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Culture, relativism and the expression of mental distress: South Asian women in Britain

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Abstract Social anthropology and medical anthropology have presented a challenge to the belief that there are universal categories of mental illness. A relativist position would suggest that there are as many categories of mental health (or physical health) as there are languages and culture in which they are expressed. Intermediate arguments suggest that there may be common elements in ideas of mental illness but that cultural expression of syndromes may differ significantly, or that symptoms may cluster in different ways in different cultures. These arguments have been raised, as well as in cross national comparisons, in the context of minority groups (ethnic, cultural, language groups) in Britain. The research, reported here, on South Asian women in Bristol, shows that they have a clear conception of mental health and illness, a clear understanding of relationships between physical and mental health, and make important distinctions between types of mental ill-health. They describe mental distress in a culturally specific set of language terms and their accounts differ from English speakers in important ways. At the same time they describe a syndrome of mental distress which corresponds in a number of features to the category 'depression'.

Key words ethnicity, mental health, depression, culture, medical sociology, relativism

Expressing mental distress

Sociology and social anthropology applied to medicine and health have consistently drawn our attention to both medical professional and lay concepts of illness, and to the relationship between them (Kleinman, 1977; Marsella and White, 1982). Applied to mental health and illness, and specifically 'depression', this requires the exploration of the way in

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which people in everyday life give expression to mental and emotional distress. How do people describe their thoughts and feelings and how, for example, do these descriptions compare with the mental illness category 'depression'? Questions of this kind and, more generally, the subject of peoples' own descriptions of illnesses, symptoms and causes of ill-health, have received increasing attention in the last decade (Blaxter, 1990). But with regard to ethnic, cultural and linguistic minorities in Britain little systematic research on these issues has been done. Much of the commentary has been speculative (Rack, 1982; Ineichen, 1990). Authors have made suggestions about how mental illness might be viewed among different migrant groups in Britain, but these typically have not been based on extended interviews with subjects (Cochrane and Stopes Roe, 1980; but *cf.* Currer, 1986; Krause, 1989; Weiss *et al.*, 1986). Social anthropological studies of migration, settlement, community and family among South Asians in Britain have offered detailed accounts of patterns of daily life, including interpretations of the world as seen from the vantage point of South Asian women (Shaw, 1988; Jeffery, 1976, Ballard and Ballard, 1977, Ballard, 1973, Watson, 1977) – but these studies made little or no reference to mental health and illness. (but see Shaw 1988:4).

The research literature, and the studies reported in this paper, address the empirical questions of how people describe their 'illnesses'. But we are also concerned with the theoretical or conceptual question of the link between culture and the expression of mental distress. Are conceptions of mental illness only understandable within the linguistic and cultural framework within which they are expressed? Is the bond between culture and concepts of mental distress so strong that we must not only recognise that mental illness is expressed very differently in different cultures but also question the universality of the categories of mental illness?

The belief that there is an entity called 'depressive illness' implies that its incidence and causes can be studied in many settings (Rack, 1982:11; and see Singer, 1975, Marsella, 1978, Carstairs and Kapur, 1976). Kleinman and others have argued that clinical psychiatric categories like 'depression' were specifically the construction of the Psychiatric profession in the Western world:

> Psychiatric categories are bound to the context of professional Psychiatric theory and practice in the West. Psychiatry must learn from anthropology that culture does considerably more than shape illness as an experience; it shapes the very way we conceive of illness. A true comparative cross-cultural science of illness must begin with this powerful anthropological insight. It must make a systematic analysis and comparison of the relevant illness categories prior to the study of illness phenomena (Kleinman, 1977:4).

A universalist position would argue that forms of (mental) illness can be defined and can be found in a wide variety of contexts. A relativist

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position would argue that categories of illness are only to be understood within the social and cultural context in which they are found. The opposition of 'universalist' and 'relativist' is a considerable simplification – most accounts take up intermediate positions, differing rather in the emphasis they give to cultural variation. In a study of Turkish women in Sweden (Sachs, 1983) we find a powerful example of the conception of illness categories as grounded in a specific culture:

> In the forty days after childbirth known as the *lohusa* period, a woman is liable to contract *albasmasi*. This condition, characterised by the woman seeing everything in red, turning hot and getting cramps as well as choking, is one of the most feared reactions connected with childbirth. All the women have heard about and been in touch with it one way or another in Kulu. *Albasmasi* is an illness with specific symptoms. When a case has been established, it is only the personal and folk sectors of health care that can provide treatment. A scientific doctor will not be consulted. The Kulu women know that only their own experts can cure a person from *albasmasi* and that scientific doctors have not even heard of the illness. (Sachs, 1983:86).

In a similar manner the Malaysian syndrome described as *amok* is sometimes portrayed as a culture bound syndrome, meaning a cluster of symptoms which is only found in the culture and language context in which it receives specific identification as an 'illness' (Carr and Vitaliano, 1985). These authors' view of amok is that it is ***both*** 'related' (in their phrase) to Western mental illness categories and, in a sense, culturally unique. Thus they write:

> Are disorders such as the *amok* phenomenon unique to specific cultures or are they simply culturally determined variants of universal forms of psychopathology like depression? (Carr and Vitaliano, 1985:244)

and, answering their own question,

> our hypothesis is that **depression and** *amok* **are related** and among the several alternative distress responses individuals may make to aversive (stressful) circumstances (1985:256 our emphasis).

It could be argued that symptoms (such as sleep disturbance) are to be found in all societies but form different clusters or syndromes. Kleinman and Good argue however that even fundamental emotions (*e.g.* anger, sadness) cannot be assumed to be the same things in different cultures (Kleinman and Good 1985:492). On this argument cultures is not simply a vehicle of difference in cultural expression but creates and conveys some *thing* different in and of itself: 'There can be no stripping away of layers of cultural accretion in order to isolate a culture-free entity' (Kleinman, 1977:4).

In many of these discussions the nuance of argument depends on the

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force or weight attached to cultural variation. It may also be argued that some symptoms are common to a mental illness such as depression (frequently the centre of debate) whilst others are not (Pfeiffer, 1968). If this is so it would be sensible to expect that such symptoms as sleep disturbance may be common whilst others more intimately connected with meaning and purpose in life show more variability. This would certainly follow if we accept that meaning and purpose in life are defined so differently in different societies and cultures. This is precisely the argument that Obeyesekere has made about the perception of self and meaning in life among people who are adherents of Buddhism (Obeyesekere 1985). Whilst Western observation of depressive patients may lead us to conclude that a loss of a sense of personal worth is the cornerstone of the depression experience (Brown and Harris, 1978), Obeyesekere suggests that a certain realisation of the cosmic smallness, the 'insignificance' of the individual may be part of a good Buddhist's reconciliation to the true nature of existence (Obeyesekere, 1985). If sense of self and self-worth is viewed as important in (Western) characterisations of depression, and if it is true that concepts of self differ from culture to culture (Shweder and Bourne, 1982), then it follows that considerable care must be exercised over the place that self-concept and self-worth is given in descriptions of a mental illness syndrome such as depression. This emphasis on cultural context guards against ethnocentric concepts of illness, but the emphasis on culture has also been viewed as problematic.

Culture as a problematic term

There are several ways in which culture may be viewed as a problematic term. One such problem lies in a tendency to regard cultures as fixed entities, and as fixed entities which can be grasped and described. In fact it is more sensible to think of cultures as in perpetual movement, moving through successive phases of definition and redefinition. In a similar vein we should guard against the attribution of cultures to determine, albeit frequently loosely defined, boundaries of peoples and societies. Hence we should be on our guard when we encounter such phrases as 'Asian culture' or 'Western culture' or 'English culture'. One problematic use of the term culture of direct relevance to our research question has been its use in a context which implies or asserts the superiority of one culture over another (Said, 1978; *cf.* Gellner, 1992; Leff, 1981; *cf.* Beeman, 1985). In the field of mental health and minority groups this has inspired particularly critical comment (Sashidaran, 1986; Fernando, 1988; Littlewood and Lipsedge, 1982; Ahmad, 1993). Stereotypical cultural characterisations both 'blame the victim' and deflect attention from other material influences on health and mental health (Pearson, 1986; Ahmad, 1993). They may be misleading if they propose cultural categories which are so

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general (*e.g.* 'Asian culture') and are unmindful of regional and class variations. Urban upper class Indians and Pakistanis will have quite different conceptions of mental health from rural, poorer, village Punjabis. But if the lessons of these critiques are well-learnt then we still need to address ourselves to the question of the interplay of culture and health. One important manifestation of this interest – which enhances rather than demeans the subject – lies in the examination of subjects' own descriptions of their thoughts, feelings, emotions and 'illnesses'.

As sociologists investigate peoples' own accounts of illness (Blaxter, 1990; Calnan 1987; Furnham, 1994), professional definitions may be brought into question. The psychiatric definitions of mental illness in general, and depression in particular, have been subject to challenge along with a generalised critique of what is termed 'the medical model' (Stacey, 1991). So, whilst focusing our attention on minority groups, cultural difference and concepts of mental health, by implication against a yardstick of a medical definition, it is vital to be aware that these clinical categories have been subjected to critical challenge within so-called Western cultural settings themselves (Pilgrim and Rogers, 1993). In other words we should not imagine that because inter-cultural meanings of depression are at issue, these meanings are unproblematic within Western culture. The important of clinical professional definitions of mental health and illness has been widely challenged (Pilgrim and Rogers, 1993) and especially in their manifold implications for constructions of gender and mental health (Gove, 1984; Busfield, 1982; Saltonstall, 1994; Walters, 1993).

Lay concepts of mental health: studies among South Asian populations in Britain

As the literature on bio-medical and lay concepts of mental health has grown, along with the literature on gender and mental health (Miles, 1988), only a small number of studies have focused on the specific question of personal constructions of mental distress among South Asian populations in Britain (Currer, 1986; Donovan, 1986; Krause, 1989; Fenton and Sadiq, 1993).

Currer reported that the Pathan women with whom she spoke 'viewed health and illness, happiness and unhappiness as part of the natural order, as a part and risk of living' (Currer, 1986). Illness and unhappiness were not things which they controlled, although this attitude of acceptance did not imply that they did nothing about their own or their children's health. But with specific regard to mental health, Currer argues that the profound and persistent sadness, which possibly corresponded to depression, was understood within a particular view of hope and hopelessness: 'It is not for us to feel hope. The future is in God's hands. How can we know what it will hold?' Thus the 'sense of hopelessness' often

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seen as a core element of depression was viewed quite differently by Pathan women. Several spoke of their profound sadness but only two spoke of themselves as 'ill' and this view was not supported by other women in the community (although Currer and her research associate saw them as ill). On the whole, she suggests, her study would support the view that there might be under-reporting of mental distress, depression in particular, because of the different ways in which this distress was seen.

She also concludes that her research tended to confirm 'an aspect of illness behaviour among Asians that is often reported', that is somatisation. What Currer then writes does not wholly support her own argument:

> Although we find (among Pathan mothers) a ready acceptance of the link between emotional and bodily states, it was the latter which was emphasised. Treatment was not sought for the causes of mental illness where these were seen to lie in unhappiness, but for its effects in the nature of headaches, lack of sleep and so on.

All that her summary here suggests is that Pathan women ***did not seek treatment for mental distress***. The argument that within certain cultural contexts (widely and variably identified but including 'Asian') there is a tendency to somatise mental illness, is, as Currer suggests, very frequently reported (White, 1982; Katon *et al.*, 1982). It could however mean several things: (a) a non-recognition of mental illness, so that ailments are always presented as somatic, (b) a non-recognition of the link between physical ailments and emotional states, (c) a presentation of ailments as somatic despite some recognition of mental distress, and (d) simply a non-presentation of mental symptoms to bio-medical doctors. Currer's evidence on her presentation only really confirms the last of the four above meanings.

One social anthropological account of South Asian women in Britain reports in more detail on the use of language (Krause, 1989) and illustrates an elaborate language and symbolism within which women express distress both mental and physical. She identifies 'the heart falls' (*dil ghirda hai*) as the typical form of communication of distress (among Punjabi women in Bedford).

> The heart is sinking is an English translation of *dil ghirda hai*. This refers to an illness or a state which may be physical or emotional or both.

The fact that sinking heart has both physical and emotional connotations reflects the centrality of the heart itself, seen as 'the regulator of life forces throughout the body' (Krause 1989:567). As one of her informants puts it:

> The heart is most important. It is more important than the brain (*dimaag*) . . . The heart gives us blood by doing a circle. Then the heart feels. It feels all kind of feelings: love, hate anger, desire (Krause, 1989:567).

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Her evidence makes it clear that women describe their mental and emotional states with great finesse. They see 'thinking too much' as a problem in itself and as a possible cause of ill-health:

> Some people who think too much about their fate (*kissmat*) . . . may also suffer sinking heart.

She shows how the woman in question connects this sinking heart condition to her social circumstances, particularly the absence of close family members. Another of her informants explained his view of the relationship between worry and heart attacks. Krause points out that, although there is no Punjabi phrase which directly translates as 'depression', some symptom descriptions 'must sound familiar to Western Psychiatrists' (Krause, 1989:567).

Whilst the Krause and Currer studies achieve an empathetic understanding of the South Asian women with whom they talked, other commentaries continue to imply that mental health is barely understood by Asian women. A summary article by Ineichen suggested that 'ideas of psychological causation of illness are poorly understood within Asian cultures' (Ineichen 1990). A report by the Commission for Racial Equality had attributed to Asian women a 'bewilderment about their own emotions' implying that they can either describe nor identify their own thoughts and feelings (Commission for Racial Equality 1977). The argument that British Asians are protected against poor mental health by strong families is commonly held (Cochrane and Stopes Roe, 1980); the belief that 'Non-Western' peoples do not experience depression is, of course, of much older pedigree (Singer, 1975; Fernando, 1988). Taken together then, the following are asserted or suggested: that minority women (such as the South Asian women in our study) do not experience depression or, if they do, somehow do not recognise it; that they fail to present 'it' to practitioners, either failing to acknowledge it or disguising it by way of somatic presentation; and that they fail to understand the relationships between (physical) illness and mental states. The research reported in this paper addressed many of the questions discussed above, but two in particular: How do some South Asian women in Britain describe mental and emotional distress? What does the evidence suggest about the degree of cultural specificity in the expression of and presentation of mental illness?

Methodology

Findings from two research studies are reported here. In the first study[1] the purpose was to understand how South Asian women might view health, illness and consultations with a doctor. We set out to talk to women about concepts of health in the widest sense: their views of health,

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of illness and coping with illness, of health and illness in the context of everyday life, and of treatments and visiting the doctor. Women were contracted through a Health Centre and a Community Centre where women attended a language class. Thirty-three women were interviewed in structured interviews covering household circumstances, migration, views of health, illness and doctor consultations, and aspects of everyday life including employment, housing and experience of racial hostility. Ten women were interviewed in a much more qualitative and less formalised manner. The same topics were covered but by way of continuous and extended conversations which were held over several meetings between the researcher and the subjects. Where the women agreed – and about half of the time they did – the conversations were tape recorded. The language of almost all these conversations was Punjabi. Most South Asian families in the central areas of Bristol come from the Punjab region, either side of the Pakistan-India border. They are therefore mostly either Sikh or Muslim, the latter predominating. In this study (and the second study, see below) about 65 per cent of the interviewees were Muslims, almost all the rest being Sikh. Typically they were housewives with young or teenage children. Most of our respondents had not had waged work since coming to Britain and none reported taking in homework. However, a small number of our respondents had experienced work in a local dry cleaning company. Their husbands were typically either unemployed or in low-paid employment. None of the women were British born although the youngest were in their twenties (being recent arrivals), the oldest in their fifties having been in Bristol from 10 to 30 years. Most spoke little or no English. The illustrations in the present article are taken from the long interview conversations, specifically those cases where the women described an experience of mental distress. The first study, as well as providing some individual accounts, laid the foundations methodologically and empirically for the later study.

In the second study[2] the methodology was wholly qualitative, the intention being to explore the terms in which women described mental distress. The aim therefore was to secure extended interview conversations in natural settings where the women were encouraged to speak freely about their everyday lives, their thoughts and feelings, and especially about 'mental distress'. Whereas in the first study no attempt was made specifically to contact women particularly likely to have 'troubles in their lives', in the second study the help of local (South Asian) community and health workers was enlisted to help the researcher establish relationships with women believed to have 'life troubles'. After establishing a relationship of trust, the conversations ranged over their lives and their experiences and their understandings of their mental distress. Sixteen contacts were established via a Health Centre (5), a Community Centre (5), a Social Worker (1), and a Community Psychiatric Nurse (also a Punjabi speaker) (5) who ran a drop-in facility and received referrals from

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doctors. Those met through the Health Centre had typically not consulted their doctor about mental ill-health and even those met through the Community Nurse did not necessarily think of themselves as undergoing 'treatment' for a mental disorder such as 'depression'. Rather they saw themselves as having found someone to whom they could talk (in their home language) about their worries and difficulties. Similarly all sixteen of the women to whom the researcher spoke viewed her as a friend and confidante; as well as helping them by 'lending an ear', she also helped them in many ways by responding to requests which they naturally made over their several meetings. Again, these sixteen women (bar one English-born and speaking) were born in Pakistan or India, in those villages and cities of the Punjab region characteristic of Bristol's South Asian families (*e.g.* Jullunder, Jhelum). They ranged in age from early twenties to early sixties, having come as brides over the two decades preceding the research. The conversations were held in Urdu or Punjabi, tape recorded as and when the women agreed. All the women were visited in their homes three or four times, on each occasion for at least two hours. In both studies the maximum amount of rapport and trust was established and the conversations held in as natural a setting as possible. The two researchers, though young and single, shared much by way of language and background with the women they talked to and were certainly regarded by them as 'one of us'. These aspects of method are important because they are to be compared with previous reports often based on clinical contacts or formal interviews. The women in both studies (those in the first study who volunteered accounts of mental distress and all sixteen in the second) had experiences of mental and emotional distress within a context of life troubles, all of which they described at length to the researchers, in their own terms and their home language (Fenton and Sadiq, 1993).

Describing mental distress

We have used the term mental distress in order to avoid begging the question of whether the women were describing mental illness, and specifically depression, to the researcher. There can be no doubt that all the women from whom we shall present accounts were (or had recently been) suffering psychological and emotional distress of which they gave an account within the context of life events. But few of them appeared to have any awareness of the term 'depression'; one woman referred to 'what *they* call depression' and two others mentioned it, but also as someone else's phrase rather than their own. The women certainly related their distressed thoughts and feelings to the events of their lives but, given the purpose of the present article, our main focus here is on how they described these thoughts and feelings.

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The women used a variety of evocative phrases to describe their thoughts and feelings. Two women spoke of their 'heart being burnt like a cinder' and another described her heart as like a colander – from which everything had drained. The heart was the centre-piece of most descriptions:

> My heart kept falling and falling . . . I felt as if my head was about to burst. The life would go out of my heart.
> My heart has taken many shocks.
> I'd get up in the morning and feel as if something heavy was resting on my heart.

The phrase 'my heart kept falling and falling' corresponds to the descriptions reported by Krause referred to earlier in this paper. Whereas the respondent she cites spoke of 'thinking too much' as a possible *cause* of 'sinking heart', all the women in the Bristol study used the phrase 'thinking too much, thinking and thinking in my heart' as the key description of their condition. Alongside this they would use the common descriptions of feelings and emotions such as anxiety, worry, upset, sad: *gubrahat, fikar, perishani, dhass*. Two key terms, *duk* meaning 'hurt' and *ghum* meaning 'sad' or 'sorrowful' were probably the most commonly used by Bristol Asian women. These are terms describing emotions but the term *kamjor* meaning weakness has both physical and emotional connotations. The woman who spoke of her heart as 'like a colander' – using the Punjabi term to mean the sieve used in sifting grain – was describing a weakness of both body and spirit. The speech context suggested the blood or energy drained through the holes in her heart, leaving her weak and lifeless (see Krause 1989:569). A woman whose nephew had died in an accident told us

> My heart is weak. I am ill with too much thinking . . . the blood becomes weaker with worry . . . I have the illness of sorrows (*duk bemaari*).

One woman who – unlike most of the others – did use the word depression said:

> Depression is an illness and I am very ill . . . it is when you think too much in your heart and this affects your mind . . . when the thinking in your heart is of so much force (*zor*) that it puts pressure on your mind.

Among the women to whom we spoke in Bristol the phrase 'thinking and thinking' was used by all the women and was almost always accompanied by the word heart (*dil*). In our research this 'thinking and thinking in my heart' was the core expression. 'Thinking in my heart', given the centrality of the heart in expressing thoughts and feelings, must clearly be distinguished from commonplace or everyday thinking. In English we might

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say 'I think I will take the bus rather than the train' as an example of everyday 'thinking'. But thinking in my heart indicates thoughts inextricable from the emotions which accompany them (see Krause, 1989:567). It seemed to us that 'thinking too much in my heart, thinking too much' was not only the core expression, it was the core experience. If any phrase could be said to express the essential thought-feeling-distress-illness it was this one. Of course they used many of the words we have described above – particularly *duk* and *ghum* – to describe their emotions. Yet it seemed to us that they recognised that these were in a sense 'natural' emotions, but the thinking and thinking associated with them could run out of control. Thoughts repeated themselves, as one woman expressed it 'like a film' giving this picture of a reel of film images moving across the heart-mind in a way that she could not control. The idea of 'thoughts out of control' plays a part in the descriptions although they did not use an exact Punjabi equivalent of this phrase. Nonetheless, a feature of the thoughts, *i.e.* of thinking too much, was that one could not simply stop them. Since thinking too much could be said to be the core experience, advice to 'stop thinking too much', from either doctors or husbands, seemed to them to be particularly unhelpful and inappropriate. It was like being told 'don't have this problem, the problem you tell me you have' or even like 'don't be ill, stop being ill'.

The fact that thinking in my heart is distinguished from plain thinking – in the mind (*dimaag*) – is indicated by the women saying that thinking-too-much-in-my-heart can *affect* the mind. Thus some women suggested that the pressure of thinking and thinking so much can lead to one becoming mad. To have the 'thinking illness' is not to be mad (*paagil*) and all were very clear about this, but they acknowledged that the first might, as it were, cause the second.

An excerpt from one woman's account encompasses several of these points we have made. She is very worried about her children and the dangers to them in an upper floor flat; when she has taken her children to the park she has met with racial abuse.

> The health visitor tells me to go out but I don't feel like it – I have to face this sort of trouble (referring to the 'Paki' calls and stone-throwing). I am so upset my mind (*mera dimaag*) is going bad . . . I was in such a state . . . I was shaking all over . . . I went to the doctor and told him all my problems. He said really your problem is the house problem and that you worry too much (about your children). But (the doctor is English) . . . you see I can explain myself in English somewhat but I can't tell him how I am feeling – what is in my heart – as I am doing to you now – all the small things in our language. I can't say how I am feeling in my heart . . . I can't get the right words.

Sharing with the interviewer was a help in many cases:

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I'm all right when there is somebody else here. It is when I am on my own and a lot of thoughts come into my head . . . I dwell on a lot of things . . . I think my mind is going away.

Two other women talk of the pressure affecting their heads but in a more physical way, giving them pain in the head:

(After the funeral) . . . people came to pay their respects. We were all reading the Koran . . . when we came back to Bristol, I became even more upset (*perishan*) . . . my heart kept falling . . . I felt as if my head was about to burst. I'd tie my head and hold it.
At this time I started to become ill. I became very weak with worry and anxiety. I would spend all day and night thinking in my heart . . . (at times) life would go out of my heart . . . I would tie a scarf around my head to stop it hurting so much.

I do all this thinking in my heart . . . I know it affects the brain . . . but what can I do?
That blow (an event in her life) hit me as if my heart had stopped . . . I think, think, think in my heart . . . this built up pressure in my head . . . you won't believe it but my head felt as if it was going to burst.

Thinking too much – an illness

Thinking-too-much-in the heart was a recurring phrase used by all the women. It described a state of mind which itself was frequently described as an illness. The women spoke of the 'thinking illness', the *soochne ki bemaari.*

I was really very ill (*bemaar*) then because I didn't know what was happening to me (when her husband left). My heart felt as if someone was pushing it down . . . I was so hurt/upset (*duky*) . . . I started to think there was nowhere on earth for me and my baby. All these thoughts kept coming in to my heart and I would spend all day and all night just thinking and thinking.
My illness started when I came here. My heart is not in this country . . . when I write to my mother I do not tell her that I am ill.

A woman whose husband left her only a little later suffered the death of her sister:

The hurt (*duk*) didn't stop for me there because it was then that my sister died . . . the way I found out (by telephone) made the illness grow.

Another woman described herself as having two illnesses – arthritis and the thinking illness 'which the doctor calls depression'. The thinking

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illness, she comments, can't be cured by the doctor and tablets because it is caused by her relationship with her husband.

Moving house and a hostile reception in the new area provoked the thinking illness for one woman who had heard the term depression – as a term that 'they' use:

> When we moved I got very upset . . . depressed . . . to me it seemed it was that very thing . . . then I went to the doctor . . . he gave me some tablets. Before we opened the shop I became ill. I felt like I was a prisoner. I told him that I had changed area and was not happy. I was hurt/upset a lot, thinking, thinking . . . I was lonely . . . that life is nothing, that I wouldn't feel hungry. I would feel very ill. It was really bad.

These are all examples of what they describe as the thinking-in-the-heart-illness. They are states of mind or heart and they are unequivocally described as illness. In this simple sense there is a clear recognition of a 'mental illness'. It is the same word (*bemaar*) that would be used in describing, say, diabetes – the *sugar bemaari.* At the same time the women would, as well as distinguishing the thinking illness from madness (see above), distinguish between 'ordinary illness' and the 'thinking illness'.

> There is ordinary illness and the illness of sorrows. I keep telling myself to forget the past . . . but some things are beyond our control.

A woman who described herself as having mostly recovered from her thinking illness now finds that she has a circulatory problem:

> It's a different illness . . . an illness of the blood . . . the doctors say I have to keep taking tablets for the rest of my life.

Later in the same conversation she re-tells the same sequence of events:

> But by Allah's grace I became better. We thank Allah for his blessings . . . but now that illness has left me, another one – a *blood bemaari* has started.

And the phrase so tellingly used by one woman, and very much implied by the others, showed how the thinking illness could be distinguished from normal sadness. As she phrased it:

> My sorrow (*ghum*) has become my illness.

Treatment by doctors?

Although there is the kind of recognition of illness which we have described, it is not, on the whole a condition susceptible to treatment by

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doctors or 'by tablets'. One woman (see above) described her loneliness and her thinking illness to her doctor, and other women in our study told us that they 'might ask a doctor for advice'. More common and more general is the notion that this is an illness for which there is not a doctor's cure.

> 'I feel eaten away with hurt and sorrow . . . there are hundreds of worries and I just keep thinking about them in my heart. I was very bad . . . even now there is little difference. These worries are still here. What do I do? What is the medicine for them?'
> I saw the doctor. I just told him about how I wasn't sleeping well . . . and the pain in my arm. The doctor gave me pain-killers and cream to rub in my arms. But there is no tablet for my sorrow (*ghumgeen*) is there? This sorrow will be with me for ever.

Women seemed to agree with the statement several made to us 'there is no treatment for the thinking illness'. In this sense there is a recognition of illness but not a medicalisation of the troubles of life. This was an illness no tablets could cure:

> The force from my heart to my head . . . was so bad sometimes I would feel faint. The doctor gave me some sleeping pills but I didn't feel better. This wasn't a sleeping illness . . . my heart had so much sorrow . . . my heart had sunk so much that at times I didn't know if I was dead or alive.

Some of the women had received anti-depressant prescriptions from their doctor even if they did not describe them as such. One woman spoke of some benefit from this – 'my heart grew a little stronger'.

But the general recognition was that whilst relief might come from taking tablets – for example from the physical accompaniments of mental distress – real cure lay in the resolution of the life problems themselves. They readily acknowledged that the thinking illness can bring or cause physical pains – 'much can happen with thinking' – and these may be (temporarily) relieved. Talking to others can help both physical pain and the sorrow in the heart:

> When you meet people you can talk about your pains – sitting inside you could be very ill. Who can you tell? . . . The table?

The resolution of the life crisis was hoped for and prayed for. They might see the resolution, for example of grief on a bereavements as being in Allah's hands. They also knew that separation from kin compounded everything, and might pray for relief coming from a visit to Pakistan:

> 'I don't know what to do. Should I keep taking the tablets or go to Pakistan?'

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Mental distress and depression

We stated earlier that we wished to use the term mental distress in order to avoid begging the question of whether what they described corresponded with a medicalised category such as depression. It was not the aim of the study to examine whether the women were experiencing 'depression' because to do so would give a privileged position to the term depression. At the same time the question of inter-cultural correspondence was part of the rationale of the study. For this reason, in the second study, we recorded mentions by the women, in the long interview conversations, of 'regular' symptoms of depression. These we listed as eight: loss of purpose; loss of a sense of worth as a person; tearfulness; inability to cope with daily tasks; loss of appetite; overwhelming tiredness, bodily aches and pains; suicidal thoughts; sleep disturbance. All of the women reported all or almost all of these symptoms; none reported fewer than six. In a report of this study (Fenton and Sadiq, 1993) we concluded that the women described symptoms which if reported in English to a medical practitioner would almost certainly have been taken as indicative of depression. The researchers could also make judgements based on the appearance of the women as they sat in their homes; they looked unwell and not just gloomy. We also know that some of the women were being treated for depression, or had been in the past, and that some had heard the term. Those few who had heard the term treated it rather as a term that someone else ('they', the doctor) would use. The symptoms listed above were described by the women, for the most part, in a matter of fact way, although the phrasing was in some cases particularly religious. Reporting sleep disturbance a woman said how 'the night which Allah gave us to sleep brings no sleep'. In speaking of suicide several women said they had thought how could they go on 'but Allah gives us this life, and Allah takes it away'. The two symptoms which were not so readily found among the women's accounts were the indications of first, loss of meaning in life and secondly, loss of sense of personal worth. These seemed to us to be much more imbued with cultural meaning than, say, sleeplessness. They were much less inclined to make statements of a low self-regard kind; on the whole they did not make those self-blaming, low personal worth statements often seen as characteristic of depression. On the other hand some said things which appeared to carry a similar meaning: 'What kind of person am I that Allah has given me a life such as this?'

Conclusions

The qualitative methodology adopted for this kind of study is vindicated by the depth of exploration made possible, by contrast with either infor-

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mation from formal interviews or from clinical exchanges. The formality of interviews, social scientific and clinical, especially if the subject is not speaking in her or his home language, is likely to get in the way of breadth and depth of expression. Conclusions about the expression of emotion, thought and feeling from such sources may well be unreliable for these reasons. The women in the two studies reported in the present paper spoke fully and naturally once a mutual trust had been established. The ways in which they described their inner troubles displayed a very considerable degree of similarity across all the accounts. This consistency, this recurrence of certain words, phrases and symbolism is indicative of a cultural pattern that is widely shared. The term, construed from Punjabi usage, 'thinking-in-the-heart-illness' describes a state of mind, of heart, of the emotions, which takes shape as a culturally defined illness. At the same time there are commonalities with 'depressed' subjects as described in accounts of English speaking women (Brown and Harris, 1978). Many of the common symptoms of depression were reported and the thinking illness itself usually arose from a bereavement or relationship breakdown which gave rise to almost insupportable grief or despairing sadness. There is little doubt that they are describing experiences, feelings, thoughts and symptoms which have elements in common with what English speakers describe as depression. The evidence here supports a 'universalist' position in the sense of pointing to areas of commonality in the definitions of the 'illness' offered by the subjects. Not only can we find something 'universal' in sorrow, sadness and grief in bereavement or a broken relationship, but also in the uncontrollable thoughts and feelings which accompany these emotions, and which are seen as 'illness'. This does not deal with Kleinman's claim that even 'common' emotions are culture-bound. This is too wide a social anthropological question to face in such a study as this.

The study does throw light on some of the other questions we raised at the outset, questions which have principally arisen in the context of minorities in Britain. The claim that psychosomatic illness is not recognised within 'Asian cultures' (Ineichen, 1990) is misplaced, as is the notion that there may be expected, in a group such as the subjects in our study, some failure of recognition of 'mental illness' or inability to give expression to the experience of mental distress (Rack 1982; Commission for Racial Equality 1977). Indeed it is not only unwise to suggest that Asian cultures lack some attribute, but not very helpful to speak of 'Asian' cultures at all in such highly generalised terms. Readers of the present paper should not replace one stereotyped 'culturalist' conclusion with another. What we have said derives from conversations with women who have come from particular areas of Pakistan and India with the class, regional and religious backgrounds that we described above.

We conclude from the evidence of this study that these women clearly understood the intricate relationships between mental and physical illness;

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they clearly acknowledged 'mental illness' – with the important rider that the medicalised term 'mental' is an imperfect fit with what they described. They evidently accounted for what they were experiencing as 'illness' and described their thoughts and feelings in the most intricate depth when provided with the circumstances which helped them so to do. In part this conclusion turns upon the degree of correspondence between the terms *bemaari* and illness. There is no doubt that we should allow for the possibility that *bemaari* may have a more generalised or metaphorical meaning than plain illness, thus corresponding to sickness and trouble. This would be so in the case of metaphorical use of *bemaari* in phrases such as love-sickness, thus playing the same part as the word sickness (rather than illness) does in English. In the end we concluded that it would not be right to say that the women were using *bemaari* as a generalised term for trouble; the contexts in which they used the term, the juxtaposing with physical illness, the fine contrasting of different kinds of illness (of 'thinking' and of body), and the distinction made between sadness and illness all suggest that the use of the term was not simply metaphorical.

But there are two important elements in their accounts which appear to us to give support to a 'relativist' position in which illness is seen as being crucially shaped by cultural specificity. The commonality lies in the common elements which may be uncovered (as suggested above), but these elements may cluster differently in wholes which take on a unique character, and are described in terms which reflect differences in cultural meanings. Two such elements are these: First, the women talk about their circumstances, their families, their hopes, prayers and sorrow. But, in a fashion about which it is extremely difficult to be precise, they do not talk about them*selves*. Second, whilst the thinking-in-the-heart-illness is illness, it is not a medicalised construction of thought and feeling. Among upper-class Indians and Pakistanis in the sub-continent or elsewhere, we could find conceptions of mental health which would correspond to medicalised views of life's troubles and among them – but not among villagers – there may be wide use of psychiatrists. Among the women to whom we spoke this was not the case. This is only part, but an important part of the reason why they do not on the whole seek medical help for their condition. For many of the women to whom we spoke, those who could have provided most help – their mothers and sisters or spiritual guides of a religious kind – were a long way away. The absence of a person to talk to would intensify the experience of holding their thoughts in their heart.

We conclude that there is a category – the thinking illness – which constitutes a recognition of illness other than purely physical illness but this is not to say that it corresponds simply to the English language term 'mental illness' with all that that implies. It carries with it many of the characteristics which might well be summarised in the term 'depression' but varies in the important respects we have mentioned. The absence of a

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concerted focus on 'myself' is undoubtedly significant. The development of an idea of 'myself' as an object which may be reflected upon, acted upon, and even treated is not a universal phenomenon. It requires a kind of individualistic philosophy, a degree of medicalisation of life and even a self-centredness or self-indulgence which these women do not display.

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Notes

1 Economic and Social Research Council 1987–88: S. Fenton and K. Poonia. Concepts of Health and Illness. South Asian women in Bristol. End of Award report GOO 232280.
2 Commission for Racial Equality 1988–90: S. Fenton and A. Sadiq. South Asian Women and Depression.

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