rest, do something I can get engrossed in, and go for a walk, it is not entirely surprising that the majority of the subjects found these activities not very helpful or moderately helpful rather than very helpful. It is clear that these activities are likely to be readily available much of the time in many or most ordinary environments, so that even though such activities may be unlikely in themselves to produce a solution to people's problems, they will probably at least be there to help people get themselves together sufficiently to tackle more strenuous forms of coping.

With regard to the method of coping, Table 5.18 shows that the more common anti-depressive activities chosen by women in general are those under the first category, which

was labelled as 'activities in general'. These ranged from domestic work, distracting activities, pleasurable activities, engrossing activities, and desirable activities to vigorous activities. They were chosen by 51-69% of the subjects. It was considered that most of these activities are 'close to home': 'stick to my normal routine' (66%), 'do housework' (66%), 'cleaning or tidying' (63%), and 'cooking or backing' (57%) are much more common than 'have a change of scene' (42%), 'go for a drive' (36%) or 'take a holiday' (30%). They seem also to be the activities that ordinary social life is made of: 'ring someone up' (60%), 'see a friend or friends' (51%), and 'talk to someone about how I am feeling' (42%) were much more commonly reported than 'see my doctor' (27%), 'see my psychiatrist' (18%), 'see my psychologist' (18%), or 'see some other professional helper' (18%) (see Appendix 5).

5.4.2.7.7. Depressed and Non-depressed Women and Type of Coping

In order to examine the differences between varying levels of depressed mood and coping style, the community sample was split on the basis of their BDI score into a depressed group (n=34, BDI score of 15+) and a non-depressed group (n=66, BDI score of 14 and below). Comparative statistical analysis, using independent sample t-tests, was conducted in order to examine overall differences in coping between depressed and non-depressed subjects.

Since coping activities were rated in terms of both frequency and helpfulness, and since – as has been mentioned already – only the activities which were often used and found very helpful will be considered in the analysis, separate comparative analyses were employed.

The two groups differed with regard to the number of items endorsed ($t_{.98}$=2.34, P=0.02), which indicates that depressed women used more coping activities for their depressed feelings than non-depressed women. This significant difference was found on all 100 items of the scale. When *t*-test analysis was conducted on the 19 items chosen by more than 50% of the total subjects, there was a significant difference with regard to the number of items endorsed between depressed and non-depressed women ($t_{.98}$=2.04, P=0.044), in that depressed women chose more activities than non-depressed women. No additional significant differences were found between the two groups on the frequencies of the activities which were often used or on the activities which were found very helpful, either for the 100 items of the scale or for the 19 items endorsed by 50% or more of the subjects. The results of the *t*-test analysis are presented in Table 5.19.

Table 5.19. *t*.test analysis for the coping activities endorsed by depressed and non-depressed women of the community sample

	Non-depressed (n=66)		Depressed (n=34)			
Coping responses	Mean	SD	Mean	SD	df	t.value
100 items, endorsed	33.35	17.79	43.00	22.58	98	2.34
19 items, endorsed	10.55	4.21	12.44	4.78	98	2.04
100 items, often used	11.11	5.65	13.56	8.28	98	1.55
19 items, often used	4.85	2.78	4.94	2.66	98	0.16
100 items, very helpful	11.33	5.87	13.53	8.13	98	1.40
19 items, very helpful	4.98	2.89	5.24	3.27	98	0.39

It was interesting to see next whether women who endorsed the largest number of items on the AAQ were also those with the most 'very helpful' ratings. To accomplish that, independent sample *t*-tests were employed on the number of subjects who rated the 100

activities and the 19 activities endorsed by more than 50% of the subjects as often used and very helpful. There was a significant difference ($t_{.198}$=3.46, P=0.001) between non-depressed and depressed women on the 100 items of the AAQ with regard to how often they used these activities. Non-depressed women often used these activities more than depressed women. Similar results were found with the 19 items endorsed by a majority of the subjects, with significant differences on these items between the non-depressed and depressed women in terms of how often they used these activities ($t_{.36}$=3.94, P=0.001).

There was a significant difference in terms of how helpful the subjects found the activities on the 100 items of the AAQ between the non-depressed women and depressed women in favour of the non-depressed women ($t_{.198}$=3.46, P=0.001). The analysis of the 19 items gave similar results, with non-depressed women indicating that those activities which they often used were 'very helpful' significantly more than did the depressed women ($t_{.36}$=3.86, P=0.001). Tables 5.20 and 5.21 show the items of the AAQ which were endorsed by 50% or more of the subjects in both groups and their ratings of how often they used them and how helpful they found them.

Table 5.20. AAQ items endorsed, often used, or very helpful mentioned by 50% or more of the non-depressed women (*n*=66)

	Non-depressed women (n=66)		
AAQ items	Endorsed	Often	V.H. *
1- Keep busy.	48 (73)	16 (33)	16 (33)
2- Do something I enjoy.	35 (53)	24 (69)	18 (51)
3- Give myself a treat.	33 (50)	12 (36)	21 (64)
4- Do something to take my mind off it.	40 (61)	14 (35)	12 (30)
6- Stick to my normal routine.	40 (61)	31 (78)	20 (50)
10- Go for walk.	33 (50)	10 (30)	16 (49)
18- Do housework.	42 (64)	28 (67)	23 (55)
19- Cleaning or tidying.	36 (55)	22 (61)	22 (61)
20- Cooking or baking.	35 (53)	11 (31)	9 (26)
23- Go shopping.	39 (59)	7 (18)	6 (15)
33- Have a bath.	33 (50)	22 (67)	23 (70)
37- Go to bed.	35 (53)	11 (31)	10 (29)
78- Ring someone up.	37 (56)	13 (35)	15 (41)
92- Take comfort in my religion.	39 (59)	24 (62)	23 (59)
94- Pray.	48 (73)	30 (63)	36 (75)

NOTE: Values in parentheses are percentages.

*** Very helpful**

Table 5.21. AAQ items in order of endorsed, often used, and very helpful mentioned by 50% of the depressed women (n=34)

	Depressed women (n=34)		
AAQ items	Endorsed	Often	V.H.*
1- Keep busy.	21 (62)	1 (05)	2 (10)
2- Do something I enjoy.	25 (74)	12 (48)	6 (24)
3- Give myself a treat.	21 (62)	6 (29)	9 (43)
4- Do something to take my mind off it.	20 (59)	7 (35)	3 (15)
5- Do something I can get engrossed in.	19 (56)	3 (16)	3 (15)
6- Stick to my normal routine.	26 (76)	11 (42)	10 (39)
7- Do something constructive.	17 (50)	6 (35)	3 (18)
8- Do something vigorous.	20 (59)	4 (20)	8 (40)
10- Go for walk.	18 (53)	2 (11)	5 (28)
14- Work.	20 (59)	6 (30)	4 (20)
17- Work hard.	20 (59)	6 (30)	5 (25)
18- Do housework.	24 (71)	14 (58)	13 (54)
19- Cleaning or tidying.	27 (79)	17 (63)	17 (63)
20- Cooking or baking.	22 (65)	7 (32)	6 (27)
23- Go shopping.	24 (79)	5 (21)	3 (13)
24- Buy clothes.	18 (53)	6 (33)	7 (39)
25- Buy something nice.	17 (50)	6 (35)	7 (41)
28- Take a rest.	22 (65)	7 (32)	9 (41)
31- Play with children or watch them playing.	21 (62)	10 (48)	14 (67)
33- Have a bath.	18 (53)	11 (61)	13 (72)
35- Have something to eat.	19 (56)	9 (47)	5 (26)
37- Go to bed.	22 (65)	7 (32)	8 (36)
38- Take a nap.	19 (56)	2 (11)	3 (16)
50- Have coffee or tea.	18 (53)	7 (39)	5 (28)
51- Try to find out what is making me depressed.	19 (56)	13 (68)	12 (63)
53- Reminding myself it won't last.	17 (50)	3 (18)	5 (29)
54- Think about something else.	21 (62)	5 (24)	5 (24)
55- Take myself out of it.	17 (50)	9 (53)	6 (35)
57- Have a good cry.	18 (53)	8 (44)	8 (44)
62- Get out of the house, go out.	18 (53)	7 (39)	3 (17)
70- Read a newspaper, journal or magazine.	22 (65)	9 (41)	12 (55)
76- Find peace and quite.	21 (62)	10 (48)	9 (43)
77- See a friend or friends.	22 (65)	10 (46)	11 (50)
78- Ring someone up.	23 (68)	8 (35)	9 (39)
79- Have a meal with people.	18 (53)	0 (----)	2 (11)
85- Talk to someone about how I'm feeling.	17 (50)	5 (29)	6 (35)
92- Take comfort in my religion.	21 (62)	12 (57)	13 (62)
94- Pray.	27 (79)	18 (67)	24 (89)

NOTE: Values in parentheses are percentages.
*** Very helpful**

It seems clear from this analysis that the quantity of a person's activity is not necessarily a guarantee of its quality.

5.4.2.7.8. Analysis of Coping Activities with Demographic Variables

To determine whether coping activities were related to the demographic variables, a multivariate analysis of variance (MANOVA) was first conducted on all variables, and

no significant effects were found, either for each variable individually or for the interaction between these variables. Therefore, to limit the large number of interactions between the variables, it was decided to covary the age group and the education variables. The MANOVA tables for the three analyses of the AAQ variables (endorsed, often used, very helpful) are given in Tables 5.22, 5.23, and 5.24.

Table 5.22. Analysis of variance for number of items endorsed by different demographic variables

Variables	SS	df	MS	F	Sig.
Within residual	36229.00	86	421.27		
Regression	554.66	2	277.33	.66	.520
Marital status	203.61	1	203.61	.48	.489
Occupational status	1.63	1	1.63	.00	.951
Socioeconomic status	200.80	2	100.40	.24	.788
Marital by occupational status	330.91	1	330.91	.79	.378
Marital by socio-economic status	193.07	2	96.53	.23	.796
Occupational by socio-economic status	412.96	2	206.48	.49	.614
Marital by occupation by socio-economic	15.08	2	7.54	.02	.982

Table 5.23. Analysis of variance for number of items rated often used by different demographic variables

Variables	SS	df	MS	F	Sig.
Within residual	4005.72	86	46.58		
Regression	.72	2	.36	.01	.992
Marital status	6.13	1	6.13	.13	.718
Occupational status	4.89	1	4.89	.11	.747
Socioeconomic status	27.56	2	13.78	.30	.745
Marital by occupational status	187.57	1	187.57	4.03	.048*
Marital by socio-economic status	10.06	2	5.03	.11	.898
Occupational by socio-economic status	56.97	2	28.49	.61	.545
Marital by occupation by socio-economic	6.53	2	3.27	.07	.932

Table 5.24. Analysis of variance for number of items rated very helpful by different demographic variables

Variables	SS	df	MS	F	Sig.
Within residual	4109.63	86	47.79		
Regression	2.60	2	1.30	.03	.973
Marital status	.77	1	.77	.02	.900
Occupational status	15.57	1	15.57	.33	.570
Socio-economic status	7.98	2	3.99	.08	.920
Marital by occupational status	115.17	1	115.17	2.41	.124
Marital by socio-economic status	17.29	2	8.64	.18	.835
Occupational by socio-economic status	35.14	2	17.57	.37	.693
Marital by occupation by socio-economic	15.74	2	7.87	.16	.848

It can be seen from the three tables above that there were no significant main effects of any of the demographic variables on any of the AAQ variables. However, on the second AAQ variable ('often used', in Table 5.18) there was a significant interaction between marital and occupational status ($F_{1,86}$=4.03, P=0.048).

In conclusion, the results of this study show that depression appears more severe in housewives and in low-income groups. These findings support hypothesis H1b, which predicted that married women would show severer depression than single women. The results also support hypothesis H1e, which predicted that those in low-income groups would show severer depression than those in the middle and higher ranges. The results also show that the major components of depression in this sample, according to the self-report statement (BDI), are sadness, dissatisfaction, self-accusation, irritability, and fatigability. This finding partially supports the second hypothesis, which predicted that the symptom profile of depression in women in Dubai would be characterized by the

presence of many somatic symptoms.

The study of coping strategies showed that women in Dubai are more likely to turn to domestic work, faith healing, and self-care activities as preferred strategies for coping with depression. These strategies reflect avoidance methods, active cognitive methods, active behavioural methods, and avoidance behavioural methods. They focus on emotional discharge and problem solving. This finding partially supports the third hypothesis, which predicted that women in Dubai are more likely to turn to alternatives like faith healing and social activities as more appropriate strategies for depression than psychiatric treatment.

The field observation revealed that women in Dubai used some indigenous expressions which were not included in the standardized questionnaires used in this study to describe their symptoms. This matter is addressed in the third study, which will attempt to determine which other expressions are used in Dubai.

5.4.3. Study III

5.4.3.1. Introduction and Aims

The findings of Study II indicated that there are some differences in the symptom profile of depression between patients and community subjects. Some indigenous expressions, which were not included in the standardized questionnaires that were used in Study II to screen the depressed cases and to measure the severity of depression, were used by the subjects to describe and illustrate their symptoms. It is well known that there are metaphorical meanings and idiomatic expressions in each language which would not be tapped by standard research instruments or their strict translations. For this reason, it was thought essential to collect local idioms of distress. Therefore, this study aimed to:

(a) investigate the concepts and words related to depression among the native people of Dubai; and

(b) develop a checklist of depression-related words and expressions from the indigenous language of Dubai.

5.4.3.2. Hypotheses

The hypothesis of this study is that the conceptions of depression in the people of Dubai will differ from Western psychiatric views of depression (ICD-10 and DSM-IV) in relation to clinical presentation and details of symptomatology.

5.4.3.3. Sample

5.4.3.3.1. Sampling Frame

This study was designed to collect qualitative data about the concepts and words related to depression. Two kinds of subject were therefore needed; these will now be described.

Subjects for the focus group. Since the purpose of this part of the study was to capture the opinions and perceptions of the native people of Dubai about depression, and to avoid the fallacy of assuming that any one individual can represent their culture's conceptions of depression, and with regard to the budgetary and time constraints of the research, a series of focus group interviews were conducted with participants of either sex and of different socio-demographic characteristics such as age and marital, educational, occupational, and socio-economic status. As mentioned earlier in this chapter, it was decided to concentrate on individuals whose social position brought them into contact with large numbers of people, and who occupied a position of trust and respect within the community (community leaders). This would mean that their perceptions and responses were based on wide experience of events and problems in the community. These individuals were initially selected to be the subjects of the focus groups. It was decided to restrict the participants to the native adult people of Dubai of either sex.

Two strategies were used to identify participants for focus group interviews: first, existing members or employees attending the associations mentioned above were contacted, and only the native employees were selected; second, owing to the limited quantity of information in the lists, those who had already passed through the selection screen and had agreed to take part in the interviews were asked to suggest further

participants who would meet the qualifications required.

Next, it was important to concentrate on the composition of the groups. Krueger (1994) described a focus group that is characterized by homogeneity but with sufficient variation among participants to allow opinions to be constructed. Most commonly, homogeneity is sought in terms of occupation, educational level, age, and gender. Care has therefore been taken in mixing individuals from different age groups and lifestyles. The size of each focus group was also determined by the number of individuals available in each place that they were selected from, and according to the theoretical recommended size of the focus group, namely 6-12 participants in each session (Krueger, 1994).

The subjects for focus groups were drawn from the Researches and Studies Centre in Dubai, the Dubai Police Headquarters, and the Social and Developmental Association for Women in Dubai.

Subjects for the open-ended inquiry. This part of the study was designed to obtain the words or idioms related to depression in the language used by the native people of Dubai. The sampling frame therefore concentrated on natives from Dubai who spoke fluent native Arabic and were willing and able to cooperate. It was important to get subjects as much as possible from both sexes and from different demographic statuses, since the open-ended inquiry was designed to include all of these varieties. Hence, a *random selection technique* was used to select the subjects from the community in the different study areas. The plan was to visit the places were native people from both sexes and various demographic levels could be found easily, such as the Ministry of Education, the

Ministry of Labour and Social Affairs, the Economic Developmental Department, the Social Developmental Association for Women in Dubai and the Dubai Police Headquarters. The other strategy used for selecting the subjects of this study was *snowball sampling*: the participants were asked if they knew of others who met the qualifications and who would be willing to take part in this study.

5.4.3.3.2. Sample Size

Basic characteristics of the two samples are discussed below.

Focus groups sample. Care was taken to select subjects without a history of any psychological illness or any mental disorders. From a total of 53 subjects (28 females and 25 males) contacted, only 40 (20 females and 20 males) participated in the focus group sessions; the other 13 subjects (eight females and five males) were unable to take part in the interviews for practical reasons. Table 5.25 shows summary data for the focus group subjects.

Table 5.25. Description of focus group samples in the different study areas

Study area	Female (*n*=20)	Male (*n*=20)
Researches and Studies Centre	6 (7)	8 (10)
Dubai Police Department	3 (5)	12 (15)
Social Developmental Association for Women	11 (16)	0 (---)

Note: values in parentheses are the original focus group samples, values outside the parentheses are the numbers of subjects who took part in the focus group sessions.

Community sample. As neither quantitative nor qualitative data about the local words or idioms of depression in Dubai previously existed, it was difficult initially to determine

the number of subjects that would be needed. To determine the sample size it was therefore decided to sample until saturation point was reached _that is, when the data began to stop telling us anything new about the emotional words under scrutiny. This point was reached with approximately 100 cases in each group. The decision was therefore taken to discard the 66 last questionnaires (from 46 females and 20 males) since they did not add any new data. This left 100 females and 100 males in this community sample. Tables 5.26 and 5.27 shows summary data for the original community sample and for the sample which was used for analysis.

Table 5.26. Description of original community sample in the different study areas

Study area	Female (*n*=146)	Male (*n*=120)
Ministry of Education	27	19
Ministry of Labour and Social Affairs	17	15
Economic Developmental Department	25	50
Social Developmental Association for Women	45	0
Dubai Police Headquarters	12	23
Snowball sample	20	13

Table 5.27. Description of the community sample that was used, broken down by study area

Study area	Female (*n*=100)	Male (*n*=100)
Ministry of Education	18	16
Ministry of Labour and Social Affairs	17	12
Economic Developmental Department	10	39
Social Developmental Association for Women	29	0
Dubai Police Headquarters	10	20
Snowball sample	16	13

5.4.3.4. Instruments

The open-ended inquiry was only the instrument used for this investigation. Details of this instrument were outlined earlier in this chapter (see section 5.3.5).

5.4.3.5. Procedure

Focus groups. Since it was difficult for most of the subjects who were contacted to join the interviews because of other commitments, each subject was contacted individually at their place of work or at the relevant organization and was asked to participate in a group at a particular time and place after obtaining permission from the administration of the organization. Subjects were also informed of the general topics for the interview, and an effort was made to let all participants feel that they were needed at the interview and that their special experiences or insights would be of value in the study; meanwhile, they were asked to put us in touch with other native people.

Nine females selected from Dubai Police Headquarters and from the Researches and Studies Centre were involved in the first focus group interview, which was conducted in the Centre's conference room on 1 April 1996. Eleven females selected from the Social Developmental Association for Women in Dubai were involved in the second focus group interview, which was conducted in the same place on 9 April 1996. On 3rd and 20th May 1996, focus group interviews for males were conducted. Eight males were selected from the Researches and Studies Centre and were interviewed in the Researches and Studies Centre conference room, while the second focus group interview comprised

12 males selected from different departments of Dubai Police Headquarters and was conducted in the conference room at the Public Relations Department of the Dubai Police.

Since the purpose of this part of the study was to conduct an initial investigation about how the people of Dubai perceive depression, it was important to keep in mind that the intent of the focus groups was not to infer but to understand, not to generalize but to determine the range, not to make statements about the population but to provide insights about how people perceive a situation. As a result, and owing to time limitations, the decision was made to conduct only four focus groups (two for females and two for males). Fortunately, each of first focus group interviews for either sex provided a considerable amount of new information; much less derived from the second focus groups, suggesting that there would have been little value in continuing with additional group discussions.

The schedule of each focus group interview was based partly on previous reports about focus groups theory and practice and partly on earlier research carried out in developing countries and using vignettes (Wig, Suleiman, Routledge, et al., 1980). The schedule consisted of seven parts: (1) identifying data concerning a certain mental disorder as defined by a vignette; (2) questions on the subjects' knowledge of how many individuals corresponding to this vignette description and living in the area were known to them; (3) a question on the subjects' recognition of such descriptions in people they know; (4) questions on the subjects' views of depression as an illness or problem; (5) a question on the subjects' knowledge about causes of such illnesses or problems; (6) an indication of

where people would usually first seek help for depressed feelings; (7) questions on the subjects' opinions about the seriousness and the personal, family, and social consequences of such illnesses or problems.

The vignette was one of seven from Wig, Suleiman, Routledge, et al. (1980), who used them as a means of portraying several mental disorders without using technical language. Depressive neurosis was the condition chosen for the vignette in this study. The skeleton vignette simply indicated the age, sex, and main symptoms or behaviour of the person being described, and it was to be as interesting and lively as possible. The skeleton account was embellished by using local names and expressions and by referring to local events and customs. The aim was to produce an account which gave a concise, vivid and easily understood picture of the clinical condition which at the same time was interesting and striking to the listener. The vignette is reproduced below.

'A person complains of different troubles at different times; troubles such as head-aches, pains in the stomach, general weakness of the body and tiredness. He/she may not be doing her/his work as well as he/she usually can. He/she finds it difficult to fall asleep. In addition, he/she is worried about problems he/she faces (money, children, housing) and was irritable with close relatives and friends. He/she cannot relax or enjoy his/herself properly'.

The focus groups were conducted by the researcher, who led the groups through questions that sought to facilitate the discussion among the group members (these questions are given in section 5.4.3.6.2). The discussions were tape recorded in order to facilitate later analysis. Each session lasted two hours. As soon as each focus group

session was completed, the tape recording was transcribed, and studied along with the researcher's notes.

The open-ended inquiry. Subjects for this part of the study were selected randomly and by the snowball technique from different associations, organizations, and residences of the Emirate of Dubai. Permission to participate in the study was obtained from the administrations of the Ministry of Education, the Ministry of Labour and Social Affairs, the Economic Developmental Department, the Social Developmental Association for Women in Dubai, and the Dubai Police Headquarters, and from each participant.

The single point of entry for data collection was the indigenous word for 'emotion'. No standardized checklists, inventories, rating scales or *a priori* theoretical definitions of emotion categories were employed.

The 200 subjects (100 males and 100 females) were given an explanation about the main aim of the research and were asked to list on the open-ended inquiry form all the words that they could think of which indicated emotion and which complete the frame 'I feel...'. They were also informed that all the information would be treated confidentially and that no-one would be identified by name. Finally, subjects were asked to answer honestly and independently, and were reminded that there were no right and wrong answers.

The majority of the subjects (135 of 200) completed the inquiry on their own and returned it to the investigator in person. The other 65 (all women) completed the form with the investigator's help at the Social Developmental Association for Women in Dubai

in three group sessions (involving 18, 22, and 25 subjects respectively).

5.4.3.6. Results

5.4.3.6.1. Social and Demographic Features of Focus Group Subjects

(1) ***Female samples.*** The mean age of the 20 female participants in the two focus groups was 33.6 years (range 23-54).

(2) ***Male samples.*** The mean age of the 20 male subjects who participated in the two focus group interviews was 34.85 years (range 27-50).

The basic data for both samples are shown in Table 5.28.

Table 5.28.The socio-demographic status of the focus group samples (20 females, 20 males)

Demographic variables	Females	Males
Age groups		
23 - 29	9 (45%)	4 (20%)
30 - 39	7 (35%)	11 (55%)
40 - 54	4 (20%)	5 (25%)
Marital status		
Married	11 (55%)	13 (65%)
Single	9 (45%)	7 (35%)
Educational status		
Illiterate	5 (25%)	0 (--------)
Educated	15 (75%)	20 (100%)
Occupational status		
Working	12 (60%)	20 (100%)
Not working	8 (40%)	0 (--------)
Socio-economic groups		
Low	5 (25%)	0 (--------)
Middle	12 (60%)	18 (90%)
High	3 (15%)	2 (10%)

5.4.3.6.2. Analysis of Focus Group Sessions

In order to present the groups' opinions and perceptions about depression, the findings of the focus group sessions were organized around the key questions which followed the vignette.

5.4.3.6.2.1. Female Sessions

(1) Do you know individuals in the community matching this description?

In each group session most of the women cited a number of cases they knew or had heard about with symptoms mentioned in the vignette or with additional symptoms. Most of them felt that such individuals were not seriously ill. Typical comments by the women included:

- *'Yes, there are a lot of people who suffer from these symptoms and they frequently visit the hospitals seeking treatment, but they are not really ill...they are psychologically tired...'*

- *'I know many people from my family and neighbourhood who have similar symptoms, but they are not suffering from a serious illness...'*

- *'I have heard about people with these symptoms...I think everybody might have them... . Since you are psychologically not good...'*

(2) What kind of symptoms does she have?

The most common response to this question was that the people that the subjects knew were suffering mainly from physical problems, but they also reported that, as far as they knew, these individuals' medical reports from clinics or hospitals showed that they were not seriously ill. Some participants reported other symptoms such as social withdrawal, feeling fearful, loss of appetite, irritability, insomnia, neglecting their appearance,

agitation, sadness, aggression, jealousy, paranoid thinking, sensitivity, boredom, loss of libido, eating too much, excessive thinking (worries), and crying. Typical comments by the participants on this question included:

- *'... she always feels unwell, she has pain in her heart and it is beating too much...she visited many hospitals and doctors and all of them said she has nothing serious...she is uncomfortable at home...all the medicine she has had was useless... her mind is busy all the time with a lot of problems... in other words she wants to get rid of the problems at home...but they are increasing...'*
- *'My neighbour is suffering from very strong pain in her heart and very severe head-aches...she has visited many doctors...they said that there is no medical reason for that...and they treat her with pain killers...'*
- *'My sister is divorced and has one child, she is always suffering from pains in her stomach and back, and complaining all the time...we took her to many doctors and* motawas *[religious healers] and all of them reported that she has no serious physical problems...'*
- *'My aunt is in her late forties, always suffering from feelings of fear, crying most of the time, feeling general weakness in her body, and she has no appetite to eat or to sit with anybody, she gets nervous very easily and cannot sleep well or relax...'*
- *'My friend is suffering from difficulty in breathing, she cries and has no appetite, she does not want to talk, neglects her appearance, and she always complains that she feels contraction in her muscles and something creeping on her skin...'*

It was realized that there were different opinions towards crying: older and less educated women saw it as shameful and unusual for an Emirates woman to cry when she feels depressed, and felt that she should not show her feelings to others and should keep them to herself. If these feelings were too much, she should only cry when she was alone. Depression should be 'inside' and nobody should know about it. Responses from these

women included:

- *'Women in the past never showed their feelings...a woman kept her problems inside and tried to act as if she was not depressed, and if she wants to cry she avoids showing that to others...but as much as she can she keeps it hidden inside...'*

- *'We are the Arabs, we never cry...we endure...but these new generations they are so soft and weak... they cry for any reason...'*

- *'It is a shameful thing for a mature woman to cry...she has to be patient and accept her situation...'*

By contrast, the younger women, who were more highly educated, felt that crying was better than keeping stresses and sad feelings inside yourself; they said that hiding your feelings may cause a lot of physical illness, and they did not think that there was any problem about showing your feelings. Their responses included:

- *'If a woman cries she will not suffer from these symptoms, but if she keeps her feelings inside she will suffer from many other symptoms...'*

- *'A woman who cries feels better...'*

- *'Why should I keep my feelings bottled up...?'*

(3) Do you think there is a problem? If so, what would you call it?

All the participants agreed that there was a problem behind the symptoms mentioned in the vignette, but they also felt that there was no serious illness. Some of them mentioned that such symptoms may arise for internal reasons in some personalities and do not always occur for external reasons, such as life events. The words they used to name this problem were varied and based more on the personal attributes of the sufferer than on any knowledge or technical expertise concerning the problem. The participants used words

such as 'obsessive', 'anxiety', 'sadness', 'delusions', 'fear', 'depression', 'bad mood', 'paranoid', and 'psychological illness' to label the symptoms they recognized. Typical comments were:

- *'I call these symptoms psychological illness...'*

- *'I think this is obsession* [waswas] *because it makes you think too much and be worried about something that does not exist sometimes...'*

- *'...when you think or are afraid of something that does not exist I call it delusions* [halwasa]...'

- *'I think these feelings of fear of something unknown is called paranoia...'*

(4) What do you think are the causes of her illness or problems?

The majority of respondents reported that the reason for depression might be marital problems, such as polygamy, divorce, or emotional distance between the couple. Others said that the responsibilities of women are increasing, especially as far as bringing up children is concerned, since husbands rarely share these responsibilities with their wives, and are always busy with their businesses or distracted by having two or more families if they have more than one wife. It was clear that the participants were strongly influenced by the effects of rapid social changes upon women in Dubai, and by the effect of the conflict, which has invaded the region over the last three decades, between the traditional and inherited interpretation of some Islamic rules about women=s situations and the facts of modern life.

Passing the age of marriage was a possible reason for depression among single women, especially given society's pressure on the single woman. Women's position in the family and other people loading them with a lot of pressures without paying attention to their feelings and needs were other reasons reported by many of the participants. The responses

of the participants included sentences such as the following:

- *'Husbands are the main reason for women's depression...'*

- *'My husband is the reason for all my problems...he left me and got married to another woman...'*

- *'...this polygamy is widespread in our society, it is very easy for a man to marry another woman and leave his first wife and children without a minimum level of support...'*

- *'It is true many families were destroyed and many women got psychological problems...'*

- *'Bringing up children nowadays is very difficult, a mother on her own cannot afford it, a father should take part in that responsibility...but where is he?!...'*

- *'A father should sit with his wife and children and talk to them; children do not always listen to their mother...'*

- *'Many young women got married to anyone who knocked on their doors because they were afraid that they would pass the age of marriage...but after less than one year some of them got divorced...they create for themselves another bad situation because our societies put a lot of pressure on the divorced woman...'*

- *'Passing the age of marriage puts the girl in a very bad situation, she has to face a lot of troubles and pressures from her family and the society, she has to be tied to her family all her life even after her parents die, she must live with one of her brothers, she has no right to live by herself, nobody will support her...not even the government, at least for divorced and widowed women there are some facilities offered for them by the government such as [a] monthly salary and house or piece of land, but not for a single woman...'*

- *'I think this problem is much more difficult for the illiterate than for working single women...'*

- *'It seems to me that single women have no rights in our societies, she should be always under a man's supervision...'*

- *'I think that a single woman has less problems than a married women, especially if she is educated and working; she can depend on herself although she is living with her family. At the end she is their daughter and they will give her more care...but the married woman, nobody helps her, even not the law...the man has all the rights...'*

The interesting point in these sessions was that all the women who participated were

critical of polygamous marriages and talked in detail about the problems which are provoked by such marriages for the first wife and the children. The women spoke very loudly and with enthusiasm, but when one of them said that this kind of marriage is permitted for men in Islam and that they have the right to marry up to four wives, some other women said that this kind of marriage should be allowed only under special conditions and that the man should be fair to all his wives, but that nobody can guarantee that. After these interactions the participants stopped talking about this problem, as they realized that they had committed a 'sinful act'. This feeling was normal for them, especially when they talked about something which they knew they were forbidden (*haram*) to talk about, as the religious people always say, because in this case it is 'against Allah's will'.

(5) Is there anything that can be done about it? Who should do it?

The responses to this question varied with the age and educational level of the participants, except that the effect of the perception of others was a major factor in all responses. It was clear that the older and less educated women tended more to religious behaviours, self-help, and acceptance of the situation, or if necessary sought help from relatives or friends. They were less enthusiastic about help from professionals.

The younger and more educated women, although they criticized the psychiatric services, did suggest that some types of case with the symptoms under discussion need psychiatric help. These women were, however, not much different from the older women in their recommended ways of confronting these symptoms. Keeping yourself busy, talking to members of the family or to friends, asking God for help, reading the Koran and praying,

or finding a good faith healer (*motawa*) were strongly recommended by the majority of the participants.

It is useful to highlight the responses of the participants, because they reflect the effect of culture on their concepts of mental illness and treatment. Their responses included the following:

- *'If a woman is depressed due to her marital problems, she has to be patient and try to survive, because if she leaves her house she will lose everything...the man will come back to her one day...'*
- *'...read the Koran and depend on Allah...'*
- *'...keeping herself busy will help her a lot...'*
- *'It depends on one's personality...if she can keep herself busy with working or studying or anything which lets her forget her problems, I think in that case she doesn't need help from anybody...but if she can't...then she has to seek help...'*
- *'Deep and strong faith in Allah will help her to overcome her problems...praying and asking Allah for help without deep faith is useless...'*
- *'Reading the Koran helps a person to reduce his stresses and fears and gives him great strength for facing his problems...'*
- *'I think complaining to Allah is enough...'*
- *'She should get involved in social life by joining a women's association or visiting friends...etc...she shouldn=t shut herself away at home...'*
- *'If she is very sick she could go to a psychiatrist...'*
- *'A psychiatrist cannot help the depressed patient if the problems which create this depression still exist, but he may be able to help her to accept her situation and try to deal with it'*
- *'...a psychiatrist cannot help unless he gives her some pills to calm her down and to help her to sleep...'*
- *'Psychiatrists use only pills or ECT and this is not good for the patient's health in general...'*
- *'If there are symptoms like pain in different parts of her body, it would be better to give her pain killers,*

because as long as she has these pains she will never concentrate on her psychological problems which I think are the source of her pains...'

- 'If there is no real problem but only some fears and delusions, then psychotherapy will be very useful to change these negative ideas...'

- 'Psychotherapy is better for these cases...'

- 'If we consider that 50% of our people are illiterate, so they will never think about psychiatric treatment, and if we consider that the other 50% are educated, so psychiatric treatment means for them that they are going mad...'

- 'Our society looks at the person who visits the psychiatric clinic as though he is mad [majnoon]*...even the psychiatric hospitals in our society are not distinguishing between the serious and the simple cases...they mix them together in the in-patients' departments...'*

- 'Since there is no awareness about psychological problems among our people they will never understand about cases they may find among their families, and especially if this case is a woman...they think she has some emotional problems, or she wants to get married if she is single, or it is something normal because women are always emotional...and don't worry she will be fine...'

- 'There are some cases that cannot be treated by psychiatrists, but they go for a treatment to a religious healer [motawa]*, these cases are like they have been affected with black magic...'*

- 'Yes, some people harm others with black magic which affects one's life and causes the same symptoms as a psychiatric patient...this case cannot be treated in the hospitals, she just needs a good motawa *to decipher this black magic...'*

- '...[in] cases which have been affected by hasad *[evil eyes] the* motawa *can help them by reading some verses of the Koran...'*

- 'Motawas *are not always good, some of them cheat people and take a lot of money...some of them who are good, they cannot treat psychological problems but they treat* hasad *cases and people who are affected by black magic or possessed by* jinn*...'*

It can be seen that a large number of women among the participants, although they believe in modern psychiatric treatment and show their desire for modernization, tend to

believe in religious healers since their practices are more related to the Muslim religion. This faith in religious healers may also be due in part to the limited availability of specialized psychiatric services in Dubai.

(6) Do you think this disorder will get worse? To what extent?

The prevalent feeling was that the disorder would progress to a madness (*jinoon*) if the person could not cope with this feeling and did not receive any treatment. This question gave a clear indication of the extent of the participants' concern for and awareness of the various conditions which affect women. This could be seen very clearly in their responses, of which the following are typical:

- *'It may progress to madness and she may spend the rest of her life in the hospital...'*
- *'It may cause sexual problems, she may lose all her interest and enjoyment in her sexual relationship...'*
- *'She may lose all her relatives' and friends' support, and they will not be interested in her complaints...'*
- *'It may cause her a serious physical illness like ulcers, colitis, paralysis...'*
- *'The improvement of this disorder may take different forms and that depends on the person's level of education, cultural background, and social class...'*
- *'It may increase suicidal ideas...'*

(7) Do you think this disorder is harmful to the individual, her family, and the community? How?

The responses to this question and to the next three questions revealed a degree of sufferance on the part of the women participating in the focus group sessions, which may represent the sufferance of the majority of women in UAE society. Their responses indicated awareness of a larger problem to which they might otherwise not have given

attention or priority: women's position in the family (especially for married women). The following are some examples:

- *'If there is a women suffering from depression, the first bad thing that will happen to her is that her husband will divorce her or get married to another wife, because men in our societies cannot tolerate a depressed women...'*

- *'That is true...but if a man is depressed the woman should be patient and has to accept the situation and try to live with it...'*

Other responses concerned family relations and social life, and concentrated on social withdrawal:

- *'It is harmful for the individual at first and then for her children and the family because her depressed feelings will affect her behaviour towards them...'*

- *'When she cannot act normally with herself and with her family, usually she cannot act normally in the community...'*

- *'She will have no communication with her neighbours or friends...'*

- *'She may withdraw from social life...'*

(8) Do you think this disorder will impair her chances of marriage, or the continuation of an existing marriage?

- *'It could impair the chances of marriage for some girls who are affected with these feelings and who have isolated themselves from society...'*

- *'Those who think that marriage is a solution for depression may find themselves in more trouble since they may accept anyone who asks them to get married...and maybe he is not a good person...'*

- *'...the depressed girl will look older than her age and that may impair her chances of marriage...she will*

neglect her appearance and have no interest in taking care of herself...she will lose her self-confidence...'

- 'For an unmarried person maybe he or she will be not able to start a new life because they are not interested in that...'

- '...an existing marriage for women could be destroyed if her husband divorced her or got married to another wife...and for a man he may affect his wife and children and make a lot of troubles for them...and maybe in time his wife will become depressed...'

- 'In an existing marriage more problems and sadness and arguments will provoke serious problems between the couple and the husband may neglect his wife and get married to a second one...'

(9) Do you think that the individual will provoke problems at home during her/his illness?

Several participants felt strongly that the individual would provoke a lot of problems for her family and for others around her. Their responses included:

- 'She will provoke a lot of problems at home, the children will be neglected by their mother because she has no interest in anything, she will cause problems with her husband and that may be a good reason for him to get married again...there will be problems also with her husband's family...'

- 'Yes, she creates an atmosphere of sadness around her family's life...'

- 'She will cause a lot of troubles because of her nervous mood...'

- 'If her depressed feelings last for a long time, this may cause dislike and jealousy of others, and in that case she may try to revenge herself upon happy people...she will be nervous with everybody around her...'

(10) How much do you think the individual will be capable of work or study?

Most of the participants agreed that there would be difficulties for a depressed person at work or during study, but others saw that work or studying may be a solution for depression:

- *'It will affect her ability to study or work, especially if her depressed feeling are very strong...'*

- *'It depends on her personality... some people feel better when they are involved in work or keep themselves busy by studying...'*

5.4.3.6.2.2. Male Sessions

(1) Do you know people in the community matching this description?

- *'Yes, I know somebody who has continuous head-aches and tiredness...'*

- *'I know many people who have some of these symptoms, such as tiredness and irritation...'*

- *'I have a relative who always complains of head-aches and he is always nervous with his family...'*

- *'I know a person who has isolated himself and does not like to talk to anybody...'*

- *'Anybody can suffer from these symptoms in difficult circumstances...'*

(2) What kind of symptoms does he have?

- *'He is isolated, doesn't integrate with others, and doesn't like to talk to anybody...'*

- *'He is pessimistic and silent...'*

- *'He is not happy with anything and sees everything around him as wrong...'*

- *'Listens to sad music...'*

- *'He thinks about suicide...'*

- *'Generally silent, not talking to anybody, afraid of meeting people, crying...especially at night...'*

- *'He suffers from some skin diseases such as alopecia...'*

- *'He has lost a lot of weight...'*

- *'I think these symptoms are rare among Arab men, because always they can find somebody to support and listen to them...'*

(3) Do you think there is a problem? If so, what would you call it?

- *'It is a problem, and I call it depression...'*

- *'It is a psychological problem...'*

- *'It is sadness...or we could call it irritation...'*

(4) What do you think are the causes of his illness or problems?

- *'Problems in the family...'*

- *'Neglected and disturbed childhood increases the possibility of being depressed in adulthood...'*

- *'Friends may ruin a person's life by making fun of him and insulting him...these things make a person so depressed...'*

- *'Emotional problems....such as failing in love...'*

- *'Nastiness and hatred for others make the person always feel depressed...'*

- *'Anything that is against human nature causes depression...'*

- *'The political situation and the oppressive laws in our society, which people cannot change, causes depression...'*

- *'I think the person should adapt himself to these situations and let life go on...'*

- *'Sometimes even this adaptation is considered as an illness...if the person adapted himself to the wrong things he is not normal...'*

- *'When the person cannot fulfil his gaols or defend his gaols...in other words... when he feels helpless, he will be depressed...'*

- *'I think that the cause of depression is that a person is unable to solve his problems...these problems differ because people's interests are different...therefore for the employee, for example, his problems lie in his house, family, and money, so if he is faced a problem in these areas and he was not able to meet his financial obligations to support himself and his family...I think he will be in trouble...but if he could find a solution to these problems, so men are more resistant to depression...'*

- *'...the employee who works in a place for a long time without any change in his situation, I think in time he will feel depressed...why? Because he feels unable to change anything...and so on. You can measure it in administrative and political changes...you cannot expect that changes to happen in a few months...and if the person has tendency to suffer from depression, and he has never been thought to solve his problems because there always somebody to do it for him, it will happen very easily...'*

- 'Our educational system encourages these kinds of behaviours...that a person depends on others to solve his problems...you can see that a student at school wants the questions in the exam to be like the questions he studied in his book...he doesn't want creative questions...and so on with the students in the university and the employees...all of them are too dependent...'

- 'I think that a person should try to change the thing which he thinks is wrong, and we all know the people who are responsible for these mistakes...if they don't want to change it, it will not change...but the important thing is that you should know that you tried to change but you couldn't...you should believe that you know what is right...but don't wait for others to solve your problems...'

- 'If you reached the point that you tried and you couldn't make any changes, don't give up... try with other people...'

- 'We say that religion is related to all our life. In the past if anyone had a problem he would have gone to one of his older relatives and discussed his problem with him, but nowadays you cannot trust anybody. It is difficult to reveal your feelings to anyone, even your relatives, nobody has time for you...in the past if you had had any social or financial problems, or any kind of problems, all the people around you would have offered their help and supported you...life in [the] past was something else and now it is different...people are so much less religious nowadays...'

- 'If situations and life change then there is no doubt that there will be a drift away from religion...'

- 'I see some people sitting in the mosque not praying and not reading the Koran but just sitting silently. Are they religious people? Maybe they are depressed...'

- 'I think there are two ways of causing depression. The first way is inflexibility, if a persons fixed in one environment, with the same people, his problems are always the same, and there is nothing new in his life he will be depressed. The second way is with food; I think that the food which people eat is related in some way to depression...if you look at monks and priests they always depend on vegetarian food while the primitive people always eat meat...I think to find a balance for food and flexibility is very helpful to protect you from depression...'

- 'Yes, I agree with these points...if you are living in a changeable environment you will not be depressed and you wish to stay in it forever, but if you are living in [a] limited environment you will never see the beauty of the life, you will be depressed even if you have a charming wife...'

- 'I think depression in our society starts from 20 years old and above...'

- *'The problems between the couple drive one of them to depression...'*

- *'Mostly [it is] the woman who becomes depressed because she lives with all the problems and she cannot change anything or make any decisions...she is worried about society, people, and her family...compared to the man's situation she is worse off...'*

As the participants started to talk about depression in women, it was a good opportunity to add a question about their opinion of depression in women and what they think causes it.

- *'Women are more depressed than men...because they are emotional...'*

- *'The reason for depression in women is their husbands...I know 18 women whose husbands were the main reason for their depression...and I think that it is the main reason for depression in UAE's society...'*

- *'I think women's emotional natures are the main reason for their depression, and because of that nature women are very sensitive, and maybe a sad film can make a woman depressed for a whole day...'*

- *'I think that women's lack of knowledge about the men's natures is the reason for their depression; for example, a man likes to have freedom of movement...to come and go whenever he wants...he loves to be free...and if a wife can't understand that and she tries to do the same as him and go shopping or visiting friends whenever she wants...and tries to be free like him...in this case she will feel that her husband is like the cork in the bottle and she can't get out of it easily...and this will cause her depression, but a real woman who knows her duties toward her husband and her children will stay at home obeying what Allah said in His book...I think this kind of woman will not feel depressed if she doesn't go out of her house, because her house is in her priority...'*

- *'I think that a woman who is used to having that kind of freedom of movement and being able to visit her friends before her marriage, if after she gets married her husband tries to prevent her...this will create a conflict between the new life at her husband's house and her previous life at her father's house, and if she couldn't adapt herself to this new life she will be depressed...'*

- *'I don't think that she will be depressed for these reasons...I think that the main reason for depression in women is to be unable to be a mother...if she is barren...she is always depressed...'*

- *'I believe that the nature of women as an emotional creature is the first reason for her vulnerability to depression...the second reason is the atmosphere around her in our society, such as husband, customs and*

traditions, the absence of her husband most of the time because he is always busy at his work in the morning and with his business in the evening and she is neglected at home...in other words everything around is to her disadvantage...the atmosphere at home, having to stay at home most of her time...her husband not talking to her...not discussing anything with her...and if he wants to talk to somebody his wife will the last one he thinks of...our traditions don't give a woman enough chance to talk and express herself...there is always a limit on her talking and if she tries to exceed this limit she will be disobedient from society's point of view...I agree that husbands are the main reason for depression in married women...and for the single woman, there is another authoritarian figure like her father or brother, which means that depression in women in the majority of the cases is due to domination of men over women's lives under the guise of religion and traditions...'

- 'Yes, the men are one of the reasons that women become depressed but not always...and he is not doing that on purpose...he is also controlled by a system which obliges him to do that...this system and its traditions and customs are also a source of depression for men...they project their own depression onto women...and at the end she becomes a victim and transfers her depression to her children...so the whole system is depressed and they are only exchanging their roles...'

- 'Depression in women or in anybody is due to failure in making decisions or due to loss of rights and being unable to achieve it...however, these reasons differ proportionately from person to person, but men are not always the causes of women's depression, there are many things affecting women's lives: the conditions of the society, modernization, how the society, family, and men appreciate women and their participation in life...a lot of reasons...I believe that women are stronger than men in tolerating all these social and physical pressures and still managing their lives and continuing their duties...'

- 'Yes, although women make a big effort to bring up their children and take care of their homes, they have been deprived of a lot of their rights, while men do less but get most of their rights...'

- 'The personal status law in our society is an injustice to women...'

(5) Is there anything that can be done about it? Who should do it?

- 'A man can talk to his family, father, mother, or one of his brothers or friends...'

- 'He should try to integrate in the society by getting involved in community work...'

- *'Find a good friend...'*

- *'Maybe he has no friends...'*

- *'Mix with other people...'*

- *'I think it is better for him to pray and read the Koran...'*

- *'When a person is very seriously depressed then only his faith will prevent him from committing suicide...'*

- *'I believe that it is a kind of treatment for depression to read the Koran and pray...Allah will protect him...'*

- *'One should read the Koran to protect oneself from* jinn *and evil eyes* [hassad]...'

- *'It [reading the Koran] is also useful for obsessive thoughts...'*

- *'I think it is a psychological situation, if you can persuade yourself that Allah has cured you then it is a solution...but not everybody can do that...'*

- *'Then he can go to a religious healer* [motawa]*...he will protect him with verses from the Koran...'*

- *'The* motawa *exists in our society, and also very highly educated people visit him if they can't find anybody else to help them, especially if they have heard that this* motawa *helped many people and they have been cured...'*

- *'In the past people depended on the* motawa*, but now people go to psychiatrists...'*

- *'Yes, a psychiatrist may give him medical permission not to work for a while and may advise him to go abroad for a holiday...'*

- *'I don't agree, the psychiatric clinics in our country are underdeveloped, they don't know anything about psychotherapy...'*

- *'There are no clear ideas about psychological illnesses or psychological treatments...so how can I go there...?'*

- *'If you go to visit any psychiatrist it is as if you are visiting an ENT practitioner...'*

- *'I think that the psychiatrists themselves need treatment...'*

- *'Maybe the psychiatrist increases the risks in the situation when he admits a new case with some simple symptoms alongside other cases which are very serious...'*

- *'It is better that one tries to avoid the hospitals as much as one can...since they aren't nice to the patients...'*

- *'Treatment by talking to the patient and therapy sessions is much better than giving him some pills...'*

- *'When a person has a financial problem and he becomes depressed because of this problem, nobody can help him until he finds somebody to solve his financial problem, but there are some people who can manage their situation, while there are some who cannot if the problem still exists...'*

(6) Do you think this disorder will get worse? To what extent?

- *'He may lose his mind and become mad* [majnoon]...'

- *'He may commit suicide...'*

- *'He may kill his wife and children...'*

(7) Do you think this disorder is harmful to the individual, his family, and the community? How?

- *'It could be very harmful for the individual if he tried to commit suicide...'*

- *'It will provoke a lot of trouble between the couple at home...and he may be very aggressive toward his wife and his children...'*

- *'He may withdraw from society...'*

(8) Do you think this disorder will impair his chances of marriage, or the continuation of an existing marriage?

- *'It may be a reason for divorce...'*

- *'For a single man it will reduce his chances for marriage because he has no interest in it...'*

- *'Some people think that getting married will cure your depression...maybe it is true because I know a person who was very depressed before his marriage but now he has changed...he is another person...'*

(9) Do you think the individual will provoke problems at home during his illness?

- *'He may become careless about his family, and neglect his wife and his children...'*

- *'He may be rude and very nervous for any reason and harm his wife...'*

- *'I think it depends on his level of education...if he is aware of his feelings then he will try to avoid any*

troubles with his wife or his family, so he might go out to see some friends and that will help him to relieve these feelings and be normal with his family...'

- 'It has no relationship to education...I know some people who are very highly educated but their behaviour is worse than illiterate people...it is a matter of manners and how they were brought up during their childhood...'

- 'Sometimes you cannot talk to your wife about your problems, you need another man to talk to...but wives don't understand that and they think that the man is thinking about another woman...and it makes a lot of troubles between them...'

(10) How much do you think the individual will be capable of work or study?

- 'He will not have any interest in going to work...he will find it difficult to do that...'

- 'It depends on the source of his depression; if it is his work then he will have a lot of psychological pressures if he goes to his work, but if it is his home, then he will be glad to escape from home...'

- 'Some people consider work as a therapy...and I think if a man doesn=t work he will be depressed...'

- 'Work for a man means many things...one of them is finance...without money he cannot run his house...'

- 'If his depression is very severe, I think he will not be able to work...he will make a lot of mistakes and this is not to his advantage...they may dismiss him from work...'

- 'He may resign...'

5.4.3.6.3. The Most Important Findings of the Focus Group Sessions

(1) The most serious problems

Depression, in the minds of this sample, is a problem of adjustment to life events, and results in many sorts of difficulty for both men and women in Dubai's society. The emotional distance between men and women, especially between husbands and wives, was felt to be partly responsible; this was particularly so for husbands who are so busy achieving financial security that they do not have adequate time with their wives and

families. Polygamy and lack of social security for women, and weakness in intimacy between the members of the family were also frequently identified as serious problems leading to depression. Other common concerns were weakness in faith, marriage troubles, and financial problems.

(2) The most common symptoms of depression

Subjects indicated that the depressive symptoms which they usually notice are pain in different parts of the body, head-aches, back ache, chest pain, tachycardia and palpitation, chest discomfort, too much thinking, insomnia, dyspnoea, muscle spasms, sense of fear, neglect of appearance, social withdrawal, hypochondriasis, high sensitivity, crying, feeling bored with everything, itching, abnormal somatic sensations, lack of interest in other people, irritability.

(3) Coping strategies

Subjects in the focus groups talked about the positive influence of religion. Islamic rules are important in protecting the person from any psychological problems; these rules provide guidelines for behaviour and for the soul. All the subjects recommended reading the Koran and praying as a first step in confronting the depressive feelings. Another strategy was to discuss the problem with friends or members of the family. Although subjects suggested seeking help from a psychiatrist or psychologist, they criticized the psychiatric hospitals and clinics in Dubai for using only pharmacological treatments, and the general practitioners for being unaware of local circumstances. Some subjects suggested seeking help from a faith healer (*motawa*).

5.4.3.6.4. Social and Demographic Features of the Community Sample

Female sample. The mean age of the 100 females who participated in the community sample was 31.4 years (range 18-51).

Male sample. The mean age of the 100 males of the community sample was 28.7 (range 18-56).

The basic data for the both samples are shown in Table 5.29.

Table 5.29. The socio-demographic status of the community sample (100 females, 100 males)

Demographic variables	Females	Males
Age groups		
18 - 19	10 (10%)	6 (6%)
20 - 29	39 (39%)	46 (46%)
30 - 39	35 (35%)	29 (29%)
40 - 56	16 (16%)	19 (19%)
Marital status		
Married	57 (57%)	64 (64%)
Single	43 (43%)	36 (36%)
Educational status		
Literate	18 (18%)	11 (11%)
Preparatory school	27 (27%)	23 (23%)
High school	32 (32%)	36 (36%)
Graduate and above	23 (23%)	30 (30%)
Occupational status		
Working	55 (55%)	95 (95%)
Not working	45 (45%)	5 (5%)
Socio-economic groups		
Low	23 (23%)	17 (17%)
Middle	56 (56%)	51 (51%)
High	21 (21%)	32 (32%)

5.4.3.6.5. Analysis of the Open-ended Enquiry

Four hundred words, phrases, and metaphors were listed by the subjects. All of these were put into a table and presented to an additional indigenous sample (n=50, 25 males and 25 females) who were chosen to judge whether the elicited words were feelings, traits or behaviours. Only those words considered feelings by the majority of the sample (i.e., not less than 50%) formed the emotion lexicon of the Dubai language. Phrases, metaphors, or uses of imagery were not eliminated if they were considered to be primarily emotional or used to express emotional feelings.

The elicited emotion terms were submitted to the same sample of 25 females and 25 males for them to place the words, phrases and metaphors referring to depressed feelings together so as to form a group that made sense to them. No further instructions were given and no restrictions were placed on the number of words in the group.

The cluster provided by the 50 respondents comprised 173 words, phrases and metaphors, which all referred to depressed feelings, ranging from mild to severe. This cluster was presented to three psychiatrists and three psychologists (three males and three females) at the psychiatric department of the Rashid Hospital in Dubai. Four of them were local; the other two were Arabs who had worked in the department for more than 20 years. They were asked to decide whether these words were usually used by local depressed patients, and to place the elicited emotion words together to form groups or categories that made sense to them and described the different symptoms of depression. Ninety-six words were considered by the experts' group to be usually used by local depressed patients. Upon completion, the words that each respondent placed together were recorded

using word identification numbers.

An agreement frequency value B the number of respondents who placed a particular pair of words together B was calculated for each word pair. Only word identification numbers were used in the analysis. For example, if four of the six expert respondents paired word 03 with word 07, then 4 is the agreement frequency value B that is, four respondents independently agreed that these two words (03 and 07) belong together or are closely associated.

The resulting groups were labelled by the psychiatrists and psychologists by examining the indigenous words contained in each group. A checklist of indigenous words referring to depressed feelings was compiled. The list included 22 symptoms of and attitudes to depression. Each symptom was described by several words and phrases. This list is reproduced in Table 5.30. The field work was carried out between July 1996 and January 1997.

Table 5.30. List of depression-related words used by the native people of Dubai

Classification	No.	Indigenous words of native Arabic of the UAE	English translation of the indigenous words	English expression
1- Fatigability	1	Tabana	I'm tired, fatigued	
	2	Mob qadra asheel omri	I can't carry myself	I feel so tired
	3	Mob qadra awqaf ala reuoli	I can't stand on my legs	I can hardly stand. My legs won't carry me.
	4	Batih min tooli	I will fall	I feel I'm going to collapse
	5	Ma aqdar afakker fi shay	I just can't think about anything	I feel so tired that I can't think.
	6	Metlaweza	I'm troubled	I am so tired and troubled
	7	Metgarbela	I'm exhausted	
2- Somatic symptoms	1	Mob sahya	I'm not well	I am unwell
	2	Dayka / Rasi yedoor	I feel dizzy	
	3	Barajja	I feel vomit, throw up	I am physically sick
	4	Layaa kabdi	I feel sick	
	5	Ma aroom atnassak	I can't breathe	
	6	Maknooqa	Strangling	I feel a noose around my neck
	7	Sadri dayeq alayya	My chest feels tight	
	8	Zahri yeawerni	I have a back ache	
	9	Rasi yeawerni	I have a head ache	
	10	Batni yeawerni	I have a belly ache	I am aching all over
	11	Jesmi metkasser	Broken body	
	12	Qalbi yeawerni	I have a heart problem	Palpitations and pain in the cardiac region
3- Loss of interest and pleasurable feelings	1	Ma ashtehi ay shay	I'm not interested in anything	
	2	Mostakkah	It is a pressure on my chest	
	3	Qalbi matroos	My heart is heavy	
	4	Maqboodah	I feel constricted	My heart feels under pressure
	5	Bamoot gassah	I'm choked with anger	I am consumed with anger
4- Guilt	1	Metallemah	It's painful	I feel guilt
5- Sense of failure	1	Mebtelyah	Calamitous	I am an abject failure
	2	Monharah	I am falling to pieces	

6- Feeling of punishment	1 2 3	Metazebah Mazloomah Mahsoodah	Torn I feel I am unjustly treated, oppressed, victimised I feel I'm envied	I'm being punished I am cursed
7- Excessive thinking	1	Afakker wayed	I think too much	I dwell too much
8- Pessimism	1 2 3 4 5 6 7	Addunya tedeeq alya wa la atsawar honak hal Qaleqa ala almostaqbal Gair motafaela belgad Dayea Mool mali haz Metshamah Ennas ma fihom kayr	My world is shrinking and I don't imagine there is any solution I am worried about my future I'm not optimistic about tomorrow I feel lost I'm unlucky I am pessimist People are not good	I can't see a light at the end of the tunnel. Everything is getting me down
9- Being persecuted	1 2	Eddunya kulha dedi Fiyah hrqah	All the world is against me I'm boiling	 I'm tormented
10-Unresponsive to circumstances	1	La amtalik la ehsas wa la mashaar	I have no sense and no feelings	I don't feel anything. I feel numb
11- Irritability	1 2 3 4 5 6 7	Mali kelq / Mallana Metwattera Ma ateeq shay / Ma astahmel Metmallela Tafrana Hassasa Sareeat alenfial	I'm fed up / I'm bored I'm tense I can't bear it / I can't stand it I feel fidgety I feel gust, outburst, surge I feel very sensitive I'm very irritated	 I am anxious I am really angry. I am so very angry
12- Social withdrawal	1 2 3 4 5 6	Ma abgi ashoof wajh ahad Ma abgi ajles ma ahad Ma aqdar atkayaf ma ennas Ma abgi atkallam ma ahad Mool ma fiyah aseer makan Monazelah an el alam	I don't want to see anybody I don't want to be with anybody I can't get on with people I don't want to talk to anybody I don't feel like going anywhere I feel a sense of alienation towards others	

13- Loneliness	1 2	Waheedah Ma ahad yehess fini	I feel lonely Nobody feels about me, I feel ignored	 Nobody cares about me
14- Agitation	1 2 3 4 5 6 7	Banfejer min alqahar Abgi asarek Bakasser kull shay Metrawwa Asabiya Qalqana Ahes be adam al isteqrar	I'll explode from defeat I want to scream I'll smash everything up I am terrified I am nervous I am anxious I feel no steadiness	I feel defeated I feel insecure
15- Suicidal ideas	1 2 3 4 5 6 7	Akrah eddunya Almowt ahsan min alhayat Taeesa min hayati Dayqa min hazihi eddunya banteher Afakker fi almowt fi koll waqt Atamanna law eddunya tezool min ayni	I hate life Death is better than life I'm wretched, distressed and unhappy with my life I'm fed up by life I want to commit suicide I think about death all the time I wish the world to vanish from my eyes	 It's all too much I wish I had never been born
16- Indecisiveness	1 2	Mowaswesah Mehtarah	I'm obsessive I feel perplexed	I am plagued with negative thoughts I feel confused
17- Low self-esteem and self-confidence	1 2 3	Magloobah ala amri Mali dowr fi alhayat Tayhah	I feel helpless I'm nobody, nothing Astray	 I am worthless I feel lost
18- Self-accusation	1 2	Motdayeqah min omri Mub zaynah	I'm unhappy with my-self I'm no good	 I feel worthless
19- Insomnia	1	Ma aqdar arqed	I can't sleep	

20- Lowering of mood	1 2 3 4 5 6 7 8 9 10 11 12 13	Hzeenah Mahmoomah Bamoot min addeeq Moktaba Motkadra Motnakda Mogtamma Motdayeqah wayed Sharat alhasa ala qalbi La ahad yefhamni Aba aseeh Aseeh Qalbi yiawerni	I feel sad I am distressed I'll die of restlessness I feel depressed I feel troubled I am unhappy, miserable Gloomy, Blues, Grief, Sorrow I'm restless too much Heavy-hearten Nobody understands me I feel I want to cry I cry continuously I'm broken hearten	I can't go on I feel depressed I can't take much more
21- Capacity for enjoyment, interest and concentration is reduced	1 2 3	Mali barid Ma aqdar afakker fi shay Waslah andy	I'm not interested I can't think about things I'm fed up	I have lost all interest in life
22- Self-dislike	1 2	Ma ahib nafsi Akrah nafsi	I don't like myself I hate myself	

5.4.4. Study IV

5.4.4.1. Introduction and Aims

This study follows Study III. A checklist of indigenous words and idioms for depression was compiled in Study III (see Table 5.30). The aim of the present study was to investigate the values of this checklist in a pilot study. It was hoped to develop a culturally sensitive and cross-culturally comparable self-report scale for measuring the severity of depression in women in Dubai and, probably, in similar cultures.

5.4.4.2. Hypotheses

It was postulated that the instrument developed would be more sensitive in measuring the severity of depression in the specific culture of Dubai.

5.4.4.3. Development of the DDI Raw Scale

The development of the preliminary Dubai Depression Inventory (DDI) went through several stages. The procedures for finding the words related to depression in the indigenous language of Dubai, and for item determination, face validity evaluation, and the finalizing of the raw scale of the DDI, have been described in detail in Study III (see section 5.4.3.6.5).

The DDI was designed as a self-report scale. It included 22 symptoms: (1) fatigability; (2) somatic symptoms; (3) loss of interest; (4) guilt; (5) sense of failure; (6) punishment; (7) excessive thinking; (8) pessimism; (9) being persecuted; (10) unresponsiveness to circumstances; (11) irritability; (12) social withdrawal; (13) loneliness; (14) agitation; (15) suicidal ideas; (16) indecisiveness; (17) low self-esteem and self-confidence; (18) self-accusation; (19) insomnia; (20) lowering of mood; (21) low capacity for interest, enjoyment and concentration; (22) self-dislike.

Each symptom of the DDI was described by several words and phrases. Thus, the first version of the DDI included 96 sentences divided among the 22 symptoms. To detect whether they were understood by subjects, these 96 sentences were tested with eight women from Dubai who were studying in London in October 1997. Further discussion took part with two psychiatrists and two psychologists from the psychiatric department of the Rashid Hospital in Dubai. The result of this initial investigation and discussion was that we discarded sentences that the majority of subjects felt had the same meaning as another sentence. This reduced the scale to 72 sentences.

The severity of these symptoms is rated as follows: 0 = never; 1 = sometimes; 2 = most of the time; 3 = always. Subjects are asked to rate the sentences belonging to each symptom according to her feelings during the past week, including the interview day. The maximum total score is 216, and higher scores reflect greater intensity of depressive symptomatology. Information on socio-demographic variables (age and marital, educational, occupational and socio-economic status) is obtained at the time of the administration of the inventory.

5.4.4.4. Finding a Reliable and Valid Scale as an External Criterion for Measuring the Severity of Depression

It was important to find a reliable and valid scale as an external criterion for measuring the severity of depression. The BDI was semantically translated into the Arabic language and validated for use within UAE society in 1988 by Ghareeb (1990), and it was also used in Study II; its use there provided a rigorous re-evaluation of its validity and reliability. The results showed that the BDI's internal reliability was excellent (Cronbach's alpha of 0.91, standardized for items); split-half reliability was 0.85. The validity of the BDI was tested by correlating the BDI score with the GHQ-28 score. A strong positive correlation was found (r=0.92, P<0.000), indicating that the BDI reflects the overall level of disability of depressed people. Hence, the BDI could be used as a standard for assessing the validity of the DDI.

5.4.4.5. Sample

5.4.4.5.1. Sampling Frame

To determine whether the DDI was useful, it was important to check its validity with both psychiatric and non-psychiatric subjects. The instrument was therefore tested on both a clinical sample and a community sample. The sampling frame differed for the two groups, as described in the following paragraphs.

Clinical sample. Purposive selection was used to obtain the clinical sample from the psychiatric department of the Rashid Hospital in Dubai. Only local female patients who

met inclusion criteria of depression according to ICD-10 depressive episode at the mild, moderate, or severe levels were recruited. These criteria included the presence of single episodes of depressive reaction, psychogenic depression, or reactive depression. Patients with psychotic symptoms, organic brain syndromes, or mental retardation were excluded. Selection was carried out with the help of the psychiatrists at the hospital.

Community sample. Two types of sampling frame were used. First, a random selection technique was used to select subjects from the general population in the different study areas _the Ministry of Education, the Social Developmental Association for Women in Dubai, and the Dubai Police Headquarters. Second, snowball sampling was used, whereby the researcher began with one subject and asked her to put us in touch with other native women who would like to take part in the study.

5.4.4.5.2. Sample Size

Clinical sample. From an initial sample of 18 local female patients with current depression who attended the psychiatric department of the Rashid Hospital in Dubai between 20 November 1997 and 5 March 1998, 15 patients took part in this study (two patients refused to take part, and one did not fill in the questionnaires).

Community sample. Since the community sample for the present study was derived from the same areas as the sample in Study II, the statistical tool STATCALC Epi-Info-6, which was used in Study II, was used again for this study to calculate the sample size. This statistical analysis indicated that at least 100 subjects would be needed to represent the entire population of females in Dubai. The questionnaires were therefore distributed

among the selected women in the different study areas as mentioned above. Of the 135 women who received the questionnaires, seven did not return it, nine were rejected because they did not fill in the majority of the questions in one or both inventories, and 23 filled in only one of the inventories. To reach a total of 100 subjects, an attempt was made with four of the latter to complete the second inventory. Accordingly, 100 non-psychiatric women completed the inventories, allowing us to construct the community sample for this study. Table 5.31 presents data on this community sample.

Table 5.31. Description of the community sample in the different study areas

Study area	Original sample (n = 135)	Sample used (n = 100)
Ministry of Education	28	23
Social Developmental Association for Women	60	45
Dubai Police Headquarters	15	10
Snowball sample	32	22

5.4.4.6. Instruments

The following instruments were used in this study:

1. The Beck Depression Inventory (BDI);

2. The Dubai Depression Inventory (DDI).

Details on the BDI were outlined earlier in this chapter, while details on the DDI were given in section 5.4.4.3.

5.4.4.7. Procedure

5.4.4.7.1. Piloting of the Preliminary DDI

Clinical sample. Fifteen subjects with current depression, all local female patients aged between 19 and 53 years and attending the out-patient clinic at the psychiatric department of the Rashid Hospital in Dubai, took part. Sample subjects were first contacted by a research assistant, who assessed their willingness to answer the inventories. The aims of the study were explained to them, with emphasis on the confidentiality of all information. Each patient was interviewed individually, and the field interview began with the DDI. A brief explanation of the DDI and how to fill it in was given to each patient; the patient then completed the form, which took about half an hour. Next, the BDI was handed to the patient; she was asked to read it carefully and choose the items which matched her feelings. Patients who had difficulties in reading received help from the researcher or her assistant, who read the items slowly and carefully and filled in the answers together with the patient. The BDI took about 20 minutes to complete for the patients who filled it in on their own; it took longer for the patients who found difficulties in reading.

Community sample. One hundred native women from Dubai aged 18-53 years were the subjects for this study. Permission was obtained from the administrations of the Ministry of Education, the Social and Developmental Association for Women in Dubai, and the Dubai Police Headquarters to select samples from their staff. Individual consent was also obtained from each subject who took part in this study and from the housewives who were interviewed at their houses. Subjects were also asked to put us in touch with other local women who might want to take part in this study.

The field interviews for 45 subjects were conducted at the Social and Developmental Association for Women in Dubai, while 23 women were interviewed at the Ministry of Education, ten women were interviewed at the Research and Studies Centre at the Dubai Police Headquarters, and 22 women were met at their homes.

The main aims and characteristics of the research were explained to the subjects before the administration of the inventories as follows.

(a) We were developing for the first time an instrument for measuring depressed feelings in women in Dubai in our indigenous Arabic language, and we were interested in their attitudes to themselves and in how they viewed their depressed feelings.

(b) We stated that all the information was confidential and that no-one would be identified by name.

(c) Subjects were asked to answer honestly and independently and were reminded that there were no right and wrong answers.

(d) Subjects were asked to fill in the inventories as fully as possible.

(e) Before administering the inventories, the instructions for each were read out to the subjects.

Subjects who had difficulties in reading were again helped by the researcher. The DDI was applied first; after it had been completed and the forms collected, the BDI was distributed. The two inventories took about 45 minutes to complete, although it took considerably longer for the subjects who found difficulties in reading. Socio-demographic data were collected at the same time. The field work was carried out between November 1997 and March 1998.

5.4.4.8. Statistical Analyses

For the statistical analyses, the software package SPSS for Windows was used. To examine the reliability of the DDI, the reliability analysis scale split-half, Cronbach's alpha, and a correlation similarity coefficient matrix were computed.

To examine the validity of the DDI, Pearson correlation coefficients were computed between the sub-items of the DDI and the BDI total score so as to test the content validity of the DDI; Pearson correlation coefficients were also calculated between the DDI total score and the BDI total score in order to determine the concurrent validity of the DDI. Principal component analysis with varimax orthogonal rotation was used to examine the construct validity of the DDI. Receiver operating characteristic (ROC) curves and one-way analysis of variance (ANOVA) were used to test the sensitivity of the DDI.

To explore differences among the socio-demographic variables (age, marital, educational, occupational, and socio-economic status)and to determine whether they were independent of or associated with the severity of depression, and to assess whether there were any interaction effects or main effects between these variables and the severity of depression, a multivariate analysis of variance (MANOVA) (regression approach) was performed.

To compare the means of groups defined by the demographic variables, one-way analysis of variance was used with the Scheffe test to find significant differences, since this test is appropriate for groups with unequal numbers of subjects (Bryman & Carmer, 1997). To compare the frequencies of responses to items between cases and non-cases in both inventories (DDI and BDI), bivariate contingency analysis (chi-squared analysis) was

performed.

5.4.4.9. Results

It is generally accepted that when a concept has been operationally defined, in that a measure of it has been proposed, the ensuing measurement device should be both reliable and valid.

5.4.4.9.1. Reliability of the DDI

As depressed people are expected to show reductions in depression both as a result of therapeutic intervention and through the passage of time, estimates of test-retest reliability may not be very useful; hence, internal reliability was used, since it is particularly important in connection with multiple item scales, and since it raises the question of whether each scale is measuring a single idea, and hence whether the items that make up the scale are internally consistent.

Split-half reliability is one procedure for estimating internal reliability. The items in the scale are divided into two groups, and the relationships between respondents' scores for the two halves are computed. Hence, the DDI, which contains 22 items, was divided into two groups of 11. The correlation coefficient of the respondents' scores for the two halves was r=0.89 (P<0.001), indicating that the contents of the DDI were homogeneous. The inter-item consistency was assessed using Cronbach's alpha. The value obtained for measuring depression reached 0.94, indicating that the reliability of the DDI was satisfactory.

Finally, the item-scale consistency was evaluated by correlating each DDI sub-item score to its DDI total score. As shown in Table 5.32, correlation coefficients between each DDI sub-item score and the DDI total score were all above 0.41 (all $P<0.001$), indicating that all DDI sub-items measured related phenomena.

Table 5.32. The Reliability of the DDI

No.	The DDI items	Correlations of DDI total score with DDI sub-item score
1	Fatigability	0.76
2	Somatic symptoms	0.81
3	Loss of interest and pleasurable feelings	0.87
4	Guilt	0.77
5	Sense of failure	0.81
6	Punishment	0.70
7	Excessive thinking	0.72
8	Pessimism	0.76
9	Being persecuted	0.80
10	Unresponsiveness to circumstances	0.41
11	Irritability	0.89
12	Social withdrawal	0.74
13	Loneliness	0.78
14	Agitation	0.86
15	Suicidal ideas	0.86
16	Indecisiveness	0.75
17	Low self-esteem and self-confidence	0.82
18	Self-accusation	0.76
19	Insomnia	0.72
20	Lowering of mood	0.95
21	Low capacity for interest, enjoyment and concentration	0.85
22	Self-dislike	0.60
	Split-half	0.89
	Cronbach's alpha	0.94

5.4.4.9.2. Validity of the DDI

In discussing the validity of the DDI, the following three types are considered: content validity; concurrent validity; and construct validity.

Content validity. Using the BDI total score as the external standard of measuring the severity of depression, the item validity and scale validity of the DDI were tested (Table 5.33). The correlation coefficients between DDI sub-item scores and BDI total score ranged between 0.29 and 0.68 ($P<0.001$), indicating that all sub-items of the DDI are valid for measuring the severity of depression.

Table 5.33. The Content validity of the DDI

No.	DDI items	Correlation of BDI total score with DDI sub-item score
1	Fatigability	0.61
2	Somatic symptoms	0.61
3	Loss of interest and pleasurable feelings	0.68
4	Guilt	0.59
5	Sense of failure	0.60
6	Punishment	0.45
7	Excessive thinking	0.53
8	Pessimism	0.55
9	Being persecuted	0.59
10	Unresponsiveness to circumstances	0.29
11	Irritability	0.60
12	Social withdrawal	0.52
13	Loneliness	0.59
14	Agitation	0.58
15	Suicidal ideas	0.66
16	Indecisiveness	0.57
17	Low self-esteem and self-confidence	0.57
18	Self-accusation	0.66
19	Insomnia	0.41
20	Lowering of mood	0.63
21	Low capacity for interest, enjoyment and concentration	0.61
22	Self-dislike	0.51

Concurrent validity. In order to determine whether the DDI accurately reflects severity of depression in depressed people, the DDI total score was compared with the BDI total score. The correlation coefficient between them (r=0.72, P<0.000) showed that the severity of depression measured by the DDI was very closely related to the result from the BDI.

Construct validity. Factor analysis was used to examine the construct validity of the DDI. The method used was principal components analysis with varimax orthogonal rotation (with an eigenvalue of 1). Five factors were extracted, which together accounted for 67% of the total variance (Table 5.34). Items 1, 2, 3, 4, 5, 7, 11, and 16 constituted the first factor, which was interpreted as being an anxiety-depression component. It was characterized by clear anxiety-related symptoms such as irritability, somatic symptoms, and excessive thinking. This factor accounted for 24% of the total variance and was labelled 'anxiety symptoms'.

Items 15, 17, 18, 21, and 22 made up the second factor, which accounted for 15% of the total variance and was primarily concerned with suicidal ideas, which were described by the native people of Dubai in the focus groups as *'waswas'* obsession. This factor was labelled 'self-pity'.

Items 6, 8, 9, and 13 comprised the third factor, which accounted for 12% of the total variance and represented paranoid complaints. It was labelled 'paranoid symptoms'.

Items 12, 14, 19, and 20 (social withdrawal, agitation, insomnia, and lowering of mood respectively) were clustered together to form the fourth factor. This was labelled 'discomfort', and accounted for 11% of the variance.

Item 10, unresponsiveness to circumstances, comprised the fifth factor, which accounted for 4% of the variance and was labelled 'indifference'.

Table 5.34. Principal component analysis of the DDI

		Varomix Rotation Components (Factors)				
No.	DDI item	I	II	III	IV	V
4	Guilt	0.776*	0.172	0.278	0.256	0.015
2	Somatic symptoms	0.747*	0.298	0.134	0.259	0.214
5	Sense of failure	0.716*	0.334	0.304	0.237	-0.038
3	Loss of interest and pleasurable feelings	0.709*	0.339	0.390	0.250	-0.005
7	Excessive thinking (worries)	0.661*	0.085	0.329	0285	0.144
1	Fatigability	0.649*	0.562	0.213	-0.056	0.200
11	Irritability	0.583*	0.250	0.418	0.434	0.249
16	Indecisiveness	0.526*	0.373	0.155	0.417	0.182
22	Self-dislike	0.127	0.844*	0.107	0.200	0.055
15	Suicidal ideas	0.389	0.665*	0.349	0.332	0.030
18	Self-accusation	0.391	0.587*	0.284	0.225	0.235
21	Low capacity for interest, enjoyment and concentration	0.376	0.576*	0.348	0.407	0.128
17	Low self-esteem and self-confidence	0.336	0.572*	0.422	0.311	0.207
13	Loneliness (being deserted)	0.155	0.355	0.707*	0.389	0.117
8	Pessimism	0.344	0.290	0.692*	0.142	0.194
6	Punishment (feeling of being punished)	0.496	0.035	0.681*	0.173	-0.023
9	Being Persecuted	0.407	0.343	0.600*	0.241	0.181
19	Insomnia	0.348	0.209	0.179	0.776*	0.129
12	Social withdrawal	0.191	0.317	0.448	0.599*	0.106
14	Agitation	0.418	0.397	0.381	0.556*	0.095
20	Lowering of mood	0.499	0.408	0.457	0.519*	0.104
10	Unresponsiveness to circumstances	0.108	0.147	0.138	0.144	0.935*
	Factors' contribution	5.364	3.241	2.677	2.447	0.935
	Variance (%) explained	24.3	14.7	12.2	11.1	4.2
	Factor label	Anxiety symptoms	Self-pity	Paranoid symptoms	Discomfort	Indifference

*** Is a marker variable for that factor.**

5.4.4.9.3. Sensitivity and Specificity of the DDI

It was important to determine the best DDI cut-off score for discriminating between depressed and non-depressed subjects. The tool used for establishing the optimal cut-off point was the receiver operating characteristic (ROC) curve (Streiner & Norman, 1995). A computer program, STATA (logistic), was used to perform this technique on the total scores of the DDI; it also analysed total scores on the BDI for comparison.

The ROC curves illustrating the performance of the total DDI and BDI scores in relation to the diagnosis of depression are shown in Figures 5.7 and 5.8.

Figure 5.7.
ROC curve for the 22-item DDI

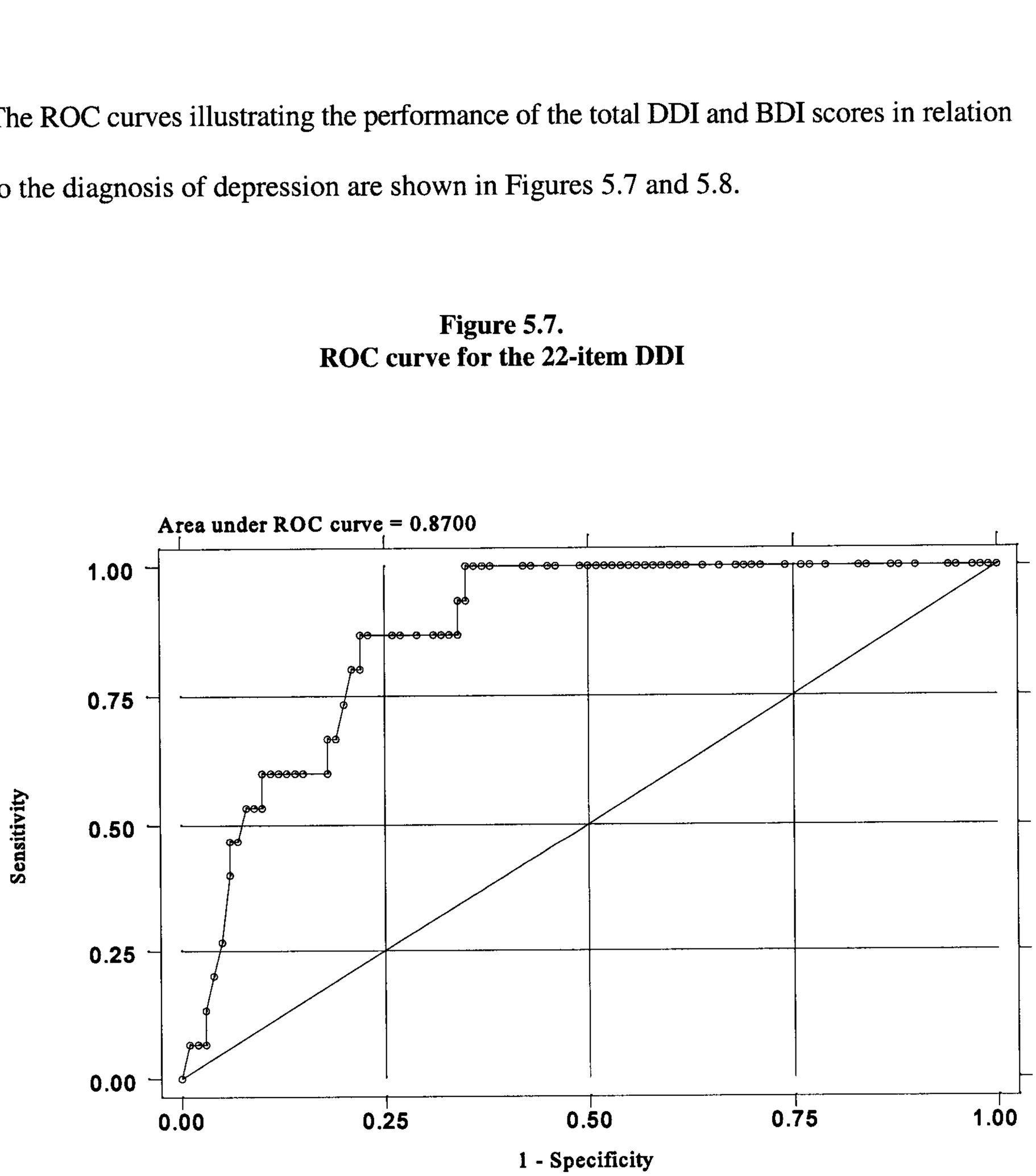
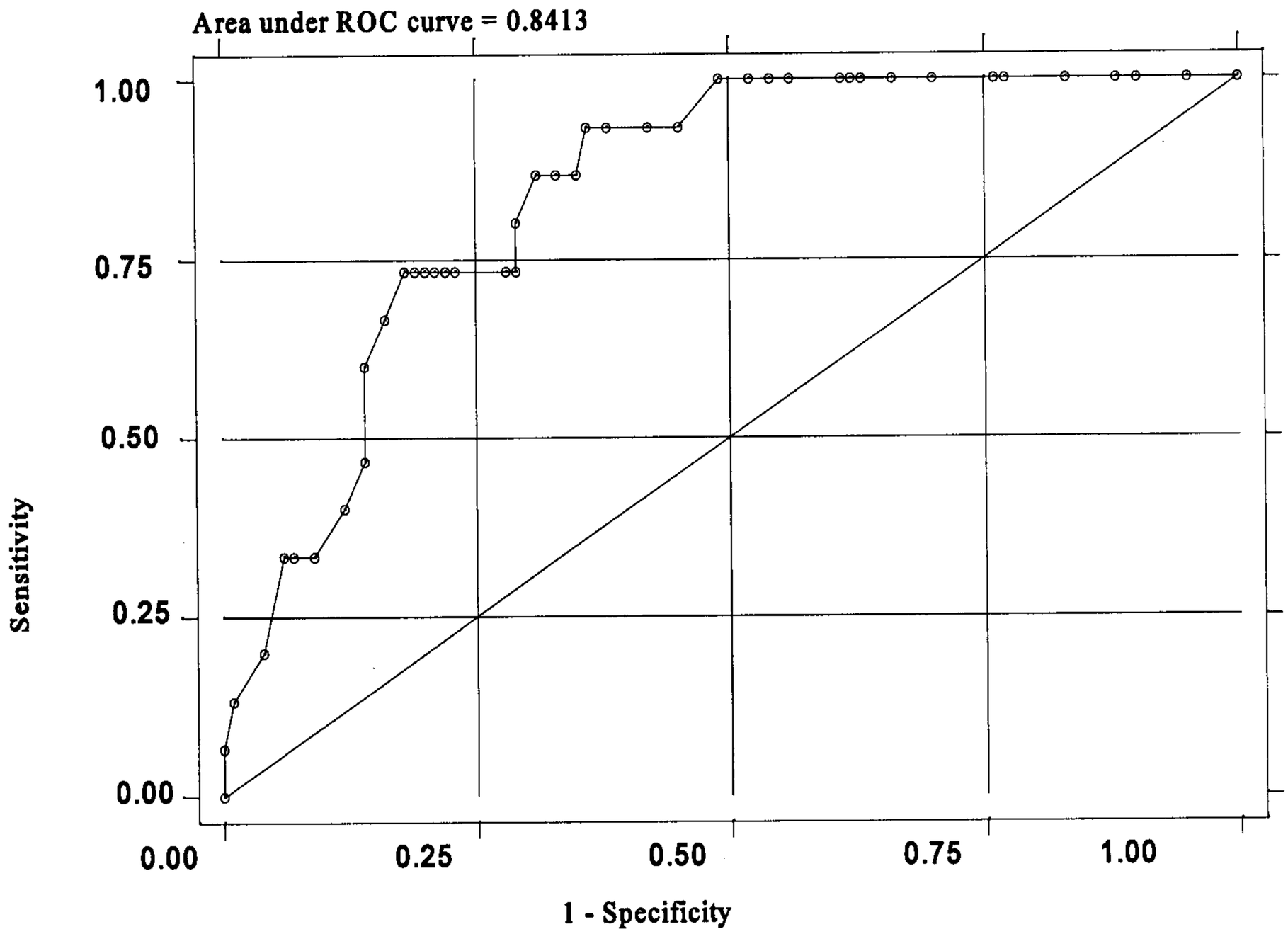


Figure 5.8.
ROC curve for the 21-item BDI



ROC curves are evaluated visually by comparing them with a diagonal line of no information on which at every point the percentage of true positives equals the percentage of false positives _in other words, where prediction is no better than chance (Lustman, Clouse, Griffith, et al., 1997).

Streiner and Norman (1995) stated that the better a test is in dividing cases from non-cases, the closer the curve will approach the upper left-hand corner, and the cut-off point which minimizes the overall number of errors (false positives and false negatives) is the one whose curve is closest to this corner. They mentioned also that there may be some circumstances in which it may be preferable to move this point up or down, even

though the number of false positives or false negatives may increase more than does the number of true positives.

The overall accuracy of the DDI and BDI in differentiating depressed and non-depressed subjects is described by the area under the curve index (AUC). An area of 1.0 indicates that one of the test's selected probabilities perfectly classifies depressed and non-depressed subjects (percentage of true positives = 100, percentage of false positives = 0), and an area of 0.5 means that the test correctly classifies subjects 50% of the time, a performance no better than chance (Lustman, Clouse, Griffith, et al., 1997).

The area under the curve for the entire 22-item DDI was 0.87 ($P<0.001$), indicating that the DDI accurately discriminated between the depressed and non-depressed subjects. A cut-off score of ≥104 fell closest to the point at which the minor diagonal crosses the ROC curve, which is often used to locate the score providing an optimal balance between sensitivity (0.73) and specificity (0.80). The AUC index for the entire 21-item BDI was 0.84 ($P<0.001$), indicating that the BDI also discriminated between the depressed and non-depressed subjects, although the DDI has better selected probabilities for discriminating between cases and non-cases. A cut-off score of ≥22 for the BDI was the closest to the point at which the minor diagonal crosses the ROC curve, providing an optimal balance between sensitivity (0.86) and specificity (0.71).

The sensitivities and specificities of selected DDI cut-off scores are shown in Table 5.35.

Table 5.35. Sensitivity and specificity of the DDI using selected cut-offs for distinguishing depressed subjects from non-depressed

DDI cut-off score	Sensitivity	Specificity
≥ 70	1.000	0.620
≥ 73	1.000	0.630
≥ 74	1.000	0.640
≥ 76	1.000	0.650
≥ 78	0.933	0.650
≥ 81	0.933	0.660
≥ 84	0.866	0.660
≥ 85	0.866	0.670
≥ 87	0.866	0.680
≥ 92	0.866	0.690
≥ 93	0.866	0.710
≥ 94	0.866	0.730
≥ 95	0.8666	0.740
≥ 97	0.8666	0.770
≥ 98	0.866	0.780
≥ 101	0.800	0.780
≥ 102	0.800	0.790
≥ 104	0.733	0.800
≥ 105	0.666	0.810

Cut-off scores between 70 and 105 inclusive displayed the best balance between sensitivity and specificity. Streiner and Norman (1995) stated that low cut-off scores will pick up few true cases, but also make few false positive errors. Increasing the cut-off score will pick up true cases more than false cases but at the cost of mislabelling many cases as non-cases. In another words, higher cut-off scores may be utilized to minimize false positives, but at the expense of decreasing sensitivity. For example, a cut-off score of ≥78 yielded sensitivity and specificity values of 0.93 and 0.65 respectively; a score of ≥105 yielded sensitivity and specificity values of 0.66 and 0.81 respectively.

In order to determine the optimum cut-off score for the DDI in the present study, it was essential to take into account the aims of this project. Since one of the major aims was to explore the symptom profile of depression in women in Dubai, it was preferable to move the cut-off point downwards, accepting that a few false positive errors may occur. The decision was made to choose a cut-off score of ≥ 76, which gave very high sensitivity (1.00) and a reliable specificity (0.65).

In order to determine score distributions for different severities of depression, the DDI total raw score for each subject was transformed to a standardized score (*z*-score), where the total score for an individual was subtracted from the mean score of the sample, and the resulting number was divided by the sample's standard deviation. This transforms the scale so as to have a mean of 0 and a standard deviation of 1, so the individual scores are expressed in standard deviation units (Streiner & Norman, 1995). The BDI cut-off scores for discriminating between cases and non-cases and for the different severities of depression among people of the UAE were determined by Ghareeb (1990); hence, for a comparison this approach was also used on the BDI raw scores of the total subjects of the present study. Accordingly, our DDI *z*-scores were put into the equation with our BDI *z*-scores, to establish whether the cut-off point for the DDI reflected degrees of depression similar to those of the BDI at its cut-off point, although the raw scores themselves were very different. These cut-off points are as follows: scores below 76 are considered normal; scores of 77-123 indicate mild depression; scores of 124-173 indicate moderate depression; and scores of 174-216 indicate severe depression.

With the above cut-off points, the sensitivities of the DDI for the patient group and for

the community group were tested separately using one-way analysis of variance (ANOVA). The means of patients' total scores and community total scores on the DDI among the four severity groups differed: the patients' mean was $F_{2,12}$=59.78 (P=0.001), and the community mean was $F_{3,96}$=145.54 (P=0.001), suggesting that the DDI is sensitive in differentiating various severities of depression. The cut-off points for the different severities of the DDI were determined, and are shown in Table 5.36.

Table 5.36. Cut-off points for the different severities of depression of the DDI

	Normal	Mild	Moderate	Severe
DDI score	< 76	77 - 123	124 - 173	174 - 216
Clinical sample	n = 0	n = 6	n = 8	n = 1
Community sample	n = 65	n = 23	n = 9	n = 3

Definitions (Knapp & Miller, 1992)

Sensitivity: *the sensitivity of a diagnostic test is the probability that a diseased individual will have a positive test result. Sensitivity is the true positive rate (TPR) of the test.*

Specificity: *the specificity of a diagnostic test is the probability that a disease-free individual will have a negative test result. Specificity is the true negative rate (TNR) of the test.*

True positives: *individuals with the disease who were correctly identified as diseased by the new test.*

False positives: *disease-free individuals falsely labelled as diseased by the new test.*

True negatives: *disease-free individuals who are correctly identified as disease-free by the new test.*

False negatives: *individuals with the disease falsely labelled as disease-free by the new test.*

5.4.4.9.4. Social and Demographic Features of the Clinical Sample

The mean age of the patients was 31.3 years (range 19-53). The basic data are shown in Table 5.37.

5.4.4.9.5. Clinical Characteristics of the Clinical Sample as Measured by the DDI and the BDI

Of the 15 female patients who completed the DDI, six (40%) had mild depression, eight (53%) had moderate depression, and one (7%) had severe depression. The mean DDI score was 130.13 (SD=31.18). The relevant data are shown in Table 5.37.

Table 5.37. Level of depression on the DDI and socio-demographic variables for the 15 female patients comprising the clinical sample

	DDI			
Demographic variables	Mild	Moderate	Severe	Total
Age groups				
18 - 19	-----	1 (100)	-----	1 (07)
20 - 29	2 (33)	4 (67)	-----	6 (40)
30 - 39	2 (40)	2 (40)	1 (20)	5 (33)
40 - 53	2 (67)	1 (33)	-----	3 (20)
Marital status				
Married	5 (45.5)	5 (45.5)	1 (09)	11 (73)
Single	1 (25)	3 (75)	-----	4 (27)
Educational status				
Literate	3 (50)	2 (33)	1 (17)	6 (40)
Preparatory school	-----	1 (100)	-----	1 (07)
High school	1 (100)	-----	-----	1 (07)
Graduate or higher	2 (29)	5 (71)	-----	7 (46)
Occupational status				
Working	2 (33)	4 (67)	-----	6 (40)
Not working	4 (44.4)	4 (44.4)	1 (11.1)	9 (60)
Socio-economic group				
Low	2 (40)	2 (40)	1 (20)	5 (33)
Middle	3 (33)	6 (67)	-----	9 (60)
High	-----	1 (100)	-----	1 (07)

NOTE: values in parentheses are percentages

The patients also completed the BDI; their BDI scores indicated that four of them (27%) had mild depression, six (40%) had moderate depression, and five (33%) had severe depression. The mean BDI score was 35.73 (SD=10.75). The relevant data are shown in Table 5.38.

Table 5.38. Level of depression on the BDI and socio-demographic variables for the 15 female patients comprising the clinical sample

	BDI			
Demographic variables	Mild	Moderate	Severe	Total
Age groups				
18 - 19	-----	-----	1 (100)	1 (07)
20 - 29	1 (17)	2 (33)	3 (50)	6 (40)
30 - 39	2 (40)	3 (60)	-----	5 (33)
40 - 53	1 (33.3)	1 (33.3)	1 (33.3)	3 (20)
Marital status				
Married	4 (36)	5 (46)	2 (18)	11 (73)
Single	-----	1 (25)	3 (75)	4 (27)
Educational status				
Literate	1 (17)	3 (50)	2 (33)	6 (40)
Preparatory school	1 (100)	-----	-----	1 (07)
High school	-----	1 (100)	-----	1 (07)
Graduate or higher	2 (29)	2 (29)	3 (42)	7 (46)
Occupational status				
Working	1 (17)	2 (33)	3 (50)	6 (40)
Housewife	3 (33.3)	4 (44.4)	2 (22.2)	9 (60)
Socio-economic group				
Low	1 (20)	2 (40)	2 (40)	5 (33)
Middle	3 (33.3)	3 (33.3)	3 (33.3)	9 (60)
High	-----	1 (100)	-----	1 (07)

NOTE: values in parentheses are percentages

5.4.4.9.6. Social and Demographic Features of the Community Sample

The mean age of these 100 subjects was 31.22 years (range 18-53). Table 5.39 illustrates the basic data.

5.4.4.9.7. Clinical Characteristics of the Community Sample as Measured by the DDI and BDI

Of the 100 non-psychiatric females who completed the DDI, 65 did not show any significant symptoms, 23 showed mild depression, nine had moderate depression, and three revealed severe depression. The mean DDI score was 67.51 (SD=44.4). The relevant data are shown in Table 5.39.

Table 5.39. Level of depression on the DDI and socio-demographic variables for the 100 non-psychiatric females comprising the community sample

	DDI				
Demographic variables	Normal	Mild	Modert.	Severe	Total
Age groups					
18 - 19	4 (44.4)	4 (44.4)	1 (11.1)	-----	9 (09)
20 - 29	16 (57)	9 (32)	2 (07)	1 (04)	28 (28)
30 - 39	34 (68)	10 (20)	4 (08)	2 (04)	50 (50)
40 - 53	11 (85)	-----	2 (15)	-----	13 (13)
Marital status					
Married	38 (72)	8 (15)	4 (07)	3 (06)	53 (53)
Single	27 (57)	15 (32)	5 (11)	-----	47 (47)
Educational status					
Literate	25 (64)	6 (15)	5 (13)	3 (08)	39 (39)
Preparatory school	1 (33)	2 (67)	-----	-----	3 (03)
High school	13 (62)	6 (29)	2 (09)	-----	21 (21)
Graduate & higher	26 (70)	9 (24)	2 (06)	-----	37 (37)
Occupational status					
Working	24 (73)	6 (18)	3 (09)	-----	33 (33)
Not working	41 (61)	17 (25)	6 (09)	3 (05)	67 (67)
Socioeconomic groups					
Low	20 (54)	10 (27)	6 (16)	1 (03)	37 (37)
Middle	26 (64)	10 (24)	3 (07)	2 (05)	41 (41)
High	19 (86)	3 (14)	-----	-----	22 (22)

Note: values in parentheses are percentages.

By contrast, their scores on the BDI showed that 53 of these subjects were without any symptoms of depression, while 29 of them had mild depression, 12 had moderate depression, and six suffered from severe depression. The mean BDI score was 16.85 (SD=13.87). The relevant data are shown in Table 5.40.

Table 5.40. Level of depression on the BDI and socio-demographic variables for the 100 non-psychiatric females comprising the community sample

	BDI				
Demographic variables	Normal	Mild	Moderate	Severe	Total
Age groups					
18 - 19	3 (33.3)	2 (22.2)	2 (22.2)	2 (22.2)	9 (09)
20 - 29	15 (54)	9 (32)	3 (10)	1 (04)	28 (28)
30 - 39	26 (52)	15 (30)	6 (12)	3 (06)	50 (50)
40 - 53	9 (69)	3 (23)	1 (08)	-----	13 (13)
Marital status					
Married	33 (62)	12 (23)	7 (13)	1 (02)	53 (53)
Single	20 (42)	17 (36)	5 (11)	5 (11)	47 (47)
Educational status					
Literate	20 (51)	10 (26)	6 (15)	3 (08)	39 (39)
Preparatory school	1 (33.3)	1 (33.3)	1 (33.3)	-----	3 (03)
High school	10 (48)	8 (38)	3 (14)	-----	21 (21)
Graduate or higher	22 (60)	10 (27)	2 (05)	3 (08)	37 (37)
Occupational status					
Working	19 (58)	11 (33)	3 (09)	-----	33 (33)
Not working	34 (51)	18 (27)	9 (13)	6 (09)	67 (67)
Socio-economic group					
Low	15 (41)	10 (27)	6 (16)	6 (16)	37 (37)
Middle	19 (46)	16 (39)	6 (15)	-----	41 (41)
High	19 (86)	3 (14)	-----	-----	22 (22)

NOTE: values in parentheses are percentages.

5.4.4.9.8. Analysis of Severity of Depression with Demographic Variables as Measured by the DDI and BDI

The individual effects of each socio-demographic variable on the level of depression in all of the subjects of this study (clinical and community samples) were examined by conducting a one-way analysis of variance (ANOVA) on the mean DDI and BDI scores. Significant associations between level of depression and some of the demographic

variables were found on both instruments.

The proportion of depression in the ***age range*** 18-29 years among the entire group of subjects was significantly higher than that in the age range 30-53 on the BDI ($F_{3,111}$=2.84, P=0.041); it was not significant on the DDI.

Although there was no significant association between ***marital status*** and the level of depression on the DDI, there was a trend towards a significant association between marital status and level of depression on the BDI (P<0.50) ($F_{1,113}$=2.91, P=0.091). Surprisingly, single women had a higher rate of depression than married women. This result was the reverse of that in Study II, which found that single women had lower rates of depression than married women.

Both the DDI and BDI results indicated that there are no significant associations between ***educational status*** and the level of depression, although the means and standard deviations revealed that the less educated women tended to show higher levels of depression.

A preponderance of the unemployed was not observed in relation to the severity of depression. Females' own ***occupational status*** did not significantly differ with their severity of depression on either the DDI or the BDI, although the mean scores of the subjects on both instruments showed that the unemployed women tended to be more depressed.

As expected, there was a significant association between ***socio-economic status*** and the severity of depression on the DDI ($F_{2,112}$=5.49, P=0.005) and on the BDI ($F_{2,112}$=7.99, P=0.001). According to Scheffe tests, there was a significant difference on both instruments between the low-income group and the high-income group in favour of the low-income group, and between the middle-income group and the high-income group in favour of the middle-income group. Low- and middle-income groups were associated with severer depressive symptoms. Tables 5.41 and 5.42 show the relevant data.

Table 5.41. One-way analysis of variance of socio-demographic variables and depression on the DDI for the 115 females comprising the sample of Study IV

	DDI				
					ANOVA
Demographic variables	Mean	SD	F	df	P
Age					
18-19	90.92	41.82			
20-29	83.76	43.01	2.05	3,111	.111
30-39	62.13	53.85			
40-53	68.94	45.69			
Marital status					
Single	78.51	40.79			
Married	72.73	52.88	0.41	1,113	.522
Educational status					
Primary school	77.18	54.47			
Preparatory school	91.25	54.21			
High school	77.09	35.36	0.29	3,111	.829
Graduate or Higher	71.02	46.42			
Occupational status					
Not working	76.12	49.15			
Working	73.69	45.58	0.07	1,113	.798
Socio-economic group					
Low	84.33	47.68			
Middle	80.70	49.81	5.49	2,112	.005
High	47.04	31.81			

Table 5.42. One-way analysis of variance of socio-demographic variables and depression on the BDI for the 115 females comprising the sample of Study IV

Demographic Variables	BDI Mean	SD	ANOVA F	df	P
Age					
18-19	27.50	15.52			
20-29	20.02	13.42	2.84	3,111	.041
30-39	15.32	13.25			
40-53	15.94	13.45			
Marital status					
Single	21.14	14.34			
Married	16.72	13.36	2.91	1,113	.091
Educational status					
Primary school	20.00	15.87			
Preparatory school	22.00	15.71			
High school	17.68	11.56	0.34	3,111	.794
Graduate or Higher	17.52	12.99			
Occupational status					
Not working	19.79	14.78			
Working	16.51	11.94	1.43	1,113	.234
Socio-economic groups					
Low	22.66	15.63			
Middle	19.66	12.77	7.99	2,112	.001
High	9.26	7.72			

The relationship between all the socio-demographic variables and depression was examined next by multivariate analysis of variance (MANOVA) for both the DDI and the BDI. Age groups and educational status were treated statistically only as covariate variables, as they were shown above to have little predictive power for level of depression. The other three socio-demographic variables included in the modelling were marital, occupational, and socio-economic status. It was interesting to see that the same results were derived from both the DDI and BDI analyses. With both instruments, only socio-economic status was found to exert an independent effect on the prevalence of depression (DDI: $F_{2,101}=3.28$, $P=0.042$; BDI: $F_{2,101}=4.30$, $P=0.016$). The other socio-demographic variables did not have any association with depression, and the interaction between these variables had no significant effects on the prevalence of depression.

Details of DDI and BDI multivariate analyses are shown in Tables 5.43 and 5.44.

Table 5.43. Multivariate analysis for socio-demographic variables and severity of depression on the DDI

Demographic variables	SS	df	MS	F	Sig
Within residual	223482.08	101	2212.69		
Regression	5280.04	2	2640.02	1.19	.308
Marital status	151.75	1	151.75	.07	.794
Socio-economic status	14512.78	2	7256.39	3.28	.042
Occupational status	186.72	1	186.72	.08	.772
Marital by socio-economic status	269.76	2	134.88	.06	.941
Marital by occupational status	3317.92	1	3317.92	1.50	.224
Socio-economic by occupational status	3012.00	2	1506.00	.68	.509
Marital by socio-economic by occupational status	1242.78	2	621.39	.28	.756

Table 5.44. Multivariate analysis for socio-demographic variables and severity of depression on the BDI

Demographic variables	SS	df	MS	F	Sig
Within residual	17990.13	101	178.12		
Regression	176.14	2	88.07	.49	.611
Marital status	1.12	1	1.12	.01	.937
Socio-economic status	1531.51	2	765.75	4.30	.016
Occupational status	43.36	1	43.36	.24	.623
Marital by socio-economic status	54.04	2	27.02	.15	.859
Marital by occupational status	46.16	1	46.16	.26	.612
Socio-economic by occupational status	373.13	2	186.57	1.05	.355
Marital by socio-economic by occupational status	135.29	2	67.64	.38	.68

In general, these results reveal that socio-economic status had an independent effect on the DDI depression score in both one-way analysis of variance (ANOVA) and multivariate analysis (MANOVA). The results of the BDI MANOVA were similar to those of the DDI analysis, since socio-economic status had an independent effect on depression, but the results of the BDI ANOVA revealed that age groups also had the same effect.

5.4.4.9.9. Analysis of Symptoms of Depression as Measured by the DDI

In order to analyse the symptoms of depression recorded by the DDI, the approach used in Study II was applied. An attempt was therefore made to delineate the symptoms of depression in this sample with the DDI.

Following the approach of Study II, symptoms reported by less than 50% of the total community sample were excluded. This resulted in only two symptoms being excluded: unresponsiveness to circumstances, and self-dislike. Table 5.45 shows the results of this approach.

Table 5.45. Percentage of the community subjects who endorsed DDI items greater than 0 (n = 100)

DDI item	Endorsed choices greater than 0%
1- Fatigability *	97%
2- Somatic symptoms *	94%
3- Loss of interest and pleasurable feelings *	81%
4- Guilt	68%
5- Sense of failure	55%
6- Punishment	72%
7- Excessive thinking *	91%
8- Pessimism *	92%
9- Being persecuted	62%
10- Unresponsiveness to circumstances	23%
11- Irritability *	94%
12- Social withdrawal	74%
13- Loneliness	71%
14- Agitation *	92%
15- Suicidal ideas	65%
16- Indecisiveness	74%
17- Low self-esteem and self-confidence	66%
18- Self-accusation	66%
19- Insomnia	59%
20- Lowering of mood *	94%
21- Low capacity for enjoyment and concentration *	79%
22- Self-dislike	44%

***Items endorsed by 75% or more.**

Table 5.45 shows that 20 items were endorsed by more than 50% of the subjects. Because the DDI presents the symptoms of depression in the native language of the UAE's people, it was not entirely surprising that the subjects who filled in this inventory endorsed the majority of the symptoms B the terms are readily used in the ordinary speech of the women. The decision was therefore taken to consider only those symptoms endorsed by at least 75% of the subjects. This resulted in nine symptoms being endorsed:

fatigability; somatic symptoms; loss of interest and pleasurable feelings; excessive thinking (worries); pessimism; irritability; agitation; lowering of mood and low capacity for interest; and low capacity for enjoyment and concentration.

The next task was identifying the depressed subjects in the sample and then determining the symptoms endorsed by three-quarters of them. For this purpose, a depressed subject was defined as one whose score on the DDI exceeded 76. Accordingly, scores of 77-123 indicated mild depression, scores of 124-173 indicated moderate depression, and scores of 174- 216 indicated severe depression. Thirty-five subjects met this criterion (23 mild, nine moderate, and three severe). These results are presented in Table 5.46.

Table 5.46. Percentage of community subjects with depressed symptoms who endorsed DDI items greater than 0 (n = 58)

DDI item	Endorsed choices greater than 0%
1- Fatigability *	56 (97%)
2- Somatic symptoms *	58 (100%)
3- Loss of interest and pleasurable feelings *	55 (95%)
4- Guilt	54 (93%)
5- Sense of failure	46 (79%)
6- Punishment	58 (100%)
7- Excessive thinking *	57 (98%)
8- Pessimism *	58 (100%)
9- Being persecuted	55 (95%)
10- Unresponsiveness to circumstances	22 (38%)
11- Irritability *	58 (100%)
12- Social withdrawal	53 (91%)
13- Loneliness	54 (93%)
14- Agitation *	57 (98%)
15- Suicidal ideas	54 (93%)
16- Indecisiveness	54 (94%)
17- Low self-esteem and self-confidence	53 (91%)
18- Self-accusation	51 (88%)
19- Insomnia	46 (79%)
20- Lowering of mood *	58 (100%)
21- Low capacity for enjoyment and concenteration *	58 (100%)
22- Self-dislike	36 (62%)

***These nine items were endorsed by the subjects between 95% and 100% of the time.**

From Table 5.46 it can be seen that 20 of the 22 items constituting the DDI were endorsed by more than 75% of the depressed subjects. Comparing Tables 5.45 and 5.46, it can be seen that the nine items endorsed by more than 75% of the total sample in Table 5.45 are the same as those endorsed by the depressed subjects in Table 5.46. These items ranged in endorsement from 95% to 100% in Table 5.46. They could therefore be considered as the major cultural components of depression in the community sample

according to the DDI.

It is important to clarify that these nine items could be cultural aspects of depression in the UAE. These symptoms may be considered by women in this society as normal phenomena, and they should not be considered key symptoms for diagnosing depression, even though these nine items will occur more in depressed cases. This means that one should look for further symptoms when diagnosing depression in women in Dubai.

This finding could be observed in the analysis of the depressive symptoms found in the clinical sample _their results did not differ from those of the normal women with depressed symptoms. As can be seen from Table 5.47, only two items were endorsed by less than 75% of the subjects, while the nine items endorsed by 75% of the community subjects appear as major items in Table 5.47 _and they are endorsed by 100% of the subjects.

Table 5.47. Percentage of the clinical subjects who endorsed DDI items greater than 0 (*n* = 15)

DDI item	Endorsed choices greater than 0%
1- Fatigability *	15 (100%)
2- Somatic symptoms *	15 (100%)
3- Loss of interest and pleasurable feelings *	15 (100%)
4- Guilt	15 (100%)
5- Sense of failure	13 (87%)
6- Punishment	14 (93%)
7- Excessive thinking *	15 (100%)
8- Pessimism *	15 (100%)
9- Being persecuted	12 (80%)
10- Unresponsiveness to circumstances	04 (27%)
11- Irritability *	15 (100%)
12- Social withdrawal	15 (100%)
13- Loneliness	15 (100%)
14- Agitation *	15 (100%)
15- Suicidal ideas	15 (100%)
16- Indecisiveness	14 (93%)
17- Low self-esteem and self-confidence	14 (93%)
18- Self-accusation	14 (93%)
19- Insomnia	15 (100%)
20- Lowering of mood *	15 (100%)
21- Low capacity for enjoyment and concenteration *	15 (100%)
22- Self-dislike	10 (67%)

***These nine items were endorsed by 100%**

For comparative purposes, bivariate contingency analyses (chi-squared) were conducted on each of the 22 items of the DDI in order to determine the differences in the symptoms of depression between the 15 female patients from the clinical sample and the 35 females with depressed symptoms from the community sample. The results illustrated the fact that this kind of analysis is not useful when the number of degrees of freedom is less than one. This is because, as in the case of a one-sample chi-squared analysis, this test should not

be used if any cell has an expected frequency of less than 1 or if 20% or more of the cells have an expected frequency of less than 5 (Bryman & Carmer, 1997). Therefore, only the items with computable numbers were used. The results showed that there was only one item which showed a significant difference between the patients and the depressed women (chi-squared=3.71, df=1, *P*=0.053). This item was number 19, 'insomnia': the patients tended to show this symptom more than the normal women with depressed symptoms.

In conclusion, the results of this study show that the new instrument was sensitive as a measure of depressive symptoms in the clinical and community samples and was easily understood by subjects. These findings prove that native expressions of depression exist, and that they can be and should be used by mental health professionals.

Chapter 6

Discussion and Conclusion

6.1. Limitations of the Study

The limitations of the present study centre around several areas, but one in particular should be kept in mind: that the method of gathering data can influence the strength of any results (Brown, Andrews, Harris, et al., 1986). The first matter to be addressed is that of how representative the samples are of their respective populations. This is primarily a problem in interpreting information regarding chronicity and severity of symptoms, rather than the processes that may influence outcome. Where possible, an attempt to address this issue was made. For example, the depressed patients in the clinical sample were predominantly those receiving treatment at a secondary care (referral) clinic; many of these may present more severe psychosomatic symptoms than is usual, and they may thus not be representative of the depressed population as a whole. It may be precisely because of the stress that they were experiencing (that is, severe stressors and an inability to cope successfully) that they sought treatment.

The community sample might also not have been truly representative: because resources were limited, it was not possible to interview a large enough sample of women who were representative of the general population to find sufficient numbers who had experienced a severe crisis. Using a snowball method to select some subjects also affected the nature of the sample. Hence, the data reported in the present study may overestimate or

underestimate the levels of depression. Data may be skewed not only by the nature of the sample, but also by the nature of the questions presented to them.

Brown and Harris (1978) found that some factors which were of aetiological importance in depression (such as social class, number of children) had not been found in clinical samples, because the same factors tended to prevent women with the features in question from seeking treatment. Although some of these factors proved to be predictive of depression in the present study, in both the clinical and community samples, only a study on a larger community sample of women with depressive symptoms could determine whether this is actually the case.

How far these data generalize to other mental disorders remains to be investigated. The apparent generalizability of the effects of culture is great, so caution is needed in order to avoid overgeneralization, at least until the contextual factors that influence the power of the effects in a given situation are more clearly defined.

While it is possible that our sample selection methods created differences in the rates of use of certain coping strategies, it is important to note that the measure used to detect the coping strategies was a retrospective scale. For subjects who were describing recent depressive feelings and their coping behaviour for it, recall may not have been a problem. However, subjects who had not recently experienced these feelings may have been anticipating their coping behaviours rather than reporting actual behaviour. In addition to the possibility of a failure to recall information, subjects' memories and hence responses may have been influenced by their current mood, and this would affect the

nature of the coping strategies they reported. Although this fact was not controlled for in the present study, if the only reliable difference between the two groups of women _those with and without depressive symptoms_ is the way they report coping with their depressive feelings, these results should not be dismissed lightly.

Another potential criticism of the measurements of the present study concerns one of the major aims of this research _namely to investigate the cultural perception of depression among the native people of Dubai. In this type of cross-cultural research, a major problem is the vast array of instruments available and their incompatibility with each other. Furthermore, the existing depression measures used in this study rely on Western perceptions of depression, and cannot therefore be said to provide a truly objective measure of culture-specific perceptions. This shortcoming in measuring the true perception of depression among the people of Dubai raises the question of whether the world really needs another depression scale. The present study has argued that it does, as most existing measures are concerned with general Western perceptions of depression rather than indigenous perception within a specific culture.

Another important potential limitation of the present study was that it was strictly looking at the unique aspects of a particular culture; this practice, according to Falicov (1994), introduces the risk of oversimplification and stereotyping.

6.2. Why the Study was Carried Out

Women's experiences in society, from birth until old age, generally expose them to a greater degree of stress than men (Shainess, 1974; MIND, 1992; Stewart, 1998). Women worldwide, but especially in traditional, conservative societies, are bombarded by numerous messages about how they should be _which often means how the male-dominated institutions want them to be. The messages that women receive are often contradictory; for example, as discussed in Chapter 3, if a woman in the UAE conforms to the stereotype of feminine behaviour within the traditional Islamic context, she will be seen as a normal woman. If she does not conform, she is likely to be subjected to interventions geared towards adjustment to a more feminine role.

The realities of abusing Islamic laws and of life as a second-class citizen create an enormous amount of distress for women in UAE. However, the services to which women might turn for help often perpetuate their distress; they are often medicalized, treating symptoms only with drugs or ECT, with little time or attention paid to the sources of distress.

The present study involved women in Dubai (one of the seven emirates which comprise the UAE), and focused on their depressive symptoms and conceptions of depression (in other words, their own verbal expressions for depression), and on the coping strategies they use to confront the condition. Interest in this topic derived partly from the fact that these concepts have not yet been investigated in the UAE, while sufficient evidence about other cultures already exists. Further motivation derived from the results of Ghubash (1992), which indicated that depression was the most common psychiatric disorder

among women in Dubai (see Chapter 3, section 3.5).

As described in Chapter 2, culture affects the diagnostic patterns of clinicians as much as it influences the forms and patterns of disorder and the strategies that individuals engage in to cope with a disorder. Loring and Powell (1988) found empirically that the gender and race of both the patient and the clinician can influence diagnosis. This influence of gender and race on diagnostic outcome can exist even when clear-cut diagnostic criteria are presented. For example, in two case studies representing actual patients receiving psychiatric treatment for undifferentiated schizophrenic disorder with a dependent personality disorder, researchers found that 56% of the psychiatrists studied chose undifferentiated schizophrenia as the diagnosis when the patient was described as a White male or when no gender or racial data were provided, but only 21-23% of the psychiatrists chose undifferentiated schizophrenia as the diagnosis when the patient was identified as an African-American woman, a White woman, or an African-American man. Loring and Powell (1988) added that clinicians' judgements also varied according to their own gender. For example, male psychiatrists have been found to be biased towards giving a diagnosis of recurrent depression to female patients regardless of race, and towards using hysterionic personality disorder when diagnosing white female patients.

Similarly, many other researchers (e.g., Lopez, 1989; Landrine, 1989; Homma-True, Greene, Lopez, et al., 1993) have found evidence supporting the existence of differences based on race or gender in diagnosis and treatment in different cultures. Comas-Diaz (1996) argued that clinicians who rely solely on clinical judgements can misdiagnose. She added that practitioners need to expand their assessment beyond the use of clinical

judgement. A contextual and comprehensive approach is required; this should include information provided by significant others and culturally relevant standardized psychological and neuropsychological testing, as well as screening for physical illnesses whose symptoms are similar to those of certain mental illnesses.

It is obvious from the literature that culture interacts with the life-cycle at each stage of an individual's development, and that cultural factors influence individuals' definitions of the nature, timing, tasks, and rituals of life-cycle phases and transitions. Furthermore, cultural norms and values inform members of a particular society of their roles and the rules regarding problem definition, problem resolution, expression of emotion, communication styles, and help-seeking behaviour.

It was therefore important to obtain sufficient data about the symptoms, conceptions, and help-seeking behaviour related to depression among women in the cultural context of the UAE. This is not only because these concepts are largely unexplored, either separately or in relation to each other, for people of the UAE, but because mental health clinicians in the UAE, for the majority of whom the UAE's culture is not their own, must develop an awareness of the ethnic and cultural traditions of the UAE's people B especially their women, who face many conflicts during a period of rapid socio-economic and cultural change within that society. This will enable clinicians to have a greater appreciation of the interaction between cultural and individual dynamics.

The findings in the present study showed, first, that symptoms of depression among women in Dubai do reflect cultural expectations. Second, native verbal expression of

depression does exist, and can be and should be used by mental health professionals. Finally, the coping strategies used by women in relation to their depressive feelings also reflected cultural influences.

In this chapter, the symptoms of depression among our samples of clinically depressed and non-clinically depressed women will be described, then the native verbal expression of depression and the development of the Dubai Depression Inventory (DDI) will be discussed, and the strategies for coping with depression will be analysed. The weaknesses and the strengths of this thesis will also be discussed.

6.3. How this Study Progressed

This project was carried out step by step in four inter-related studies. The project was conceived as a descriptive comparative study of cultural constructs of emotion across the clinically depressed and non-clinically depressed women of Dubai. The research was conducted from a psychiatric perspective, and was designed as an exploration of culture-specific illness categories or illness classification systems for depression. However, it shares a basic premise with ethnographic semantic research, since much of our covert everyday knowledge about the world is reflected overtly in language used to encode and express that knowledge (White, 1982).

The present project started by exploring, in a clinical sample of women in Dubai, the symptoms of depression and the association of depression with some socio-demographic variables. The results suggested that a series of patients could not be regarded as

representative of the spectrum of depressive symptoms among the women of Dubai. Hence, the second study was designed to explore these symptoms and associations in a community sample of women, and to find out how these women cope with their depressive feelings. During the field observations, it was noted that women in Dubai use some indigenous expressions which are not included in the standardized Western questionnaires. Accordingly, the decision was made to investigate concepts and words relating to depression among the native people of Dubai, and to develop a checklist, in Arabic, of indigenous depression-related words and expressions.

After this checklist had been constructed, it was important to assess whether it was applicable as a culturally sensitive scale for measuring depression in women in Dubai.

6.4. Findings of the Four Inter-related Studies

6.4.1. Symptoms of Depression among the Clinically Depressed Women

6.4.1.1. Socio-demographic Factors and the Severity of Depression

Associations between depression and demographic factors have been found consistently in many studies (e.g., Surtees, Ingham, Kreitman, et al., 1983; Cheng, 1988; Lehtinen & Joukamaa, 1994). Such associations, as assessed by screening questionnaires, were also demonstrated in the present study. For example, analysis of variance of the demographic details clearly indicated that there was a significant difference in the level of depression between the illiterate and educated patients: the illiterate patients tended to show more severe depressive symptoms than the educated patients. This may be because educated patients have more opportunity to cope with their difficulties, express their feelings in

different ways, and have more appropriate antidepressive behaviour. This finding is consistent with those of many other studies (e.g., Costello, 1991; Rajala, Uusimaki, Keinanen-Kiukaanniemi, et al., 1994; Pahkala, Kesti, Kongas-Saviro, et al., 1995), and supports hypothesis H1c.

The results also indicate that the low socio-economic status group differs significantly from the other two groups (middle and high) in the level of depression, with patients of low socio-economic status showing the most depressive symptoms. This could be a result of role and status deprivation; there are limits to the number and types of behavioural alternatives available to people on low incomes, which may increase a sense of helplessness and inadequacy. Furthermore, it may be that middle- and high-income people are prepared for the experience of depression through higher levels of education and socialization. This finding is supported by those of Brown and Harris (1978), Weissman and Myers (1978a, 1978b, 1980), and Surtees, Ingham, Kreitman, et al. (1983); it also confirms hypothesis H1e.

It was also hypothesized that age, marital status, and occupational status would be associated with depression, but the study failed to find any significant associations between these demographic variables and the level of depression. However, the means of the patients' scores on the instruments used showed that the younger and older patients tended to show more depressed mood than those of middle age; this finding agrees with others, such as Gotlib and Colby's (1987) (see section 2.2.3.2). Our mean values also showed that married, divorced, and widowed patients tended to show more severe symptoms than single patients. According to the findings of Renne (1971) (cf. Gotlib &

Colby, 1987), which suggest that both men and women who are unhappily married are more depressed than their separated and divorced counterparts, one should be careful in interpreting the association of depression with marital status. However, in the light of the socio-cultural pressures on married and divorced women in UAE society, one can argue that marital status is likely to predict the severity of depression.

The means of the patients' ratings on the depression scales also showed that housewives tended to exhibit more depressive symptoms than employed patients. This was not surprising, since many studies (e.g., Surtees, Ingham, Kreitman, et al., 1983) have found that the highest prevalence of psychiatric disorders is found among those women who are not employed.

In order to find further support for the socio-demographic hypotheses, the interactions between all the demographic variables were examined, but no significant effects were found. This could be due to the small numbers of patients in each demographic sub-group.

In conclusion, it is unsurprising that low-income and illiterate patients scored higher on the depression scales than the middle- and high-income groups and the educated patients. It has been shown universally that low income and illiteracy relate to a higher risk of psychological disturbance (e.g., Cochrance & Stopes-Roe, 1980; Surtees, Ingham, Kreitman, et al., 1983; Dilling & Weyerer, 1984; Madianos, Vlachonikolis, Madianou, et al., 1985).

6.4.1.2. Symptoms of Depression: Cross-cultural Comparison

The results of the present study show that symptoms of depression vary with culture. The symptom profile of depression among Dubai's patients was somewhat different from that of US patients. Dubai's patients scored significantly higher than US patients on the BDI items of feelings of punishment, loss of appetite, weight loss, body image change, fatigability, somatic preoccupation, insomnia, irritability, and social withdrawal, and lower than US patients on self-dislike, suicidal ideas, indecisiveness, and self-accusation. This finding confirmed the second hypothesis.

It is clear that patients from Dubai were more likely to associate depressive symptoms with organic or somatic factors, which is consistent with sub-cultural values, while patients from the USA were more likely to associate depressive symptoms with cognitive factors. Many previous studies (e.g., Sue, Wagner, Ja, et al., 1976; Crittenden, Fugita, Bae, et al., 1992; Furnham & Malik, 1994; Krause & Liang, 1992; Mumford, 1993) have suggested that Eastern people may somatize emotional problems because the expression of physical symptoms is more culturally acceptable than the expression of emotional difficulties. Similarly, women in Dubai may be less likely to talk about their psychological problems, in order not to bring attention to the way they are feeling, and for fear of ruining their family's reputation. Consequently, they do not seek psychiatric or psychological help, and attend other medical departments for help with their 'organic' problems. The reports of our study's patients showed that the majority were referred from other medical departments to the psychiatric department because they were not 'physically' ill.

The association of depressive symptoms with organic or somatic factors was not an unexpected finding, since numerous psychiatric studies from non-Western cultures have reported a high rate of somatic presentation of psychiatric disorders. Such studies include reports from China (Tseng, 1975; Kleinman, 1982), India (Teja, Narang, & Aggarwal, 1971; Janakiramaiah & Subbakrishna, 1980; Srinivasan, Srinivasa Murthy, & Janakiramaiah, 1986; Saxena, Nepal, & Mohan, 1988), Iraq (Bazzoui, 1970), Saudi Arabia (Racy, 1980), Nigeria (Binitie, 1975), Kenya (Ndetei & Muhangi, 1979), and Ethiopia (Keegstra, 1986). Depressed patients are often found in general medical settings, seeking physical treatments for their somatic symptoms. Very few are correctly diagnosed as suffering from an emotional or psychiatric problem, so most do not receive appropriate treatment (Mumford, 1993).

However, there are other explanations for the somatization of depressive symptoms. It may be that depressed patients tend to adopt biological symptoms because it removes from them the responsibility for both onset and recovery from depression. The attribution of somatization to the very distressing symptoms of depression may make the depression more understandable and tolerable, and justify to patients the use of drugs in treating depression. It is possible that because the depressed patients were receiving treatment they were told that their distress was of organic origin.

Considerations of cross-cultural comparability in the present study enable a more realistic comparison of the symptoms of depression to take place between Dubai's patients and patients from Western cultures. However, these comparisons may imply that, overall, symptoms of depression are largely similar among all non-Western cultures _a conclusion

that does not take account of the effect of changes within any particular culture over time. Moreover, the largely similar findings of numerous studies from non-Western cultures indicating that non-Westerners are more likely to somatize their depressive symptoms could be due to the ethnocentric model of transcultural psychiatry based on Western concepts of illness.

6.4.2. Symptoms of Depression among the Non-clinically Depressed Women

6.4.2.1. Socio-demographic Factors and the Severity of Depression

As we believe in multifactorial causes of depression, it has to be recognized that the analyses carried out in the present study regarding the association of severity of depression with demographic status do not allow any conclusions to be drawn concerning the direction of causality, if any, in the relationships discerned. Although in some instances there are quite strong grounds for making a causal assumption in one direction rather than the other, regarding (for example) age, occupational status or socio-economic groups, it could in fact be that these variables affect severity of depression, or that severity of depression affects them, or that the apparent relationship is actually produced by mutual dependence on a third variable. However, the unjustified assumption is often made by some researchers that socio-demographic variables have causal priority in the relationship with psychological states.

The implicit assumption behind the use of socio-demographic status in the present study as a variable for differentiating relative severity of depression is that similarities of status reflect similarities of life style, which embrace factors likely to be causal B factors likely

to be, in other words, predictive factors for depression.

Many of the data reported here are in line with those from studies carried out in other cultures. Given the weight of previous evidence, it was not surprising to find that employed women and those in higher-income groups enjoy better mental health on average than other groups. In each case, the occupants of these social categories enjoy some advantage over those in other categories. The advantage may be materially defined in the case of occupational and socio-economic status.

In this study, unemployment was strongly related to severity of depression. The problem of direction of causality is particularly relevant here. It is quite conceivable that someone may fail to secure a job, or lose a job they have, because of psychological difficulties; equally, it may be that the stress of being unemployed produces elevated symptom levels.

For women in Dubai, the most reasonable explanation for the prevalence of depression could relate to marriage and family situations, as discussed in Chapter 3 (see section 3.4.2.2). These situations involve specific life stresses which women in Dubai, in particular, and in most Arab countries, in general, experience. One of the strongest stresses among women in Dubai may be insufficient social support. This social support could be defined primarily as emotional support (from a spouse, relatives, or friends), personal law, and the degree of engagement in social activities outside the home. It was mentioned in Chapter 3 that polygamy, custody of children, and unexpected divorce have large and negative effects on women's mental health. Hence, one reasonable explanation for the strong association of unemployment with severity of depression among women

in Dubai is that the financial dependence of unemployed women on their husbands may produce a deterioration in their psychological state.

Another explanation may be that the role of unemployed women in Dubai, especially the housewives (who have to deal with housework, child care, and their low status), is intrinsically less satisfying than that of employed women.

The association between low income and severity of depression has long been suspected, and has more recently been very well documented (Bagley, 1973; Warheit, Holzer, & Schwab, 1973; Quesada, Spears, & Ramos, 1978; Cochrance & Stopes-Roe, 1980). It was also substantially confirmed in the present study. The debate now is not so much over the existence of an association but over the explanation which best accounts for it. Reviewing most of the epidemiological and aetiological studies of psychological or psychiatric disorders, one can see that the single socio-demographic variable that has received most attention is social class. Lower social status has almost universally been shown to be related to higher risk of psychological disturbance, however measured.

There are, of course, various explanations for these findings, such as the *drift* hypothesis, which implies a genetic cause of psychological disorder, which supposes that those with poorer mental health decline in status, or do not improve their position as readily as more healthy members of their (original) class, and thus accumulate in the lower strata. There is also the *social causation* hypothesis, which suggests that the stresses and strains of lower-class life play a part in the aetiology of mental disorder. Then there are intermediate positions and variations on these main themes.

It is difficult to devise a direct empirical test on the basis of which a choice can be made between these explanations. However, the *indirect* evidence available in the present study tends to support the social causation hypothesis rather than the other hypotheses. Although it is clear that socio-economic status influences material security and comfort, and that this then underlies psychological symptom levels, it still remains possible that continuous psychological instability from childhood through adulthood has a causal influence on socio-economic status. However, this is certainly less likely than an explanation of elevated symptom levels in terms of the obvious disadvantages of low income and its associated life style.

The effect of age on rates of disorder was found to be significant, with higher GHQ scores (more psychological stress) among those aged 18-19 and 30-39 years. This finding is consistent with those of Weisman, Myers, and Thompson (1981) (cf. Gotlib & Colby, 1987) (see Chapter 2, section 2.2.3.2). It was hypothesized that depression is associated with those most affected by the rapid socio-economic changes in the UAE B those in the 20-40 age range. Younger women, who are the ones experiencing the rapid socio-cultural changes and playing the dual role of women (as modern women who have to participate in different spheres of life, and as a guardians of traditional culture), probably suffer from psychological disturbances as a result of this confusion between values; this factor should not be neglected.

Another explanation could be that education and new systems of communication (both the mass media and modern means of transportation) have provided women in the UAE with a new-found awareness of the world around them, which increases the number of

women, especially younger ones, who do not accept the traditional system and claim changes in their social status. Of course, these claims are mostly regarded by society as a disaster for traditional values and Islam. Accordingly, many of these women experience social pressure, or pay the price of remaining apart from the international march of women towards modern life. These conflicts between internal and external demands may be among the causes of high psychological stresses among young women in Dubai.

Although there was no significant association between marital status and level of depression in non-clinically depressed women in either Study II or Study IV, the mean BDI scores were of interest in this respect. In Study II, the mean scores showed that single women had a lower rate of depression than married women, while in Study IV this result was completely reversed _the single women had the higher rate of depression.

As this result was unexpected, it was important to find a reasonable explanation for it. A review of the socio-demographic details of the subjects in the two studies showed that the mean age of single women in Study II was 26.0 years, while it was 29.3 in Study IV. This may suggest that as the mean age of single women rises in traditional societies such as the UAE, it may be associated with increasing rates of psychological stress. In general, the findings of the present study support hypotheses H1a, H1d, and H1e.

6.4.2.2. Symptoms of Depression: Cross-sectional Comparison

This study explored the nature of depressive symptoms among women from the community, and investigated whether these symptoms differed from those found among depressed patients. The study showed that most of the women from the community who were classified as depressed by the BDI did not meet the diagnostic criteria for clinical depression of ICD-10 (ICD-10 diagnostic criteria for depressive episode). The depressive symptoms identified in this way indicated mild depression in the majority, with a few instances of moderate and severe depression. This suggests that the findings from self-report questionnaires cannot be generalized to those based on a categorical diagnosis of depression.

The present study reveals that five of the 21 symptoms of depression on the BDI were present in more than 50% of the community sample. These symptoms were considered to be a specific cultural aspect of depression among the women of Dubai, since they were regularly mentioned by a majority of the women as being common feelings of stress. These symptoms, in general, reflect a cognitive component of depression rather than a somatic component. For example, sadness, dissatisfaction, self-accusation, and irritability are more related to how a person evaluates a situation and responds to it, and this obviously happens cognitively.

Owing to the stressful role of women in the UAE, and to the fact that they cannot discuss their situation in many spheres of life openly, one can suggest that they tend to deny their own feelings about their situation in order to protect themselves from any social accusations or blame. This might then result in them feeling irritable, sad, or dissatisfied

with their situation, or accusing themselves, perhaps because they cannot change the situation or because they feel that they should not think about it. These suppressed feelings may provoke a general feeling of fatigability, which was one of the five main symptoms found in the community sample.

By comparing the symptoms of all the community subjects with those of the subjects who had high scores on the BDI, it was shown that the depressed subjects experienced other symptoms in addition to the main five symptoms. Of these additional symptoms, 83% were somatic, while only 42% were cognitive. This would suggest that when depression becomes more acute in a woman, she tends to show the symptoms in somatic ways more than in cognitive ways. This finding supports the second hypothesis of this study, and illustrates the cultural influence on the manifestation of psychological disorders.

In collective (non-Western) cultures, the concept of the self differs from that in contemporary Western societies, which have been described as individualistic in orientation. Individuals in collective cultures, which would include the UAE's, are seen as co-participants in the social and universal realities that generate continuities and meaning, and which can also produce illness. Illness is therefore a social affair, since it affects the individual's immediate group, and treatment can involve the members of this group. All are affected by the burdens of illness and have a stake in its outcome. The individual's altered bodily perceptions and bodily functions denote, on cultural grounds, a behavioural change as illness.

Accordingly, one can argue that whenever a woman in Dubai need sympathetic attention,

she develops physical symptoms, since patients with physical problems usually get this kind of attention. Furthermore, physical symptoms provide the woman with a physical explanation for her failure to achieve according to social indices of feminine success. The physical symptoms protect her against the shame of being considered inferior to others and, by demonstrating how ill she is, excuse her social failure in her role as a woman and elicit attention and sympathy instead of shame and contempt. By somatizing her feelings she also protects herself and her family's reputation from the stigma attached to a mentally disordered patient. This finding is consistent with those of Kapp (1967), who indicated that somatic symptoms cover a great deal of unhappiness, discontent, and resentment.

Another explanation for somatizing feelings could be that women in Dubai believe that only somatic symptoms are of interest to members of the medical profession; hence, they present bodily symptoms as a cover for their psychiatric illness. El-Islam, Moussa, Malasi, et al. (1988) found that many primary care practitioners encourage this attitude by their greater attention to somatic than to emotional complaints.

Another comparison made in this study was between the depressed subjects from the community sample and the depressed patients from the clinical sample. This showed that scores for 11 symptoms were significantly or nearly significantly higher among the clinically depressed women: sense of failure, crying, pessimism, suicidal ideas, self-dislike, and insomnia were significantly more common in clinically depressed patients, while work difficulty, irritability, somatic preoccupation, loss of libido, and loss of appetite were nearly significantly more common among the depressed patients.

In psychiatric illness, as Gada (1982) indicated, an important determinant of the 'choice' of symptoms concerns which symptoms are assigned the status of an illness by the group to which the patient belongs, as well as the expectation on the part of patients of what local doctors consider an illness. Accordingly, the findings of this study revealed that despite the existence of a common core of symptoms of depression, there are cultural components in the symptoms of depression specific to the UAE's culture. These symptoms (sadness, dissatisfaction, self-accusation, irritability, and fatigability) should not be considered by clinicians in Dubai as key symptoms for diagnosing clinical depression, since they are commonly experienced among women in the community, even though these symptoms (especially irritability) are more frequent among depressed patients.

The findings of this study suggest that clinicians should consider the 11 symptoms that were found to be significantly more common in the depressed patients as the key symptoms of depression among women in Dubai.

6.4.3. Verbal Expression of Depression among the Native People of Dubai

One of the purposes of the present study was to investigate cultural differences in beliefs and conceptions of depression in the native people of Dubai. The responses of the subjects in this study reflect attitudes and values socialized within their families and within society; they also brought attention to community awareness of the concept of depression and of the problems provoking it, which might otherwise not have been given priority by clinicians.

Since the way in which an individual perceives and manages emotions is a major factor associated with the impact of stress, an internal pattern of suppression of unexpressed emotions may have a negative effect on physical and mental well-being (Lazarus, 1991). This possibility was borne out by the results of the present study. Complaints of general ill-health to describe the depressed person=s symptoms were used by a majority of the subjects, regardless age or gender. That is, the native people of Dubai were more likely to associate depression with organic or somatic factors; this, again, is associated with their sub-cultural values. In some cultures individuals are more likely to somatize emotional problems, because the expression of physical symptoms is more culturally acceptable than the expression of emotional difficulties in their societies.

Common symptoms of depression reported by the native people of Dubai are the following.

(a) A feeling of *tightness* or constriction in the chest. The depressed person feels unable to take a deep breath; as a result he or she may feel short of breath or sigh repeatedly. The chest is felt to be too tightly packed with an excess of unpleasant feelings to accommodate the inspiration of air. Although subjects may wish to cry to relieve this feeling, they feel unable to do so.

(b) A feeling of giddiness or faintness (*dora*) which cannot be attributed to neurogenic, cardiovascular or metabolic disorders. The depressed person usually locates this feeling in the head.

(c) Alimentary symptoms in the form of nausea or sickness and poor appetite, which are attributed to the abdomen and particularly to the liver (*chabid*).

(d) Fatigue due to generalized aches. These are described as a subjective feeling of lack

of body energy and soundness (*ta'bana*), the limbs suffering most. Some of these feelings have been described in Turkish patients (Mirdal, 1985), Kuwaiti patients (El-Islam, Moussa, Malasi, et al., 1988), and Qatari women (El-Islam, 1975).

A gender difference was found in aggression control; this was seen in the responses of the subjects to the focus group questions. Men were found to ruminate to a greater extent than women over emotionally upsetting events. Additionally, they were more likely to inhibit feelings of aggression or hostility than women. Perhaps the time spent ruminating over emotionally upsetting events kept them in an emotionally heightened state. The tendency for men to remain upset for longer periods may necessitate more control over feelings of aggression; this was reflected in the behaviours towards their families which were revealed by their responses: for example, they preferred to escape from home when they felt low or depressed in order to avoid any argument with their wives.

The results of the open-ended inquiry showed that the native people of Dubai seemed to be able to differentiate between different depressive symptoms in their own language. The resulting clusters of depressive words support this idea. There is a strong link between the availability of the appropriate words for the various symptoms of depressive emotion and the ease with which people distinguish between the severities of these symptoms. Hence, it is not sufficient for the words to be available in the language; the correct use has also to be found.

The checklist of depressive words which was developed from the indigenous language of the native people of Dubai (which will be discussed in the next section) proved that

the native words used to describe depression are correctly used by the people. These expressions reflect their feelings as well as cultural influences.

It is important to bear in mind that emotional expression is a complex process; an attempt was therefore made in this study to explore this process as a preliminary step. The conclusion was that the results of this study partially support the fourth hypothesis, since the general core of depressive symptoms described in ICD-10 were found in the expressions of the native people of Dubai. Furthermore, the results emphasized the effect of culture on the concept and expression of feelings.

6.4.4. Development of the Dubai Depression Inventory (DDI)

This part of the study was conducted in order to determine the validity and reliability of the Dubai Depression Inventory (DDI), a self-report scale involving an indigenous checklist of depressive words, for measuring depression among the native people of Dubai. The correlation of the DDI with another standardized depression scale, the Beck Depression Inventory (BDI), and the consistency of the DDI results with psychiatrists= assessments of depressed patients, indicate its reliability in measuring depressive symptomatology. Furthermore, the ability of the DDI, as compared with the BDI, to differentiate between depressed and non-depressed persons, and to assess the severity of depression, indicates its validity.

Five components resulting from factor analysis _labelled anxiety symptoms, self-pity, paranoid symptoms, discomfort, and indifference_ fit the pattern of depressive episode

adopted in the ICD-10 diagnostic criteria, disease codes F32.0 (mild depressive episode, without and with somatic symptoms), F32.1 (moderate depressive episode, without and with somatic symptoms), and F32.2 (severe depressive episode without psychotic symptoms).

The first component involves the following: clear anxiety symptoms such as excessive thinking or worries, irritability, and indecisiveness; depressive symptoms such as feelings of guilt, loss of interest, and sense of failure; and psychosomatic features such as somatic symptoms and fatigability. This fits the neurotic or reactive depression found in psychiatric samples in many studies (e.g., Kendell, 1976; El-Islam, 1975; El-Islam, Moussa, Malasi, et al., 1988).

The relative magnitude of the second component, which was characterized by cognitive symptoms such as self-dislike, self-accusation, low concentration, low self-esteem, and low self-confidence, is consistent with the view of many theorists (Beck, 1967; Brown & Harris, 1978; Seligman, 1975) that cognitive features are of central importance in depression. These cognitive symptoms could also be seen in the self-pitying attitudes of the depressed persons studied.

Authors such as Whaley (1998) have noted that the traditional view of paranoia, which considers it as a psychotic symptom linked to schizophrenia, has become less influential, for many reasons. One such reason may be that a substantial body of literature now supports the differentiation of schizophrenia into paranoid and non-paranoid sub-types, with the paranoid sub-type being less severe; another possible reason is that cognitive and

behavioural theories of paranoid symptoms suggest an association with depression. Accordingly, paranoia could be conceptualized as a protective mechanism which defends self-esteem and prevents depression (Zigler & Glick, 1988; Bentall, Kinderman & Kaney, 1994; Trower & Chadwick, 1995).

Whaley (1998) stated that depressed persons tend to make internal attributions for both positive and negative outcomes, and paranoid thinking is a dynamic process by which successes are given more weight than failures in self-evaluation. Whaley (1998) also adopted a cross-cultural perspective on paranoia, in the following terms:

'Individuals who are members of a group which continues to be victimized and exploited by the dominant culture, and who experience powerlessness in their everyday lives, may develop paranoid tendencies as a way of adapting to their circumstances. In this way, members of the culturally oppressed group do not develop the feelings of inadequacy or helplessness associated with depression, because they attribute their circumstances to ongoing experiences of oppression, i.e., the external control by powerful others. Thus their paranoid ideations are manifestations of the cultural oppression which they experience. The mildest form of paranoia is most prevalent among these individuals, due to its being most susceptible to cultural influences...this adaptive type of paranoia is usually misinterpreted by the mental health professionals as a syndrome of psychosis. These errors in clinical judgement can lead to diagnoses of schizophrenia when a diagnosis of depression, or no diagnosis at all, may be warranted'.

Stresses and the domination of tribal and traditional culture over women are still occurring in the UAE; this can be seen in the responses of the women in the focus group sessions. Hence, the substantial loading of these types of paranoid thinking on the third component of the DDI serves to specify it as a syndrome of depression in this particular culture.

The fourth component, which encompasses insomnia, social withdrawal, agitation, and lowering of mood, corresponds to the effects of multiple gender role stress on women's mental health. It has been stated that multiple roles are associated with competing demands that can lead to role overload and resulting strain (McBride, 1988). As discussed earlier, the role of women in UAE society is a dual one: as a guardian of traditional values and preserver of the cultural distinctiveness of Islam (which includes family law and the role of women within this law); and as a modern woman, taking part in the development of society. Hence, the fourth component probably represents the discomfort of women as reflected in the symptoms mentioned above.

Most of the literature regarding indifference in depression has been concerned with organic causes of indifference, such as strokes (e.g., Ghika-Schmid & Bogousslavsky, 1997) or the side-effects of a drug (e.g., Gerlach & Peacock, 1994; Hoehn-Saric, Lipey & McLeod, 1990). In their study of sensation-seeking and depressed mood, Carton, Jouvent, Bungener, et al. (1992) considered indifference as an emotional response of depressed subjects.

Carton and his colleagues (1992) first discussed psychological and psychopathological theories of emotional dimensions. They concluded that, in psychology, the dimensional approach does not consider emotion as a particular state of the organism, but as part of a wider activation process. Theorists in this field have classified emotions according to two main axes: pleasure-displeasure, and activation-deactivation. In psychopathology, the study of depressive mood identifies different pathological symptoms which rely on emotional subjectivity and on mimicry and motor expressiveness.

Carton, Jouvent, Bungener, et al. (1992) pointed out that it is possible, clinically, to explore level of activation in its behavioural and subjective interpretations: through the emotional responsiveness of depressed subjects (from emotional hyper-expressiveness to monotony and absence of affective reaction) and through the subjective aspects of emotional sensitivity (from anhedonia _the incapacity to experience pleasure_ and overall lack of feeling, to hypersensitivity to external stimuli).

According to Carton, Jouvent, Bungener, et al.'s (1992) argument, the fifth component of the DDI, which has been labelled indifference, could be considered as a subjective aspect of emotional sensitivity. Although this component included only one item, and although the responses of the subjects of the present study were not significant on that item, one can suggest that, extracted as an independent component, it could be seen as a syndrome variant of depression for women in Dubai.

It is important then to suggest that these five components could be detected by psychiatric epidemiological studies, since they would help clinicians to be more responsive to treatment or environmental factors than would the classical syndromes. The results indicated that the DDI was able to differentiate depressed and non-depressed samples at a statistically significant level, thus demonstrating the efficacy of the test among the women of Dubai.

To establish the standardized validity and reliability of the DDI will require a great deal more work. No attempt was made in this study to take into account the many factors that must be considered, such as large numbers of patients, the nature of the symptoms, and

both genders. The present study concerned the acceptability of the DDI as a tool for clinicians and patients in Dubai. Although there is a need for further investigation, it appears from the results of this study that the DDI is useful in the measurement of depressive symptomatology in the UAE.

From the foregoing it seems reasonable to conclude that although both the DDI and the BDI are potentially useful instruments for measuring depressive symptomatology in clinical samples _or for screening for depression in community surveys_ in Dubai (and are simple and economical to use, reasonably sensitive, apparently acceptable to respondents, and have demonstrated reliability and validity), receiver operating characteristic (ROC) analysis suggests that the DDI appears to be better than the BDI when used with a sample from Dubai. This superiority of the DDI may be attributable to its use of the indigenous language and indigenous expressions.

6.4.5. Strategies for Coping with Depression

The data from the focus group sessions illustrate a pattern of developmental and age differences in individuals' tendencies to express or inhibit emotions. Older individuals were found to inhibit their emotions more than the younger participants. This was very clear regarding crying, especially among women: older women preferred to keep their feelings inside instead of sharing them with others. This is may be due to their cultural background and values, which require women to be patient and tolerant of their problems, and only to ask Allah to help them. Islam emphasizes not losing hope regarding God's capacity mercifully to lift the disaster of illness; hence, from this point of view, a

depressed person who feels hopeless would implicitly be compromising his or her faith.

Older men tend to share their problems with other men, or ask for their advice. Most of the problems seen as likely to cause depression in men related to financial difficulties; men may prefer to share their problems with other men who have experience in this field. Furthermore, even when stresses related to their families are involved, they prefer to talk to another man rather than to their wives, as the majority of them believe that women are unable to discuss any serious problems.

Even though younger females felt able to express their distressed feelings more openly than older women _by crying or talking to a friend, for example_ worries about ruining their reputation and fears of people's talk were still prevalent.

Younger males tended not to express their distressed feelings verbally, and preferred to avoid such feelings, perhaps by being with their friends for as long as they could. If they did discuss their feelings, they preferred to talk to their male friends _ just like the older males, and maybe for the same reasons. Nevertheless, their responses indicated some confusion with their situation and role, and revealed their awareness of the situation of women, so there was a sense of demanding more liberation for themselves as well as for women.

In general, although there were some differences in expressing distressed feelings according to age and gender, all subjects tended to cope with their sad feelings by practising more religious rituals, such as praying.

The results of the Antidepressive Activity Questionnaire (AAQ) indicate that women from Dubai tend to manage their depressed feelings more by avoidance than by living with and managing their depression; their coping strategies are therefore focused on emotional discharge. As shown in Table 5.18 (see Chapter 5), more than 50% of subjects used these avoidance activities, such as 'keep busy', 'do something to take my mind off it', or 'do something I can get engrossed in'. Activities related to confronting depressed feelings and trying to manage them (active cognitive responses) and activities focused on logical analysis and problem solving were used by less than 50% of the subjects. Such coping strategies include 'trying to find out what is making me depressed' (45%), 'take myself out of it' (42%), and 'talk to someone about how I am feeling' (42%).

Help and comfort seeking was the second most common category of coping strategy, chosen by more than 50% of the subjects. This category includes 'praying' and 'taking comfort in my religion', which are active cognitive methods of coping focused on emotional discharge, and 'ringing someone up' and 'seeing friends', which are active behavioural methods of coping focused on problem solving. Such coping behaviours are common in other Eastern cultures, as reported by Bhugra, Baldwin, and Desai (1997) with Punjabi women. The third common category was self-care, chosen by 51-57% of the subjects. Active behavioural methods in self-care, such as taking a rest (54%) or having a bath (51%), were most commonly employed, while avoidance behaviour in self-care, such as going to bed (57%), was reported least often by more than 50% of the subjects. These coping strategies focused on emotional discharge.

The investigation also indicated that women with depressive symptoms who report

elevated levels of depressed mood tend to use significantly more antidepressive activities than non-depressed women. Surprisingly, however, results of further investigations about how frequently they used these activities and how helpful they found them showed that non-depressed women, despite using fewer activities than depressed women, use these activities significantly more frequently and find them significantly more helpful. This finding indicates that the quantity of a person's activity is not necessarily a guarantee of its quality.

Overall, these results show no significantly different *patterns* of coping response between depressed and non-depressed women; the difference was in the *amount* of these activities used by each group. This finding contrasts with that of Rosenberg, Peterson, and Hayes (1987), who stated that depressed medical patients reported a pattern of coping responses somewhat different from that of non-depressed medical in-patients. The contrast between these authors' findings and our own was not surprising, because the sample in the present study was, in general, a community sample, and the depressed subjects were not *clinically* identified as such, although according to the screening instruments they did show some depressive symptoms. Hence, as clinical and non-clinical populations differ in more ways than just sample size or symptom presentation, the structure and nature of coping may be influential as well.

It is important next to discuss the activities that were very helpful in decreasing depressive feelings among the women of Dubai. The current findings provide data about the nature of these coping activities. Religious behaviour, for example praying, was the most common activity used by women in Dubai, and 80% of them stated that it was very

helpful. Research into religious experience as a form of coping behaviour with psychiatrically disabled people is still at a formative stage, and very little is known about it. However, many attempts have been made to explore the relationship between depressive symptoms and religious affiliation (e.g., Koenig, Cohen, Blazer, et al., 1992; Koenig, Weiner, Peterson, et al., 1997; Braam, Beekman, Deeg, et al., 1997; Packer, 1997; Bickel, Ciarrocchi, Sheers, et al., 1998); most of these studies suggested that religious coping was a common and important method of dealing with depression. Many of these studies also found that religious coping was inversely associated with depressed states in their samples.

Returning to the present study's results, the mean age of the subjects was 28.06 years, and, as mentioned earlier, 80% of the them found praying a very helpful coping activity for their depressive feelings. This reflects the existential commitment in their belief system, which influences the behavioural, physical, and cognitive aspects of a mood episode. This result is consistent with the hypotheses that women in Dubai tend more to religious behaviour as a coping strategy for depressive feelings.

Domestic work was another common coping activity endorsed among women in Dubai. This finding was not predicted in the hypotheses of the present study. On the contrary, what was expected was that women in Dubai would tend more towards social activities in order to cope with their depressive feelings. This expectation was based on the fact that the majority of families in contemporary Dubai use housemaids for most domestic work, and that most women prefer not to be involved in such work. This finding may therefore provide further evidence that social activities for women in Dubai are still inadequate and

are not well enough organized to attract women, or do not cater for the actual interests of modern women in this society. For example, most of the women's associations in Dubai and the other Emirates concentrate on domestic skills, such as tailoring and cooking (which most of the women could easily learn from other resources), and amateur classes for painting or flower arranging. Many women cannot afford to join the private women's associations, which offer rather different activities.

An alternative explanation for the finding regarding domestic work is that, because depressed people mostly withdraw from social activities, such work is likely to be readily available for much of the time in most ordinary environments. Hence, these activities probably help women to buffer their stresses rather than produce a solution for their problems.

The third common activity was 'have a bath', which is categorized under self-care activities. This activity was the second most common one to be rated as very helpful (at 71% of respondents), after 'praying'. A few studies have found an effect of hydrotherapy on mood (e.g., Wolfersdorf, 1988; Vidart, 1971). Vidart found that the most successful treatment results were obtained with those forms of anxiety that take a concrete form of the neurovegetative variety. Wolfersdorf found that multidimensional treatment strategies, including hydrotherapy, for patients with complex diagnostic and management problems were significantly helpful; the cure rate using such strategies reached 85%.

An explanation for the relationship between decreasing depressive feelings and having a bath could be that this kind of coping activity reflects stressful feelings in women, and

that the water's vibration helps them to relax. This explanation is more acceptable if one considers the stresses that modern women in the UAE experience.

In conclusion, as discussed in the Chapter 2, the meaning of an event to the individual is usually determined by cognitive appraisal processes (according to Lazarus and his colleagues), which in turn affect the coping processes which the individual adopts. The problems of depressed people are not based merely in their cognitive perceptions of their circumstances, but also in their transactions with their environments. When applying this theory to our findings, it seems that the women of the present study appraised their situation as both harmful and probably permanent. Accordingly, their coping appraisal reflected their situation appraisal. In other words, since they cannot change their situation, and cannot therefore use problem-solving activities, they normally turn to emotional discharge responses, as found in the present study.

6.5. Strengths of the Study

Despite the limitations acknowledged above, the results of the present study essentially support the hypotheses. Hence, it is reasonable to include a discussion of its strengths.

This is the first study of depression in women in Dubai to have addressed symptoms, concepts and coping strategies. It is also the first study to look at indigenous individual idioms of distress regarding depression in Dubai. One can therefore state that it is a multi-dimensional study. Most previous research on depression has focused on symptoms (e.g., Chang, 1985; Gada, 1982; Krause & Liang, 1992), on demographic variables and their

association with depression (e.g., Bagley, 1973; Bebbington, Dunn, Jenkins, et al., 1988), on the concept of depression (e.g., Coyne & Lazarus, 1980; Brandt & Boucher, 1986), or on coping strategies (e.g., Coyne, 1982; Billings & Moos, 1984; Folkman, 1984).

This study attempted to examine as many factors that may be involved as possible. It was therefore designed to provide a relatively comprehensive picture of depression-related symptoms, concepts and coping strategies, and of their associations with a number of socio-demographic variables and with the specific cultural context. This design was expected to allow the researcher to indicate what factors alone or together may predict depression, and to provide us with implications for preventive therapy.

Since the study applied case-definition and case-finding methods similar to those of most other studies in this field, it provided data that could be used by researchers from other cultures for comparative purposes; this kind of comparison was in fact performed in the present study between the results from our clinical sample and those from the American clinical sample presented by Beck and Steer (1993).

The present study was also a cross-sectional one, examining symptoms of depression and coping strategies among women of different demographic statuses and with and without depressive symptoms. The focus was on the information which was available at the time the research took place, since it was not possible for this project to adopt a longitudinal perspective because of limitations on time. The recruitment of the samples followed a strict methodology, despite limited appropriate resources from which to derive them. The sampling frame was considered adequate for the nature of the resources offered. As this

study used semi-structured interviews (focus groups) to investigate the concept of depression, a good deal of contextual information was collected. This allows meaningful ratings of verbal expression, ideas, norms, beliefs, and coping behaviours to be made.

6.6. Implications and Future Studies

The data have many implications for the screening and assessment of depression. The results of the principal component analysis and of the receiver operator characteristic curve analysis, and the findings of DDI suggest that the DDI is a suitable instrument for the systematic assessment of depressive symptoms not only for community samples but also for clinical patients. Pilot work with existing standardized scales, such as the BDI and the Minnesota Multiphasic Personality Inventory (MMPI-D), suggested that respondents do not find them readily comprehensible without additional items. The DDI promises to have much screening potential, and would be invaluable in extending the present findings to larger clinical and community populations of both sexes. Furthermore, the instrument would enable indigenous expressions to be explored systematically among the native people of the UAE in general. The further development of the instrument would have much value for a common core research model, and could enable the assessment of those likely to be at risk of psychiatric disorder.

Assessment of the relationship between socio-demographic status and severity of depression also promises to be useful in helping to identify those at high risk of disorder. A major finding in this project regarding this issue was the strong relationship between severity of depression and education, occupation, and socio-economic group. This work

highlights the need for research into the association between demographic variables and depression, in order to take into account other possible causes of symptomatology.

There is a need to assess life events in UAE society, and then to study the role of these life events and their possible interactions with other factors so as to provide an adequate causal explanation of depression in this particular culture.

The present findings may also have implications for psychotherapeutic practices. While attitudinal differences in perceiving mental illness were expected in view of cultural factors, the nature of these differences may explain the difficulties that foreign psychotherapists and counsellors encounter in working with the native people of the UAE. For example, Brown, Stein, Huang, et al. (1973) (cf. Sue, Wagner, Ja, et al., 1976) found that insight-oriented therapy was not very effective with Chinese patients in a Los Angeles psychiatric hospital. Sue, Wagner, Ja, et al. (1976) argued that the ineffectiveness of the approach can perhaps be attributed to beliefs that one should not dwell on morbid or sensitive thoughts, whereas insight-oriented therapies encourage the verbalization of deep emotional conflicts.

This finding could also be applied to the results of the present study. The focus group sessions revealed that the native people of Dubai tend not to discuss their problems and difficulties openly, other than with relatives and friends, in order not to bring attention to their feelings and to protect their families' reputation from the stigma of mental illness. Thus, a therapy which requires dwelling on morbid thoughts and their in-depth analysis may be rejected by these people, or in any case will be rendered ineffective. On the other

hand, therapies which emphasize direct problem-solving techniques, self-help, and the involvement of family and respected friends may be important.

From a theoretical perspective, the implications of this study raise some important issues concerning personal adjustment to and coping strategies for depression. If the women of Dubai believe that the avoidance method of managing one's depressed feelings, as opposed to living with and managing one's depression, is a healthy process, it seems likely that such a belief is encouraged and reinforced by sub-cultural values. Yet the classical psychoanalytic system views these avoidance methods as a repressive process that is detrimental to the well-being of individuals. Are the women of Dubai then more prone to mental disorder? The perspective taken in this study is that the universal application of a particular model of deviance (such as the psychoanalytic model) is inappropriate unless cultural values are considered and appreciated. Our perspective suggests that avoidance methods for managing depressed feelings may represent a culture-based means of handling stressful situations rather than a sign or symptom of deviance. Such methods may also imply that inadequate resources for different methods of coping exist.

The data also clearly suggest that the coping activities used to deal with depressive feelings were connected with emotional discharge, in both depressed and non-depressed women. This is tremendously exciting, as it identifies a mechanism that may operate to impede or promote emotional processing. The data suggest implications for therapeutic intervention, particularly the possible use of attribution style therapy (Layden, 1982) and cognitive style therapy (Beck, Rush, Shaw, et al., 1979).

What cognitive theories in general claim is that the optimal goal of any psychological treatment of depression is to change the negative thoughts which distorted one's view of the self and of the world, usually by replacing them with positive thoughts; and what the present study suggests is that changing negative thoughts may be beneficial if this enables the person to adopt a less self-accusing attributional explanation for stressful events. As noted earlier, the direction of attributional change will depend on individual circumstances, and realistic causal attributions may involve a shift in the direction of greater or lesser personal control (Fosterling, 1985).

With this in mind, it is worth noting that many workers in the field of psychotherapy research are agreed that debriefing sessions are desirable, and that they reduce later morbidity. If this is true, the explanation may be that debriefing sessions expose individuals to information on how others reacted to the same stimuli. This consensus information enables the depressed person to make more realistic causal attributions. Less distress will result if this then prompts the person to attribute behaviour to external and controllable causes. However, it is also possible that debriefing may, depending on individual circumstances, encourage more internal and uncontrollable explanations that would serve to increase the person's psychological distress.

Another theoretical model that may deserve more attention, in the light of the results of the present study, is the reformulated model of learned helplessness (Abramson Seligman, & Teasdale, 1978). The relevance of this model in understanding the aetiology of depression, although it has been discussed by many researchers, remains to be investigated in non-Western cultures such as the UAE's. The results of this study and the

field observations suggest that further research should attempt to investigate the perception of life events in the people of the UAE and how this perception influences the person's behaviour and his or her mental and physical health. They also suggest the value of an investigation into how far the traditional religious views of women in Muslim societies involve learned helplessness.

Cognitive behavioural therapy helps us to understand the habitual errors of reasoning which usually occur with depressed people, as Beck (1991) has indicated. Although the data show that there are some cognitive distortions in the thoughts of depressed women in Dubai, further evidence is clearly needed in order to substantiate these findings. Investigations with a greater emphasis on the cognitive factors among depressed and non-depressed women would initially be desirable.

In addition, further research would be needed to assess the locus of control in the people of the UAE. Is it internal or external? What is the social learning that leads to the way in which people in this society categorize their situations somewhere along the internal-external dimension? What beliefs do the people of the UAE have about their stressed situations? The results of the focus group sessions in the present study highlighted some of these beliefs, which in general concerned social and family life events, and it is hoped that future research will confirm these findings.

From the analyses of socio-demographic variables and the focus group sessions, it appeared that the majority of women in Dubai tend to explain their distressed feelings as being a result of an impairment in their relations with their spouses. The interpersonal

theory emphasizes that social life events and the interpersonal tactics that a person uses to gain and maintain relationships and resolve conflicts, and the nature of these relationships, play a significant role in causing depression. It is clear that the results of the present study are inconsistent in some way with the interpersonal perspective. Future research should therefore attempt to study family functioning among the UAE's people, concentrating on relations between spouses.

In the view of the stress and cognitive appraisal approaches, the present work highlights a need for further development of a more valid and reliable instrument for assessing the personal characteristics and beliefs which influence the appraisal of what could be viewed as stressful situations among the people of the UAE.

Regarding the DDI, which has been developed in the present work, a larger pool of items needs to be developed and tested, in the light of the results of the principal components data. This would involve the exclusion of ambiguous items from the DDI, and inclusion of further items reflecting symptoms that are not included in the present instrument.

The hypothesized association between the social change away from traditional Muslim values and mental illness could be of particular interest to transcultural psychiatry.

6.7. Conclusions

In conclusion, the present work has found that in the society of Dubai there were many stresses for women associated with their family life _such as polygamy, unpredictable divorce, absent fathers too involved in their work and business, and the old traditions and customs, which place a heavy burden on women in particular. At risk are young mothers with large families and single women who have passed the traditional age of marriage, especially if they are from the lower-income groups, and the less educated; these groups also have higher rates of depression.

The psychiatric definitions given in DSM-IV and ICD-10 state that the essential feature of a depressive episode is either a dysphoric mood or loss of interest or pleasure in usual activities and pastimes. These are explicitly stated to be *symptoms* of the mood and not the mood *per se*. The findings of the present study suggest that the crux of the conception of depression among this study's sample was the *loss* (not absence) of positive and affirming feelings. Depression's core meaning seems to be this acute sense of loss, which creates feelings of anxiety, loneliness, and discomfort. The mood is not merely dysphoric, and neither is it merely loss of pleasure. The conception of depression among the people of Dubai which emerged from the semantic analysis was that depression is the affective state of diminished feelings, particularly marked by loss of positive, affirming emotions, where this loss or diminution remains acute.

It appears that it is useful to conceptualize the distribution of depressive symptoms in a community sample as being underpinned by five components or potential causal principles, as it is in the DDI. In addition, it appears that it is appropriate to conceptualize

these syndromes in terms of dimensions rather than categories for this sample, since people can be suffering from different degrees of each form at any one time.

Marsella (1980) has indicated that there is no universal conception of depression. Accordingly, the present study showed that although the people of Dubai do not have terms for depression that are conceptually equivalent to the Western one, there are variants of depressive symptoms similar to those found in Western cultures. The results also illustrated an important point: because the depressive experience is embedded within an entirely different cultural context, it may assume a different meaning and experience and perhaps should not always be labelled as depression.

The rapid socio-cultural changes occurring in UAE society are mostly towards the Western model. However, the traditional culture still strongly affects people's lives in this society B especially women's. The use of an existing standardized instrument, the BDI, in the present study revealed some psychological aspects of depression among women. However, the surprising finding was nature of the five components of the DDI and the items comprising this instrument, which were developed from the indigenous words of the native people of Dubai. The majority of these items reflected psychological aspects of depression rather than somatic symptoms.

Although the people of Dubai expressed their feelings by using somatic terms, they might have done so because somatization in this particular culture may merely indicate the use of somatic metaphors. In the Arabic dialect of the UAE, there are few terms relating to specific mental states. Even the words for depression and anxiety originally connoted a

physical sense of pressure. These words, in general, carry implications of unpleasant physical images that are almost subliminal, although very successful in lending force to the emotional expression. It is therefore worth revising the hypothesized association between Eastern culture and somatization of depression, since it is easy to interpret expressions in an unfamiliar language that are apparently similar to somatic expressions in one's own language as truly somatic and miss the non-somatic metaphorical meanings.

In the classical Arabic language there is a tremendous variety of expressions for the whole range of the psychological, behavioural, emotional, sentimental, cognitive, and other internal human experiences. This can be seen in literature, poetry, philosophy, and the Koran. Hence, any assumptions that the Arabic language does not have words to represent depression are likely to reflect a lack of knowledge of the language, rather than paucity of the language itself.

The results of the present study also underscore the multi-dimensional character of coping activities, each sub-scale having its own phenomenological, psychological, and possibly biological specificity. Description of coping activities provides a better understanding of depressed women's multiple behaviours in response to depressive emotions. The evidence showed that the quality of a person's activity was more important than its quantity in coping with depressive or distressed feelings.

The manifestation of depression among the women of Dubai is strongly determined by the emirate's culture. The concept of depression seems to centre upon an acute sense of anxiety and loneliness. The somatic terms used by the people of Dubai merely reflect the

use of somatic metaphors. Finally, the descriptions of coping strategies used by the women of Dubai provide better knowledge of their behaviours in stressful situations, and also provide mental health clinicians with better ideas about the implications of these activities for the treatment of depression.

It is hoped that the present study does at least answer as many questions as it poses, and that these answers will prove to be of value in guiding further research, and in developing more effective forms of treatment.

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Appendix 1

BDI_____Date:_____

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0,1,2 or 3) next to the one statement in each group which best describes the way you have been feeling the **past week, including today.** If several statements within a group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

(1)
0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it

(2)
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

(3)
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

(4)
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things as much as I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

(5)	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time.

(6)	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.

(7)	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.

(8)	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses, mistakes
	2	I blame myself all the time for my faults.
	3	I blame myself for everything that happens.

(9)	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.

(10)	0	I don't cry any more than usual.
	1	I cry more than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry though I want to.

(11)	0	I am no more irritated now than I ever am.
	1	I get annoyed or irritated more easily than I used to.
	2	I feel irritated all the time now.
	3	I don't get irritated at all by the things that use to irritate me.

(12)	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.

(13)	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.

(14)	0	I don't feel I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.

2 I have greater difficulty in making decisions than before.

3 I can't make decisions at all anymore.

(15) 0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

(16) 0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

(17) 0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired more easily

3 I am too tired to do anything.

(18) 0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now

3 I have no appetite at all anymore.

(19) 0 I haven't lost much weight, if any, lately.

1 I have lost more than 5 pounds.

2 I have lost more than 10 pounds.

3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.

Yes____ No ____

(20) 0 I am no more worried about my health than usual.

1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am worried about my physical problems that I cannot think about anything else.

(21) 0 I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.

3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____

_____ Total Score

Appendix 2

THE GENERAL HEALTH QUESTIONNAIRE

GHQ28

David Goldberg

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 you cooperation.

Have you recently

A1 - been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2 - been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3 - been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4 - felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5 - been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual

A6 - 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
A7 - been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual

---

B1 - lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2 - had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3 - felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4 - been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5 - been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6 - found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7 - been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

---

C1 - been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather more than usual	Much more than usual
C2 - been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3 - felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4 - been satisfied with the way you've carried out you task?	More satisfied	About same as usual	Less satisfied than usual	Much less well

C5 - felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6 - felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7 - been able to enjoy your normal day-by-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual

---

D1 - been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2 - felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3 - felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4 - thought of the possibility that you might make away with yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
D5 - found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6 - found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7 - found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A	B	C	D

TOTAL

Appendix 3

ANTIDEPRESSIVE ACTIVITY QUESTIONNAIRE (AAQ)

This is a questionnaire to find out what people do when they are feeling depressed. It is an inventory of preferred activities; there are no right or wrong answers. Below is a list of some things which people have said they do when they are feeling low. Please read through the list and circle the numbers of the items that describe things that you do when you feel depressed. Then go through the questionnaire again and put a tick in the columns that apply to how frequently you use the methods whose numbers you have circled and to how helpful you usually find them.

If any method that you usually use is not on the list, please add it in the space provided on the last page of the questionnaire and tick the appropriate frequency and helpfulness columns.

All information on this questionnaire is strictly confidential.

THANK YOU FOR YOUR HELP.

AGE _____ SEX _____ OCCUPATION _____ MARRIED / SINGLE _____ / DIVORCED

ACTIVITIES	FREQUENCY				HELPFULNESS	
	rarely	some-times	quite often	not very	moderately	very
1 Keep busy						
2 Do something I enjoy						
3 Give myself a treat						
4 Do something to take my mind off it.						
5 Do something I can get engrossed in.						
6 Stick to my normal routine.						
7 Do something constructive						

8 Do something physical.

9 Do something vigorous

10 Go for a walk

11 Go for a drive or bicycle ride

12 Engage in sport

13 Help out or care for someone

14 Work

15 Write letters

16 Do something not requiring much concentration

17 Work hard

18 Do housework

19 Cleaning or tidying

20 Cooking or baking

21 Laundry or mending

22 Sew, knit, crochet

23 Go shopping

24 Buy clothes

25 Buy something nice

26 Change activities or take a break

27 Have a change of scene

28 Take a rest

29 Take a holiday

30 Play a game (cards, chess, etc.)

31 Play with children or watch them playing

32 Play with or care for a pet

33 Have a bath

34 Wash my hair or have it done

35 Have something to eat

36 Eat something sweet

37 Go to bed

38 Take a nap

39 Have sex

40 Have physical contact

41 Take antidepressants

42 Take tranquillizers

43 Take sleeping tablets

44 Take aspirin or other pain-killer

45 Take recreational drugs

46 Take vitamins or tonics

47 Have a drink on my own

48 Have a drink with people

49 Smoke (tobacco)

50 Have coffee or tea

51 Try to find out what is making me depressed

52 Do something about whatever is making me depressed

53 Remind myself it won't last

54 Think about something else

55 Talk myself out of it

56 Find something to laugh about

57 Have a good cry

58 Get angry about something

59 Take my feelings out on something

60 Wallow in feeling depressed

61 Plan something for the future

62 Get out of the house, go out

63 See a film on my own

64 See a film with someone or with friends

65 Watch television

66 Listen to the radio

67 Listen to music or records

68 Read a serious book

69 Read a light or romantic novel or thriller

70 Read a newspaper, journal of magazine

71 Paint, draw, or sculpt

72 Play a musical instrument

73 Write something

74 Visit a museum or gallery

75 Go out of doors, to garden, park or the country

76 Find peace & quiet

77 See a friend or friends

78 Ring someone up

79 Have a meal with people

80 Invite people over

81 Go out with people or to a party

82 Find out where I stand with someone or with people

83 Find out how I compare to other people

84 Get moral support, sympathy or reassurance

85 Talk to someone about how I'm feeling

86 Talk to someone about something else

87 Talk to someone about their problems

88 See my doctor

89 See my psychiatrist

90 See my psychologist

91 See some other professional helper

92 Take comfort in my religion

93 Go to church or chapel

94 Pray

95 Try to get my situation into perspective

96 Read about depression

and how to cure it

97 Crawl away on my own

98 Avoid things I know
are likely to make
me feel worse

99 Find out how other
people cope

100 Try to act as if I
weren't feeling
depressed

USE THIS SPACE TO ADD ANY TECHNIQUES WHICH YOU USUALLY USE AND WHICH ARE NOT GIVEN ON THIS LIST.

Appendix 4

Field Note Reporting Form

Information About the Focus Group

Date of Focus Group	
Location of Focus Group	
Number and Description of Participants	
Moderator Name / Phone Number	

Responses to Questions

Q1. Do you know individuals in the community matching this descriptions?

Brief Summary / Key Points	Notable Quotes

Q2. What kind of symptoms did he/she have?

Brief Summary / Key Points	Notable Quotes

Q3. Do you think there is a problem? If so, what do you call it?

Brief Summary / Key Points	Notable Quotes

Q4. What do you think the causes of his/her illness or problems?

Brief Summary / Key Points	Notable Quotes

Q5. Is there anything that can be done about it? Who should do it?

Brief Summary / Key Points	Notable Quotes

Q6. Do you think this disorder will get worse? To what extent?

Brief Summary / Key Points	Notable Quotes

Q7. Do you think this disorder is harmful to the individual, his/her family, and the community? How?

Brief Summary / Key Points	Notable Quotes

Q8. Do you think this disorder will impair the chances of marriage, or the continuation of an existing marriage?

Brief Summary / Key Points	Notable Quotes

Q9. Do you think that the individual will provoke problems at home during his/her illness?

Brief Summary / Key Points	Notable Quotes

Q10. How much do you think the individual will be capable of work or study?

Brief Summary / Key Points	Notable Quotes

Appendix 5

Antidepressive Activity Questionnaire items endorsed, often done, and very helpful mentioned by all (*n*=100) subjects

AAQ items	Endorsed	Often done	Very helpful
1- Keep busy.	69*	17 (25)	18 (26)
2- Do something I enjoy.	60*	36 (60)	24 (40)
3- Give myself a treat.	54*	18 (33)	30 (56)
4- Do something to take my mind off it.	60*	21 (35)	15 (25)
5- Do something I can get engrossed in.	51*	18 (35)	15 (29)
6- Stick to my normal routine.	66*	42 (64)	30 (45)
7- Do something constructive.	42	12 (29)	7(21)
8- Do something physical.	45	9 (20)	15(33)
9- Do something vigorous.	36	12 (33)	6(17)
10- Go for walk.	51*	12 (24)	21 (41)
11- Go for drive.	36	0 (---)	3(08)
12- Engage in sport.	39	3 (08)	0(---)
13- Help out or care for someone.	39	6 (15)	12(31)
14- Work.	42	15 (36)	9(21)
15- Write letters.	30	6 (20)	6(20)
16- Do something not requiring much concentration.	39	3 (08)	3(08)
17- Work hard.	45	9 (20)	6(13)
18- Do housework.	66*	42 (64)	36 (55)
19- Cleaning or tidying.	63*	39 (62)	39 (62)
20- Cooking or baking.	57*	18 (32)	15 (26)
21- Laundry or mending.	36	12 (33)	12 (32)
22- Sew, knit, crochet.	30	6 (20)	6(20)
23- Go shopping.	63*	12 (19)	9 (14)
24- Buy clothes.	45	9 (20)	15(33)
25- Buy something nice.	45	15 (33)	24(53)
26- Change activities or take a break.	30	0 (---)	9(30)
27- Have a change of scene.	42	15 (36)	15(36)
28- Take a rest.	54*	15 (28)	21 (39)
29- Take a holiday.	30	3 (10)	3(10)
30- Play a game (cards, chess, etc.).	30	3 (10)	3(10)
31- Play with children or watch them playing.	51*	18 (35)	30 (59)
32- Play with or care for a pet.	24	3 (13)	3(13)

33- Have a bath.	51*	33 (65)	36 (71)
34- Wash my hair or have it done.	39	15 (39)	18(46)
35- Have something to eat.	48	24 (50)	15(31)
36- Eat something sweet.	33	18 (55)	12(36)
37- Go to bed.	57*	18 (32)	18 (32)
38- Take a nap.	45	3 (07)	6(13)
39- Have sex.	15	0 (---)	0(---)
40- Have physical contact.	12	3 (25)	3(25)
41- Take antidepressants.	24	0 (---)	0(---)
42- Take tranquillizerers.	24	0 (---)	0(---)
43- Take sleeping tablets.	21	3 (14)	6(29)
44- Take aspirin or other pain killer.	27	3 (11)	4(11)
45- Take recreational drugs.	21	3 (14)	0(---)
46- Take vitamins or tonics.	24	3 (13)	0(---)
47- Have a drink on my own.	02	0 (---)	0(---)
48- Have a drink with people.	01	0 (---)	0(---)
49- Smoke (tobacco).	03	1 (33)	0(---)
50- Have coffee or tea.	45	21 (47)	12(27)
51- Try to find out what is making me depressed.	45	30 (67)	21(47)
52- Do something about whatever is making me depressed.	27	0 (---)	6(22)
53- Remind myself it won't last.	48	15 (31)	18(38)
54- Think about something else.	48	12 (25)	18(38)
55- Talk myself out of it.	42	18 (43)	15(36)
56- Find something to laugh about.	36	12 (33)	12(36)
57- Have a good cry.	45	18 (40)	18(40)
58- Get angry about something.	27	15 (56)	9(33)
59- Take my feelings out on something.	21	0 (---)	6(29)
60- Wallow in feeling depressed.	15	3 (20)	6(40)
61- Plan something for the future.	30	12 (40)	15(50)
62- Get out of the house, go out.	39	15 (39)	6(15)
63- See a film on my own.	30	9 (30)	6(20)
64- See a film with someone or with friends	39	12 (31)	9(23)
65- Watch television.	48	12 (25)	9(19)
66- Listen to the radio.	39	18 (46)	15(39)
67- Listen to music or records.	36	18 (50)	15(42)
68- Read a serious book.	33	6 (18)	15(45)
69- Read a light or romantic novel or thriller.	30	12 (40)	15(50)
70- Read a newspaper, journal or magazine.	48	15 (31)	18(38)
71- Paint, draw, or sculpt.	21	12 (57)	9(43)
72- Play a musical instrument.	18	3 (17)	3(17)
73- Write something.	30	9 (30)	9(30)

74- Visit a museum or gallery.	21	3 (14)	0(---)
75- Go out of doors, to garden, park, or the country.	27	15 (56)	15(56)
76- Find peace and quiet.	45	27 (60)	26(59)
77- See a friend or friends.	51*	24 (47)	30(59)
78- Ring someone up.	60*	21 (35)	24(40)
79- Have a meal with people.	39	0 (---)	3(08)
80- Invite people over.	33	12 (36)	15(46)
81- Go out with people or to a party.	33	12 (36)	12(36)
82- Find out where I stand with someone or with people.	21	9 (43)	6(29)
83- Find out how I compare to other people.	27	6 (22)	3(11)
84- Get moral support, sympathy or reassurance.	33	6 (18)	6(18)
85- Talk to someone about how I'm feeling.	42	15 (36)	18(43)
86- Talk to someone about something else.	24	6 (25)	6(25)
87- Talk to someone about their problems.	36	6 (17)	9(25)
88- See my doctor.	27	6 (22)	6(22)
89- See my psychiatrist.	18	6 (33)	3(17)
90- See my psychologist.	18	6 (33)	3(17)
91- See some other professional helper.	18	3 (17)	0(---)
92- Take comfort in my religion.	60*	36 (60)	36(60)
93- Go to mosque.	33	12 (36)	15(46)
94- Pray.	75*	48 (64)	60(80)
95- Try to get my situation into perspective.	24	3 (13)	3(13)
96- Read about depression and how to cure it.	21	6 (29)	3(14)
97- Crawl away on my own.	33	6 (18)	18(55)
98- Avoid things I know are likely to make me feel worse.	27	12 (44)	15(56)
99- Find out how other people cope.	18	6 (33)	3(17)
100- Try to act as if I weren't feeling depressed.	39	9 (23)	12(31)

*** Endorsed by more than 50% of the subjects.**

Values in parentheses are percentages.

Appendix.6.

مقياس «د» "D"

التاريخ: / / ١٩

الاســـــــــم:

العمر وتاريخ الميلاد:

الجنـــــــــس:

الجنســـــــيـة:

الحالة الاجتمـاعيـة:

المســتوى التعليمي:

المهنـــــــــة:

الـــــديـــــن:

الطـــــــــول:

الـــــــــوزن:

عـــدد الإخـــوة والأخـــوات:

ذكـــور: ..... إنـــاث: .....

ترتيـــك بينهـــم: .....

* * *

بيـــــان الدرجات:

		الدرجة الخام	الدرجة التائية
المقياس « ل »	المقيـاس « د »		

تعليمات الاختبار

يتكون هذا الاختبار من عدة (عبارات). إقرأ كل عبارة وقرر ما إذا كانت تنطبق عليك أم لا. فإذا كانت تنطبق عليك ولو على وجه التقريب فضع إشارة × أمام كلمة (نعم).

أما إذا كانت لا تنطبق عليك فضع إشارة x أمام كلمة (لا).

وتأكد أن كل إجاباتك سوف تعامل معاملة سرية تامة، ولن يسمح لأحد بالاطلاع عليها. وحاول أن تكون صريحاً وصادقاً في استجاباتك واعلم أنه لا يوجد خطأ أو صواب في الإجابة وإنما المسألة هي أن تعبر عن فكرتك أنت عن نفسك ولا تترك أي سؤال دون إجابة إذا أمكنك هذا.

لا تهتم بالأرقام أو العلامات المدونة قبل كل عبارة.

		نعم	لا
٢ ـ	شهيتي للطعام جيدة	☐	☐
٥ ـ	من السهل أن توقظني الأصوات من نومي	☐	☐
٨ ـ	حياتي اليومية مليئة بما يثير اهتمامي	☐	☐
٩ ـ	قدرتي على العمل لم تتغير عما كانت عليه من قبل	☐	☐
١٥ ـ ل	أفكر من حين لآخر في أشياء هي من القبح بحيث لا يمكن التحدث فيها	☐	☐
١٨ ـ	قليلاً ما أصاب بالإمساك	☐	☐
٣٠ ـ ل	أشعر أحيانا برغبة في السب	☐	☐
٣٠ ـ	أشعر أحيانا برغبة في السب	☐	☐
٣٢ ـ	أجد صعوبة في أن أركز ذهني في عمل أو مهمة	☐	☐
٣٦ ـ	قليلاً ما ينتابني القلق على صحتي	☐	☐
٣٩ ـ	أشعر أحيانا برغبة في تحطيم الأشياء	☐	☐
٤١ ـ	أفضل في جميع الأوقات أن أجلس وأسترسل في أحلام اليقظة على أن أقوم بأي عمل آخر	☐	☐
٤٢ ـ	نومي مضطرب وقلق	☐	☐

		نعم	لا
٤٥ ـ ل	لا أقول الصدق دائماً		
٤٦ ـ	حكمي على الأمور الآن أفضل منه في أي وقت مضى		
٥١ ـ	صحتي الجسمية كصحة معظم أصدقائي في الجودة		
٥٢ ـ	أفضل أن أتجاهل أصدقاء المدرسة أو المعارف الذين لم أرهم منذ مدة طويلة، إلا إذا بادروني هم بالكلام.		
٥٧ ـ	إنني سهل الاختلاط بالناس		
٥٨ ـ	أعتقد أن كل شيء يحدث وفقاً لما ذكره الأنبياء والرسل		
٦٠ ـ	لا أقرأ كل مقال افتتاحي في الجريدة اليومية		
٦٤ ـ	أثابر أحيانا على القيام بعمل ما الى أن يفقد الآخرون صبرهم معي		
٦٧ ـ	أتمنى لو كنت سعيداً كما يبدو الآخرون		
٧٥ ـ ل	ينتابني الغضب أحياناً		
٨٠ ـ	أعاكس الحيونات أحياناً		
٨٦ ـ	من المؤكد انني قليل الثقة بنفسي		
٨٨ ـ	أشعر عموماً أن الحياة لها قيمة		
٨٩ ـ	إقناع الناس بالصواب يتطلب مجهوداً كبيراً		
٩٠ ـ ل	أؤجل إلى الغد في بعض الأحيان ما يجب أن أعمله اليوم		
٩٥ ـ	أتردد على المساجد كل أسبوع تقريباً		
٩٨ ـ	أعتقد في مجيء المهدي المنتظر أو عودة عيسى عليه السلام		
١٠٤ ـ	يبدو أنني لا أهتم بما حدث لي		
١٠٥ ـ ل	يضايقني أحيانا أن تسوء صحتي		
١٠٧ ـ	أشعر بالسعادة في معظم الأوقات		
١٢٠ ـ ل	لا أهتم بمراعاة آداب المائدة في منزلي كما أهتم بمراعاتها خارج المنزل.		

١٢٢ـ	يبدو أنني لست أقل نباهة أو قدرة عن معظم الناس المحيطين بي	نعم ☐ لا ☐
١٣٠ـ	لم يحدث أن تقيأت دماً أو سعلت دماً	نعم ☐ لا ☐
١٣١ـ	لا تقلقني فكرة الإصابة بالمرض	نعم ☐ لا ☐
١٣٥ـل	من الجائز أن أدخل الملعب لمشاهدة المباراة دون أن أدفع ثمن التذكرة إذا تأكدت أن أحداً لن يراني	نعم ☐ لا ☐
١٣٨ـ	النقد أو اللوم يجرحان شعوري إلى حد كبير	نعم ☐ لا ☐
١٤٢ـ	أشعر شعوراً قوياً في بعض الأحيان أنني عديم الفائدة	نعم ☐ لا ☐
١٤٥ـ	أشعر أحيانا برغبة في الاشتباك بالأيدي مع أي شخص	نعم ☐ لا ☐
١٥٠ـل	أفضل الكسب على الخسارة في اللعب	نعم ☐ لا ☐
١٥٢ـ	أنام في معظم الليالي دون أن تضايقني الأفكار	نعم ☐ لا ☐
١٥٣ـ	كانت صحتي في خلال السنوات القليلة الماضية جيدة على وجه العموم	نعم ☐ لا ☐
١٥٤ـ	لم أصب مطلقاً بأية نوبة	نعم ☐ لا ☐
١٥٥ـ	وزني لا يزيد ولا ينقص	نعم ☐ لا ☐
١٥٨ـ	أبكي بسهولة	نعم ☐ لا ☐
١٥٩ـ	لم أعد أفهم ما أقرأ بنفس الدرجة التي كنت أفهم بها سابقاً	نعم ☐ لا ☐
١٦٠ـ	لم أشعر في يوم من الأيام بأنني أحسن مما أنا عليه الآن	نعم ☐ لا ☐
١٦٥ـل	أحب أن أتعرف على الناس المهمين لأن ذلك يشعرني بالأهمية	نعم ☐ لا ☐
١٧٨ـ	يبدو أن ذاكرتي لا بأس بها	نعم ☐ لا ☐
١٨٢ـ	أخشى أن يطير صوابي	نعم ☐ لا ☐
١٨٩ـ	أشعر في معظم الأوقات بضعف عام	نعم ☐ لا ☐
١٩١ـ	إنني أتصبب عرقاً عندما أحرج في بعض الأحيان	نعم ☐ لا ☐
١٩٣ـ	لا أشكو من نوبات الربو أو نوبات الزكام	نعم ☐ لا ☐
١٩٥ـل	ليس كل من أعرفه أحبه	نعم ☐ لا ☐

٢٠٧ـ	أجد متعة في أنواع كثيرة من الألعاب ووسائل الترويح	نعم ☐ لا ☐
٢٠٨ـ	أحب أن أغازل الجنس الآخر	نعم ☐ لا ☐
٢٢٥ـل	أحب أن أدردش قليلاً من حين لآخر	نعم ☐ لا ☐
٢٣٣ـ	أحيانا ما اعترضت طريق بعض الناس ومنعتهم من القيام بأعمال معينة لا لشيء إلا المبدأ.	نعم ☐ لا ☐
٢٣٦ـ	كثيراً ما أستغرق في التفكير.	نعم ☐ لا ☐
٢٤١ـ	أحلم عادة بأشياء أفضل أن احتفظ بها لنفسي	نعم ☐ لا ☐
٢٤٢ـ	لست عصبياً بدرجة أكبر مما عليه معظم الناس	نعم ☐ لا ☐
٢٤٨ـ	أحياناً أشعر بسعادة وانشراح عظيمين بدون أي سبب، بل وعندما تكون الأمور سائرة على غير ما أشتهي	نعم ☐ لا ☐
٢٥٥ـل	أحيانا قد يحدث أن أعطي صوتي لأشخاص لا أعرف عنهم إلا القليل	نعم ☐ لا ☐
٢٥٩ـ	أجد أن من الصعب عليَّ أن أبدأ عملاً من الأعمال	نعم ☐ لا ☐
٢٦٣ـ	أعرق بسهولة حتى في الجو البارد	نعم ☐ لا ☐
٢٧٠ـ	عندما أغادر المنزل لا ينتابني الضيق أو الشك في أن أكون قد تركت النوافذ مفتوحة أو الباب غير مغلق.	نعم ☐ لا ☐
٢٧١ـ	أنني لا ألوم أي شخص يستغل من يعرض نفسه للاستغلال	نعم ☐ لا ☐
٢٧٢ـ	أشعر في بعض الأحيان أنني مملوء نشاطاً	نعم ☐ لا ☐
٢٨٥ـ	أضحك أحياناً من النكت التي قد تخرج عن حدود اللياقة	نعم ☐ لا ☐
٢٨٨ـ	تزعجني نوبات من الإغماء والقيء	نعم ☐ لا ☐
٢٩٠ـ	إنني أعمل تحت توتر عصبي عنيف	نعم ☐ لا ☐
٢٩٦ـ	تمر علي فترات أشعر فيها بانشراح دون ما سبب ظاهر	نعم ☐ لا ☐
٢٨٥ـل	أضحك أحيانا من النكت التي قد تخرج عن حدود اللياقة.	نعم ☐ لا ☐

Appendix.7.

مقياس «بيك» "BDI"

التاريخ: / / ١٩

الإســـــــم: .....

العمر وتاريخ الميلاد: .....

الجنـــــــس: .....

الجنســـــيـــة: .....

الحالة الاجتمـاعيـة: .....

المســـتوى التعليمي: .....

المهنـــــــة: .....

الـــديـــــن: .....

الطـــــــول: .....

الـــــــوزن: .....

عـددالإخـــوةوالأخـــوات:

ذكـــور: ..... إنـــاث: .....

ترتيـــك بينهـــم: .....

* * *

يضم هذا الاستطلاع عدة مجموعات من العبارات. الرجاء قراءة كل مجموعة بدقة، ثم اختر من كل مجموعة العبارة الأصدق وصفاً لإحساسك على مدى **الأسبوع الماضي بما في ذلك اليوم**!

ضع دائرة حول رقم العبارة التي اخترتها. إذا كان هناك أكثر من عبارة في المجموعة الواحدة تصدق عليك بنفس القدر، ضع دائرة حول كل منها. **تأكد من قراءة جميع العبارات في كل مجموعة قبل أن تحدد اختيارك.**

(١) ٠ ـ لا أشعر بالحزن.

١ ـ أشعر بالحزن

٢ ـ أشعر بالحزن طوال الوقت ولا أستطيع أن أتخلص منه.

٣ ـ أشعر بالحزن الشديد أو التعاسة الشديدة حتى أنني لا أستطيع التحمل.

(٢) ٠ ـ لست يائساً على نحو معين من المستقبل.

١ ـ أشعر باليأس من المستقبل.

٢ ـ أشعر أنه ليس لديَّ ما أتطلع إليه.

٣ ـ أشعر أن المستقبل لا أمل فيه وأن الأمور لا يمكن أن تتحسن.

(٣) ٠ ـ لا أشعر أنني فاشل.

١ ـ أشعر أنني أكثر فشلاً من الشخص العادي.

٢ ـ عندما أنظر إلى حياتي الماضية، كل ما أستطيع أن أراه الكثير من الفشل.

٣ ـ أشعر أنني فاشل تماماً كشخص.

(٤) ٠ ـ يتحقق رضائي عن الأشياء كما اعتدت أن أفعل.

١ ـ لا أستمتع بالأشياء كما اعتدتُ أن أستمتع من قبل.

٢ ـ لم أعد أشعر بالرضاء الحقيقي عن أي شيء يحدث.

٣ ـ أشعر بعدم الرضا أو بالضجر من كل شيء.

(٥) ٠ ـ لا أشعر بالذنب على نحو معين

١ ـ أشعر بالذنب لفترة طويلة من الزمن.

٢ ـ أشعر بالذنب الشديد أغلب الوقت.

٣ ـ أشعر بالذنب طوال الوقت.

(٦) ٠ ـ أشعر أنني لا أُعاقَبْ.

١ ـ أشعر أنني يمكن أن أُعاقَبْ.

٢ ـ أتوقع أن أُعاقَبْ.

٣ ـ أشعر أنني أُعاقَبْ.

(٧) ٠ ـ لا أشعر بخيبة الأمل في نفسي.

١ ـ لقد خاب أملي في نفسي.

٢ ـ أشعر بالتقزز من نفسي.

٣ ـ إنني أكره نفسي.

(٨) ٠ ـ لا أشعر أنني أكثر سوءاً من أي شخص آخر..

١ ـ أوجّه النقد لنفسي عن نقاط ضعفي أو أخطائي.

٢ ـ أوجّه اللوم لنفسي طوال الوقت عن أخطائي.

٣ ـ أوجّه اللوم لنفسي عن كل خطأ يحدث.

(٩) ٠ ـ لا أفكر مطلقاً في قتل نفسي.

١ ـ أفكر في قتل نفسي، ولكنني لا أخرج ذلك إلى حيز التنفيذ.

٢ ـ أود أن أقتل نفسي.

٣ ـ من الممكن أن أقتل نفسي، لو أُتيحت لي الفرصة.

(١٠) ٠ ـ لا أبكي الآن أكثر من المعتاد.

١ ـ أبكي الآن أكثر مما اعتدتُ.

٢ ـ أبكي الآن طوال الوقت.

٣ ـ اعتدتُ أن أكون قادراً على البكاء، ولكنني الآن لا أستطيع حتى إن أردت أن أبكي.

(١١) ٠ ـ لم يعد يستثار غضبي حالياً أكثر من أي وقت مضى.

١ ـ أصبحت أشعر بالضيق أو الغضب بسهولة أكثر مما اعتدتُ.

٢ ـ أشعر حالياً بالغضب طوال الوقت.

٣ ـ لا تثير غضبي مطلقاً في الوقت الحالي الأشياء التي كانت من المعتاد أن تغضبني.

(١٢) ٠ ـ لم أفقد اهتمامي بالآخريـن.

١ ـ أصبحت أقل اهتماماً بالآخرين أكثر مما اعتدتُ.

٢ ـ فقدت أغلب اهتمامي بالآخرين.

٣ ـ فقدت كل اهتمامي بالآخرين.

(١٣) ٠ ـ أتخذ قراراتي على نحو صائب كما كنت أفعل.

١ ـ أصبحت أرجىء اتخاذ قرارتي أكثر مما اعتدتُ أن أفعل.

٢ ـ أصبح من الصعب عليَّ اتخاذ القرارات أكثر من ذي قبل.

٣ ـ لم أعد أستطيع اتخاذ القرارت مطلقاً.

(١٤) ٠ ـ لا أشعر انني أبدو أكثر سوءاً مما اعتدتُ أن أبدو.

١ ـ أشعر بالقلق لأنني أبدو أكبر سناً أو غير جذاب.

٢ ـ أشعر أن هناك تغيرات دائمة طرأت على مظهري جعلتني أبدو غير جذاب.

٣ ـ أعتقد أنني أبدو قبيحاً.

(١٥) ٠ ـ أستطيع القيام بعملي بصورة جيدة كالسابق.

١ ـ احتاج إلى جهد إضافي لأبدأ القيام بعمل ما.

٢ ـ يتعين عليَّ أن أدفع نفسي بقوة شديدة للقيام بأي عمل.

٣ ـ لا أستطيع القيام بأي عمل مطلقاً.

(١٦) ٠ ـ أستطيع النوم بشكل جيد كالمعتاد.

١ ـ لا أنام بشكل جيد كما اعتدتُ.

٢ ـ أستيقظ مبكراً ساعة أو ساعتين عن المعتاد، وأجد مشقة في أن أعاود النوم.

٣ ـ أستيقظ مبكراً عدة ساعات عما اعتدتُ، ولا أستطيع أن أعاود النوم.

(١٧) ٠ ـ لا أشعر بالتعب الآن أكثر من المعتاد.

١ ـ أصبحت أشعر بالتعب بسهولة أكثر من المعتاد.

٢ ـ أصبحت أشعر بالتعب من القيام بأي شيء تقريباً.

٣ ـ أصبحتُ متعباً تماماً حتى أنني لا أستطيع أن أفعل أي شيء.

(١٨) ٠ ـ شهيتي ليست أسوأ من المعتاد.

١ ـ شهيتي ليست جيدة كما كانت.

٢ ـ أصبحت شهيتي أسوأ الآن.

٣ ـ لم تعد لدي شهية على الإطلاق.

(١٩) ٠ ـ لم أفقد كثيراً من وزني، هذا إذا كنت فقدتُ أي وزن مؤخراً.

١ ـ لقد فقدتُ أكثر من ٢ كيلو.

٢ ـ لقد فقدتُ أكثر من ٥ كيلو.

٣ ـ لقد فقدتُ أكثر من ٧ كيلو.

ـ إنني أحاول إنقاص وزني بتناول طعام أقل.

نعم لا

(٢٠) ٠ ـ لا أشعر بالقلق على صحتي أكثر من ذي قبل.

١ ـ أصبحتُ أشعر بالقلق على ما يصيب بدني من أوجاع أو آلام أو اضطراب في المعدة أو إمساك.

٢ ـ أصبحت أشعر بالقلق الشديد على ما يصيب بدني من مشكلات، ويصعب عليَّ التفكير في أي شيء آخر.

٣ ـ أصبحت أشعر بالقلق الشديد على ما يصيب بدني من مشكلات، ولا أستطيع التفكير في أي شيء آخر.

(٢١) ٠ ـ لم ألحظ أي تغيير حدث مؤخراً في اهتمامي بالجنس.

١ ـ أصبحت أقل اهتماماً بالجنس عما اعتدت عليه.

٢ ـ أصبحت الآن أقل اهتماماً بالجنس بدرجة كبيرة.

٣ ـ لقد فقدتُ اهتمامي بالجنس تماماً.

Appendix.8.

بيانات أولية

العمر : _____

الحالة الاجتماعية : _____

إذا كنت متزوجة أو مطلقة أو أرملة هل أنت (كنت) :

☐ الزوجة الوحيدة ☐ الزوجة الأولى

☐ الزوجة الثانية ☐ الزوجة الثالثة

☐ الزوجة الرابعة

عدد الأبناء : _____

المستوى التعليمي : _____

الوظيفة : _____

منطقة السكن : _____

نوع المسكن :

☐ ملك ☐ منحة ☐ إيجار

مستوى الدخل الأسري (شهريا) :

☐ أقل من ٥٠٠٠ ☐ من ٥٠٠٠ إلى ٨٠٠٠

☐ من ٨٠٠٠ إلى ١٢٠٠٠ ☐ من ١٢٠٠٠ فأكثر

عدد أفراد الأسرة : _____

استبيان الصحة العامة

الرجاء قراءة ما يلي بعناية

نود أن نعرف ما إذا كنت قد عانيت من مشكلات صحية ، وكيف كانت صحتك بصفة عامة على مدى الأسابيع القليلة الماضية . نرجو الإجابة على جميع الأسئلة التالية بأن تضع مجرد خط تحت الإجابة التي تكون أكثر انطباقاً عليك. وتذكر أن ما نريد أن نعرفه هو المشكلات الحالية أو التي حدثت مؤخراً ، لا تلك التي حدثت في الماضي .

من المهم أن تحاول الإجابة على كافة الأسئلة .

شكراً جزيلاً على تعاونكم،،،

هل حدث لي الآونة الأخيرة أن :

أ١ – كنت تشعر أنك بحالة طيبة وبصحة جيدة تماماً ؟		أفضل من المعتاد	تماماً كالمعتاد	أسوأ من المعتاد	أسوأ كثيرا من المعتاد
أ٢ – كنت تشعر أنك في حاجة إلى منشط قوي ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
أ٣ – كنت تشعر أنك متعب ومنحرف المزاج ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
أ٤ – شعرت أنك مريض ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
أ٥ – كنت تشعر بأي آلام في رأسك ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
أ٦ – كنت تشعر أن رأسك متوتر أو مجهد ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
أ٧ – كانت تنتابك نوبات تشعر خلالها بارتفاع أو انخفاض لدرجة حرارتك؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد

هل حدث لي الآونة الأخيرة أن :

ب ١ – انخفضت ساعات نومك بسبب القلق؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
ب ٢ – صادفت صعوبة في البقاء نائماً عندما تكون في وقت الراحة ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد

ب ٣ – كنت تعاني من الشد العصبي على الدوام؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
ب ٤ – كان ينتابك الغضب الشديد أو النرفزة ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
ب ٥ – كنت تصاب بالرعب أو الفزع بدون سبب معقول ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
ب ٦ – كنت تجد أن كل شيء يتجمع فوق رأسك؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
ب ٧ – كنت تشعر بالعصبية والتوتر طوال الوقت ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد

هل حدث في الآونة الأخيرة أن :

جـ ١ – كنت تتعمد أن تظل مشغولا أو منهمكاً ؟	أكثر من المعتاد	تماماً كالمعتاد	أقل قليلاً من المعتاد	أقل كثيراً من المعتاد
جـ ٢ – كنت تستغرق وقتاً فيما كنت تقوم به من أعمال؟	أسرع من المعتاد	تماماً كالمعتاد	أطول من المعتاد	أطول كثيراً من المعتاد
جـ ٣ – كنت تشعر بشكل عام أنك تنجز ما تقوم به من أعمال بصورة طيبة؟	أفضل من المعتاد	تقريباً كالمعتاد	أقل من المعتاد	أقل كثيراً من المعتاد
جـ ٤ – كنت تشعر بالرضا عن الأسلوب الذي انتهجته في أداء واجباتك؟	أكثر رضاً	تقريباً كالمعتاد	أقل من المعتاد	أقل كثيراً من المعتاد
جـ ٥ – شعرت أنك تؤدي دوراً مفيداً في مجريات الأمور؟	أكثر من المعتاد	تماماً كالمعتاد	أقل قليلاً من المعتاد	أقل كثيراً من المعتاد
جـ ٦ – شعرت أنك قادر على اتخاذ القرارات في مواجهة الأحداث ؟	أكثر من المعتاد	تماماً كالمعتاد	أقل قليلاً من المعتاد	أقل كثيراً من المعتاد
جـ ٧ – شعرت أنك قادر على الاستمتاع بأنشطتك اليومية العادية؟	أكثر من المعتاد	تماماً كالمعتاد	أقل قليلاً من المعتاد	أقل كثيراً من المعتاد

هل حدث في الآونة الأخيرة أن :

د ١ – كنت تنظر إلى نفسك على أنك شخص لاقيمة له ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
د٢ – شعرت أن الحياة كلها لا أمل فيها ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
د٣ – شعرت أن الحياة ليست جديرة بأن نحياها ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
د٤ – فكرت في إمكانية التخلص من حياتك ؟	بالتأكيد لا	لا أعتقد ذلك	مرت بخاطري	بالتأكيد نعم.
د٥ – وجدت نفسك في بعض الأحيان لا تستطيع أن تفعل شيئاً بسبب توتر أعصابك الشديد ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
د٦ – تمنيت أن لو كنت ميتاً وتركت الدنيا كلها ؟	لا مطلقاً	ليس أكثر من المعتاد	أكثر قليلاً من المعتاد	أكثر كثيراً من المعتاد
د٧ – وجدت أن فكرة التخلص من حياتك لا تفارق مخيلتك؟	بالتأكيد لا	لا أعتقد ذلك	مرت بخاطري	بالتأكيد نعم

أ ☐ ب ☐ ج ☐ د ☐ الإجمالي ☐

Appendix.9.

بيانات أولية

العمر : _____

الحالة الاجتماعية : _____

إذا كنت متزوجة أو مطلقة أو أرملة هل أنت (كنت) :

الزوجة الوحيدة ☐ الزوجة الأولى ☐

الزوجة الثانية ☐ الزوجة الثالثة ☐

الزوجة الرابعة ☐

عدد الأبناء : _____

المستوى التعليمي : _____

الوظيفة : _____

منطقة السكن : _____

نوع المسكن :

☐ ملك ☐ منحة ☐ إيجار

مستوى الدخل الأسري (شهريا) :

☐ أقل من ٥٠٠٠ ☐ من ٥٠٠٠ إلى ٨٠٠٠

☐ من ٨٠٠٠ إلى ١٢٠٠٠ ☐ من ١٢٠٠٠ فأكثر

عدد أفراد الأسرة : _____

استبيان بشان
أساليب التغلب على الاكتئاب

الأخت الفاضلة :

يهدف هذا الاستبيان إلى معرفة ما يقوم به الناس عندما يشعرون بالاكتئاب. وهو عبارة عن بيان بالأساليب المفضلة لدى البعض دون أن يتضمن إجابات صحيحة أو خاطئة. وسوف تجدين قائمة ببعض الأشياء التي قرر البعض أنهم يفعلونها عندما يشعرون بتدني معنوياتهم. الرجاء قراءة القائمة مع وضع دائرة حول رقم البند الذي يبين ما تفعلينه عندما تشعرين بالاكتئاب ، ثم أعيدي قراءةالاستبيان مرة أخرى مع وضع علامة صح (/) في العمودين اللذين يتفقان مع مدى تكرار اللجوء للأساليب التي سبق أن قمت بوضع دائرة حول أرقامها، ومدى الفائدة التي تحققها عادة.

وإذا كان لديك أسلوب آخر تلجأين إليه عادة ولا تجدينه مدرجاً بالقائمة، فالرجاء إضافته في المساحة المخصصة لذلك على الصفحة الأخيرة من الاستبيان مع وضع علامة صح (/) في الخانة المناسبة بعمودي مدى التكرار ومدى الفائدة.

يتم التعامل مع كافة البيانات الواردة بهذا الاستبيان بسرية تامة.

شكراً لحسن تعاونك

عندما أشعر بالاكتئاب :

الأساليب	مدى التكرار			مدى الفائدة		
	نادراً	أحياناً	غالباً	ليس كثيراً	متوسط	كثيراً
١ – أشغل نفسي .						
٢ – أمارس عملاً أتمتع به .						
٣ – أقوم بالترويح عن نفسي .						
٤ – أقوم بعمل شئ يبعد تفكيري عن سبب الاكتئاب .						
٥ – أقوم بعمل شئ يستحوذ على تفكيري.						
٦ – أواصل الروتين الطبيعي لحياتي						
٧ – أقوم بعمل شئ بناء.						
٨ – أمارس عملاً يتطلب جهداً بدنياً.						

٩ – أمارس عملاً يتطلب نشاطاً قوياً.							
١٠ – أذهب للمشي .							
١١ – أقوم بقيادة سيارتي .							
١٢ – أشغل نفسي بالرياضة .							
١٣ – أقوم بمساعدة أو رعاية شخص ما .							
١٤ – أعمل.							
١٥ – أكتب رسائل .							
١٦ – أقوم بعمل شيء لا يتطلب الكثير من التركيز.							
١٧ – أستغرق في العمل .							
١٨ – أمارس أعمالاً منزلية .							
١٩ – أقوم بالتنظيف والترتيب .							
٢٠ – أقوم بالطبخ أو الخبز .							
٢١ – أقوم بالغسيل والترميم.							
٢٢ – أقوم بالخياطة أو أشغال الإبرة أو الكروشيه.							
٢٣ – أذهب للتسوق.							
٢٤ – أشتري ملابس.							
٢٥ – أشتري شيئاً جميلاً .							
٢٦ – أغير نشاطاتي أو أتوقف قليلاً عما أقوم به من أنشطة .							
٢٧ – أقوم بتغيير الجو المحيط.							
٢٨ – أحصل على قسط من الراحة.							
٢٩ – آخذ إجازة .							
٣٠ – أمارس إحدى الألعاب (ورق ، شطرنج ..الخ..).							
٣١ – ألعب مع الأطفال أو أتفرج عليهم وهم يلعبون.							

٣٢ – ألعب مع الحيوانات الأليفة أو أقوم بالعناية بها .			
٣٣ – أقوم بالاستحمام.			
٣٤ – أغسل شعري أو أقوم بتصفيفه .			
٣٥ – أتناول طعاماً.			
٣٦ – أتناول بعض الحلويات.			
٣٧ – أذهب للنوم.			
٣٨ – أغفو لفترة قصيرة.			
٣٩ – أمارس الجنس.			
٤٠ – أمارس التلامس البدني .			
٤١ – أتناول أدوية مضادة للاكتئاب.			
٤٢ – أتناول مهدئات.			
٤٣ – أتناول حبوب منومة.			
٤٤ – أتناول أسبرين أو أية أدوية أخرى مسكنة للآلام .			
٤٥ – أتناول أدوية منشطة.			
٤٦ – أتناول فيتامينات أو مقويات.			
٤٧ – أتناول مشروباً كحولياً بمفردي.			
٤٨ – أتناول مشروباً كحولياً مع الآخرين.			
٤٩ – أدخن سجائر.			
٥٠ – أتناول شاي أو قهوة.			
٥١ – أحاول أن أعرف ما السبب الذي جعلني أشعر بالاكتئاب.			
٥٢ – أفعل شيئاً نحو ما جعلني أشعر بالاكتئاب .			
٥٣ – أذكر نفسي بأن ذلك لن يدوم.			
٥٤ – أفكر في شيء آخر.			

٥٥ – أتحدث إلى نفسي للخروج من حالة الاكتئاب .					
٥٦ – أبحث عن شيء يثير الضحك.					
٥٧ – أنخرط في نوبة بكاء.					
٥٨ – أشعر بالغضب نحو بعض الأشياء.					
٥٩ – أنفس عن مشاعري في شيء ما .					
٦٠ – أنغمس في الشعور بالاكتئاب.					
٦١ – أخطط لأمر مستقبلي.					
٦٢ – أغادر المنزل.					
٦٣ – أشاهد فيلماً بمفردي.					
٦٤ – أشاهد فيلماً مع شخص آخر أو مع أصدقاء.					
٦٥ – أشاهد التلفزيون.					
٦٦ – أستمع إلى الراديو .					
٦٧ – أستمع إلى موسيقى أو تسجيلات .					
٦٨ – أقرأ كتابا ذا موضوع جاد					
٦٩ – أقرأ رواية خفيفة أو رومانسية أو مسرحية					
٧٠ – أقرأ الجرائد أو المجلات .					
٧١ – أمارس الرسم أو التلوين أو النحت .					
٧٢ – أمارس العزف على إحدى الآلات الموسيقية .					
٧٣ – أكتب شيئاً ما .					
٧٤ – أذهب لزيارة المتاحف أو المعارض .					
٧٥ – أذهب إلى الحدائق أو البر.					
٧٦ – أبحث عن السلام والهدوء.					
٧٧ – ألتقي بصديقة أو بعض الصديقات.					

٧٨ – أتصل تليفونياً بشخص ما .			
٧٩ – أتناول الطعام مع آخرين.			
٨٠ – أدعو بعض الأصدقاء لزيارتي .			
٨١ – أخرج مع بعض الأصدقاء أو أذهب إلى إحدى الحفلات .			
٨٢ – أبحث عن موقفي من شخص ما أو من الناس .			
٨٣ – أبحث عن كيف يتم مقارنتي بالآخرين .			
٨٤ – أحاول الحصول على تأييد معنوي وتعاطف واطمئنان .			
٨٥ – أتحدث إلى شخص آخر عما أشعر به .			
٨٦ – أتحدث إلى شخص آخر عن شيء ما .			
٨٧ – أتحدث مع الآخرين عن مشكلاتهم .			
٨٨ – أذهب إلى الطبيب .			
٨٩ – أذهب إلى الطبيب النفسي .			
٩٠ – أذهب إلى أخصائي نفسي .			
٩١ – أذهب إلى أي متخصص آخر يمكنه مساعدتي .			
٩٢ – أستمد الرضا والقناعة من ديني.			
٩٣ – أذهب إلى المسجد أو أماكن العبادة .			
٩٤ – أصلي .			
٩٥ – أحاول أن أضع موقفي في إطاره الصحيح.			
٩٦ – أقرأ عن الاكتئاب وكيفية معالجته.			
٩٧ – أحاول الخروج ببطء من الاكتئاب بمفردي .			
٩٨ – أتجنب الأشياء التي يحتمل أن تسيء من حالتي .			
٩٩ – أبحث عن الأساليب التي يتبعها الآخرون في التغلب على مشاكلهم .			

١٠٠ – أحاول أن أبدو كأنني لا أعاني من الاكتئاب .			

يمكنك استخدام المساحة التالية لإضافة أية أساليب أخرى تلجئين إليها عادة ولا تتضمنها هذه القائمة.

عندما أشعر بالاكتئاب :

الأساليب	مدى التكرار			مدى الفائدة		
	نادراً	أحياناً	غالباً	ليس كثيراً	متوسط	كثيراً

Appendix.10.

الجنـــــــــس: ☐ ذكر ☐ أنثى

العمـــــــــر: .....

الحالة الاجتماعية: .....

المستوى التعليمي: .....

الوظيفـــــــــة: .....

أختي المواطنة.. أخي المواطن..

بلهجتنا الإماراتية نعبر عن الكثير من المشاعر والأحاسيس والانفعالات، مثل الفرح والحزن والغضب والحب والقلق إلخ... المطلوب منكم فيما يلي أن تكتبوا لنا باللهجة المحلية الإماراتية كل العبارات التي ترد إلى ذهنكم، والتي تعبر عن الأحاسيس والانفعالات المختلفة التي قد تشعرون بها في مواقف الحياة اليومية، وذلك بإكمال العبارات التالية:-

أحس إني .....

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أحس إني .....

Appendix.11.

DUBAI DEPRESSION INVENTORY (DDI)

1997 / /

الاســــــــــم : _____

العمر وتاريخ الميلاد : _____

الجنســــــــــية : _____

الحالة الاجتماعيــة : _____

المستوى التعليمــي : _____

المهنــــــــــة : _____

منطقة الســــكن : _____

نوع المسكـــــــن : ملك [ ] إيجار [ ] منحة [ ]

مستوى الدخل الأسري (شهرياً)

☐ أقل من ٥٠٠٠ ☐ من ٥٠٠٠ إلى ٨٠٠٠

☐ من ٨٠٠٠ إلى ١٢٠٠٠ ☐ من ١٢٠٠٠ فأكثر

عدد أفراد الأسرة : _____

DUBAI DEPRESSION INVENTORY (DDI)

الرجاء قراءة ما يلي بعناية :

نود أن نعرف ما إذا كنت قد عانيت من مشكلات صحيـــة، وكيـــف كـــانت صحتك بصفة عامة على مدى الأسابيع القليلة الماضية. نرجو الإجابـــة علـــى جميـــع الأسئلة التالية بأن تضعي مجرد خط تحت الإجابة التي تكون أكثر انطباقاً عليك.

تذكري أن ما نريد أن نعرفه هو المشكلات الحالية أو التي حدثت مؤخراً، لا تلك التي حدثت في الماضي.

العبارات كلها باللهجة المحلية الإماراتية.

من المهم أن تحاولي الإجابة على كافة الأسئلة .

شكراً جزيلاً على تعاونكم...

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك تعبانة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين مب قادرة تشيلين عمرك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين مب قادرة توقفين على ريولك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين بتطيحين من طولك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين مب قادرة تفكرين في شيء	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك متلعوزة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين إنك متغربلة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك مب صاحية	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك دايخة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنه راسك يدور.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين إنك بترجعين .	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنه كبدك لايعة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك ما ترومين تتنصخين .	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين إنك مخنوقة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٨ – تحسين إنه صدرك ضايق عليك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٩ – تحسين إنه ظهرك يعورك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
١٠ – تحسين إنه راسك يعورك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
١١ – تحسين إنه بطنك يعورك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
١٢ – تحسين إنه جسمك متكسر.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
١٣ – تحسين إنه قلبك يعورك .	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك ما تشتهين أي شيء	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك مصطكّة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنه قلبك متروس.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين إنك مقبوضة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنك بتموتين من الغصّة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك متألمة (نفسيا)	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك مبتلية	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك منهارة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك متعذبة	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك مظلومة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك محسودة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك تفكرين وايد.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنه الدنيا تضيق عليك ولا تتصورين هناك حل.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك قلقة على المستقبل.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك غير متفائلة بالغد.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين إنك ضايعة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنك مول مالك حظ.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك متشائمة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين إنه الناس ما فيهم خير.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إن الدنيا كلها ضدك. أبداً بعض الأوقات أكثر الأوقات دائماً

٢ – تحسين إنه فيك حرقة. أبداً بعض الأوقات أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنه ما عندك لا إحساس و لامشاعر أبداً بعض الأوقات أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنه مالك خلق . أبداً بعض الأوقات أكثر الأوقات دائماً

٢ – تحسين إنك ملاّنة. أبداً بعض الأوقات أكثر الأوقات دائماً

٣ – تحسين إنك متوترة. أبداً بعض الأوقات أكثر الأوقات دائماً

٤ – تحسين إنك ما تطيقين شيء. أبداً بعض الأوقات أكثر الأوقات دائماً

٥ – تحسين إنك مب قادرة تستحملين. أبداً بعض الأوقات أكثر الأوقات دائماً

٦ – تحسين إنك متمللة. أبداً بعض الأوقات أكثر الأوقات دائماً

٧ – تحسين إنك طفرانة. أبداً بعض الأوقات أكثر الأوقات دائماً

٨ – تحسين إنك حساسة. أبداً بعض الأوقات أكثر الأوقات دائماً

٩ – تحسين إنك سريعة الانفعال. أبداً بعض الأوقات أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك ما تبغين تشوفين وجه أحد أبداً بعض الأوقات أكثر الأوقات دائماً

٢ – تحسين ما تبغين تجلسين مع أحد. أبداً بعض الأوقات أكثر الأوقات دائماً

٣ – تحسين إنك مب قادرة تتكيفين مع الناس. أبداً بعض الأوقات أكثر الأوقات دائماً

٤ – تحسين إنك ما تبغين تتكلمين مع أحد. أبداً بعض الأوقات أكثر الأوقات دائماً

٥ – تحسين إنك مول ما فيك اتسيرين مكان. أبداً بعض الأوقات أكثر الأوقات دائماً

٦ – تحسين إنك منعزلة عن العالم. أبداً بعض الأوقات أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك وحيدة .	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنه ما أحد يحس فيك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك بتنفجرين من القهر.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك تبغين تصارخين.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك تبغين إتكسرين كل شيء.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسن إنك متروعة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنك عصبية.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك قلقانة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين بعدم الاستقرار	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك تكرهين الدنيا.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إن الموت أحسن من الحياة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك تعيسة من حياتك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين إنك ضايقة من هذه الدنيا.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنك تبغين تنتحرين.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك تفكرين في الموت في كل وقت.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين إنك تتمنين لو الدنيا تزول من عيونك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك موسوسة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك محتارة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك مغلوبة على أمرك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك مالك دور في الحياة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك تايهة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك متضايقة من عمرك.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك مب زينة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك مب قادرة ترقدين.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك حزينة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٢ – تحسين إنك مهمومة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٣ – تحسين إنك بتموتين من الضيق.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٤ – تحسين إنك مكتئبة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٥ – تحسين إنك متكدرة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٦ – تحسين إنك متنكدة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً
٧ – تحسين إنك مغتمة.	أبداً	بعض الأوقات	أكثر الأوقات	دائماً

٨ – تحسين إنك متضايقة وايد.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
٩ – تحسين إنه شراة الحصا على قلبك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
١٠ – تحسين إنه ما أحد يفهمك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
١١ – تحسين إنك تبغين إتصيحين.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
١٢ – أتصيحين.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
١٣ – تحسين إنه قلبك يعورك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك مالك بارض.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
٢ – تحسين إنك مب قادرة تفكرين في شيء.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
٣ – تحسين إنها واصلة عندك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً

هل حدث في الفترة الأخيرة إنك :

١ – تحسين إنك ما تحبين نفسك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً
٢ – تحسين إنك تكرهين نفسك.	أبداً	بعض الأوقات	أكثر الأوقات دائماً

Appendix 12

Papers submitted for publication

1. Sulaiman, S., Bhugra, D., De Silva, P. : *Depression in Dubai: A pilot study.*

2. Sulaiman, S., Bhugra, D., De Silva, P. : *Depression in females in Dubai: Social and cultural factors.*

3. Sulaiman, S., Bhugra, D., De Silva, P. : *Development and validation of culturally sensitive questionnaire to measure depression in Dubai.*

4. Sulaiman, S., Bhugra, D., De Silva, P. : *Community views and coping strategies regarding depression in Dubai.*

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