Soc Psychiatry Psychiatr Epidemiol (2000) 35: 326–334

ORIGINAL PAPER

S. Sheikh · A. Furnham

A cross-cultural study of mental health beliefs and attitudes towards seeking professional help

Accepted: 6 March 2000

Abstract *Background*: This study sets out to examine the relationship between culture beliefs about the causes of mental distress and attitudes associated with seeking professional help for psychological problems. It was hypothesised that there is a meaningful and statistical relationship between these variables and that there will be a difference in this relationship between Asians and Westerners. Participants were 287 adults belonging to three groups (British Asian, western European and Pakistanis). *Method*: Participants completed two questionnaires: the Orientations to Seeking Professional Help (Fischer and Turner 1970) and the Mental Distress Explanatory Model Questionnaire (Eisenbruch 1990) and a demographic data sheet. *Results*: Analysis indicated that positive attitudes toward seeking professional help for psychological distress were similar for British Asians, Westerners and Pakistanis. There were significant differences between the three groups in the causal attributions of mental distress. Although culture, as a variable, was not a significant predictor of a positive attitude to seeking professional help, causal beliefs of mental distress were significant predictors of attitudes to seeking help for the British Asian and the Pakistani groups. Beliefs were not significant predictors for attitudes to seeking help for the Western group. *Conclusion*: It was concluded that culturally determined causal beliefs of mental distress contribute to attitudes towards seeking professional help for psychological problems for Asians. Implications for both research and the provision of more appropriate health services for the British Asian minority group in the United Kingdom are discussed.

S. Sheikh (✉) · A. Furnham
Department of Psychology,
University College London,
26 Bedford Way, London WH1 OAP, UK
e-mail: Shaheen.Sheikh@ucl.ac.uk
Tel.: +44-20-75045346; Fax: +44-20-74364673

Introduction

The way in which people come to understand their mental distress has been shown to be strongly related to wider cultural health beliefs (Helman 1985, 1990; Herzlich and Pierret 1987). In studying the relationship between ethnicity and conceptions of mental distress, anthropologists have shown how people from different cultures explain mental distress and how these 'explanatory models of distress' influence causal attribution and presentation of a disorder as well as determining patterns of help-seeking (Kleinman 1987; Helman 1990). Healers have attested to the importance of understanding distress beliefs for good patient/healer communication (Kleinman 1978; Tuckett and Williams 1984; Greenfield et al. 1987). Weiss (1996) has suggested that illness meaning should be an integral consideration for diagnostic validity.

The association between conceptions of mental distress and the attitudes that people have towards seeking professional help for their mental health problems has been demonstrated by Hall and Tucker (1985) in the United States. Research carried out in the Indo-subcontinent by Nichter (1980) found congruence between conceptual models employed by patients and choice of healer, and Weiss (1996) found that the conceptual model by which patients understand their distress is predictive of both symptom presentation and help seeking.

Attitudinal differences underlying actual help seeking are assumed to be culturally determined (Henley 1979; Bal 1987; Schofield 1987). Whereas in the Indo-subcontinent, overall trends appear to be towards the inclusion of a more 'scientific' therapy into traditional ways of help seeking (Ramesh and Hyma 1981), it has been suggested that Asians residing in the United Kingdom are reluctant to bring psychological problems to health practitioners (Cochrane and Stopes-Roe 1981; Rack 1982; Currer 1986; Murray and Williams 1986; Gillam et al. 1989; Fenton and Sadiq 1993). However,

research has rarely examined directly the relationship between beliefs about mental distress and their influence on help-seeking behaviour. One of the few studies undertaken in the UK in this area has been that of Hatfield et al. (1996). The 'will of God' was found by this survey to be one of the three factors seen as the causes of mental illness. At the same time, the value of prayer was mentioned repeatedly as a way of seeking help for mental illness.

Most societies attribute their distresses to both natural and supernatural causes (Landy 1977; Furnham et al. 1999). Anthropologists such as Helman (1990) and others (Marsella and White 1982; Kleinman 1987) differentiate between Western and non-Western causal beliefs about mental distress along certain dimensions. Social and supernatural aetiologies are associated with the more traditional cultures of the non-Western societies in general, while natural or patient-centred explanations of distress are more common in the Western industrialised world (Landrine and Klonoff 1992, 1994). However, the essential distinction between Asian and Western cultures is a medical pluralism that is a tradition in the Indo-subcontinent (Leslie 1976; Weiss et al. 1986). This applies to the constructions of mental health and distress as well as the range of treatment options (Bhattacharya 1986; Weiss et al. 1986).

Beliefs of individuals of migrant communities, such as the British Asians in the UK, are influenced by the values of both their home culture, and the host society as well as those perpetuated by its health system (Helman 1990). However, there is evidence that beliefs of traditional cultures are more deep rooted and structured than those that exist within Western societies (Helman 1985; Ballard 1994). Littlewood and Lipsedge (1997) emphasise the historical importance of religion in such cultures and its significance in the understanding of mental illness. This study aims to investigate the role of culture in the attitudes associated with seeking professional help for mental distress as well as in beliefs about the causal attributions of mental distress. It sets out to investigate the relationship between culturally determined causal attributions of mental distress and attitudes to seeking professional help.

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

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

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

It was hoped that this comparison would clarify what was independently functional in cultural groupings and what was borrowed from other, often the host, culture. Lonner, too, has suggested that this might be a significant step in clarifying shared *etic* features and idiosyncratic *emic* features. Therefore, in this investigation, although the role of culture is assumed to be substantial, and universality is not assumed in advance, an analysis of cultural differences and similarities will be made with reference to the cultural and social context.

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

It is hypothesised that the Asian groups will have higher scores in beliefs of supernatural causes of mental distress, while the Western group will have higher scores in beliefs related to stress-related causes. The Western group will have higher scores in physiological causes of mental distress (such as chemical imbalance in the brain) compared to the Asians groups, while the latter will have higher scores on non-Western physiological causes (such

as the balance of humours in the body). It is also hypothesised that the Asians groups will have a less positive attitude to seeking professional help. It is predicted that demographic variables such as age, sex, religion and levels of education will influence attitudes to seeking professional help across the three groups as well as causal beliefs of mental distress. The association between causal beliefs of mental distress and attitudes to seeking professional help will be investigated.

Subjects and methods

Participants

Participants were 287 adults, comprising 115 British Asians, i.e. those with origins in the Indo-subcontinent (73 Pakistanis, 30 Indians, 12 East Africans), 85 white Westerners (58 English and 27 Europeans), and 77 Pakistanis, i.e. those born in the subcontinent and still resident in Pakistan. The Pakistani sample was drawn from the city of Karachi. The two groups resident in the United Kingdom were drawn mainly from three areas in London: Central London, and suburbs in the south-west of London (near Kingston upon Thames) and in the west of London (Southall). One-fifth (21.5%) of the Asians were born in the United Kingdom.

In the case of the British Pakistanis, respondents were approached through two drop-in centres in Southall over a period of 8 months. These centres, funded by the local council, provide some teaching in art, sewing and computers, but they cater predominantly to the Asian community in the areas as a meeting place for people to play cards or to chat in the common room. Out of a total of 140 people approached. 10% declined and a further 10% were not included because of incomplete questionnaires (questionnaires were considered incomplete when more than three items were not completed).

There were greater problems in accessing the Western sample. This was largely due to the fact there was a lack of representative community meetings or places (other than ones that reflected a particular interest group). Furthermore, a door to door strategy was considered unsafe. As a consequence, they were randomly approached through a dentist's surgery as well as in a park (Russell Square) in Central London. Out of a total of 110 people approached, there were 18 refusals.

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

There were no significant differences between British Asians, Westerners and Pakistanis with regard to marital status, highest education level obtained and income (Table 1).

There were several reasons for incorporating Indians, Pakistanis and East African Indians in one sample termed 'British Asians'. Firstly, religious and regional identities cut across their national identities of origin; secondly, these sub-groups have some traditions, as well as languages, in common, although others are specific to each group; thirdly, their experiences as immigrants shape their identity and experiences in this country; lastly, and most importantly, research has shown important common beliefs amongst South Asians in the Indo-subcontinent (Hofstede 1980; Kakar 1982) and abroad (Clarke et al. 1990). This point is particularly pertinent because Ware and Kleinman (1992) have suggested that illness beliefs can be one way of operationalising culture in research.

The Pakistanis a large number of whom migrated from India during Partition, can also be considered culturally heterogeneous, having arrived from all parts of the sub-continent to a large metropolitan city such as Karachi. Although it is assumed that there will be more similarities than differences between this group and the British Asian group, this group is considered a culturally separate group for purposes of this investigation.

Table 1 The distribution of cultural groups by sex, age, religion, marital status, education and income

Variables	Cultural groups		
	Westerners *n* (%)	British Asians *n* (%)	Pakistanis *n* (%)
Sex			
Men	33 (38.8%)	42 (36.5%)	30 (39.0%)
Women	52 (61.2%)	73 (63.5%)	47 (61.0%)
Age			
18–30 years	45 (53.0%)	51 (44.4%)	50 (65.0%)
31–40 years	22 (25.9%)	23 (20.0%)	13 (16.9%)
41–50 years	7 (8.2%)	25 (21.8%)	12 (15.6%)
51–60 years	10 (11.8%)	14 (12.2%)	2 (2.6%)
Over 60 years	1 (1.2%)	2 (1.7%)	
Religion			
Muslim	2 (2.5%)	82 (71.7%)	67 (87%)
Hindu	1 (1.2%)	16 (13.3%)	0
Christian	48 (57.1%)	8 (6.7%)	5 (6.5%)
Sikh	0	6 (5.0%)	1 (1.3%)
Jewish	3 (3.8%)	0	0
Parsi	0	0	4 (5.2%)
No affiliation	30 (35.7%)	1 (1.5%)	
Marital status			
Single	59 (72.2%)	52 (45.0%)	47 (61.5%)
Married	21 (22.8%)	55 (50.0%)	25 (32.5%)
Divorced	3 (3.8%)	3 (2.5%)	2 (2.6%)
Widowed	1 (1.3%)	3 (2.5%)	3 (3.9%)
Education			
University degree	45 (50.6%)	75 (65.5%)	55 (71.4%)
Secondary education	38 (46.9%)	37 (31.9%)	13 (16.9%)
Primary education	1 (1.3%)	3 (1.3%)	9 (11.7%)
Income[a]			
3000–5000	7 (8.9%)	12 (10.3%)	6 (8.0%)
5001–10,000	7 (8.9%)	6 (5.1%)	7 (9.4%)
10,001–15,000	9 (11.4%)	13 (8.5%)	9 (11.8%)
15,001–20,000	9 (11.4%)	16 (13.7%)	10 (12.0%)
20,001–25,000	19 (21.4%)	16 (13.7%)	12 (12.6%)
25,001 +	33 (40.5%)	50 (43.6%)	33 (45.2%)

[a] Annual income for British Asians and Westerners in pound sterling; monthly income for Pakistanis in rupees

The Western group (British and European) comprised the native English population and Europeans who had been living in the United Kingdom for more than 10 years. This group, as a reference group to the British Asian group, also comprises subgroups with different nationalities, languages and religious orientations (although, by and large, Christian in faith).

Inevitably, this sample was not representative of the general population from which they were drawn, being younger and better educated. Those factors would no doubt be associated with fewer beliefs in supernatural causes and this may obscure cultural differences. Thus, the result of the study will tend to be a somewhat conservative investigation of cultural differences.

Measures

The Orientations for Seeking Professional Help (OSPH) questionnaire

The OSPH is a 29-item questionnaire that assesses attitudes associated with seeking professional help for psychological problems. The scale has a four-point Likert format, with responses to each item ranging from 'strongly disagree' to 'strongly agree'. This was

adjusted to a seven-point Likert format scale in order to pick up a wider range of nuances in the responses. Eleven of these items are positively and 18 negatively worded. Negative items are reversed for scoring.

The structure of this questionnaire was hypothesised by Fischer and Turner (1970) to be multidimensional, with four factors. Although they seemed to possess good psychometric properties when used in diverse populations both in the United States and in other countries (Raviv et al. 1989), later studies showed the underlying sub-structure to be unstable (Surgenor 1985). Fischer and Turner advised using the total scale scores as a unidimensional measure for assessing a help-seeking attitude – the higher the rating the more positive the attitude. The scores of the OSPH were therefore used here as a unitary measure only. The internal reliability of the summated scores of the OSPH was 0.84 for the British Asian sample, 0.81 for the Western sample and 0.77 for the Pakistani sample.

The Mental Distress Explanatory Model Questionnaire (MDEMQ)

The MDEMQ is a 42-item questionnaire that explores how people from different cultures explain mental distress. It was constructed to include a range of personalistic, naturalistic, internalising and externalising items, based on the models of culturally constructed beliefs by both Foster (1976) and Young (1976a, b) and the classificatory systems of Murdock et al. (1978a, b) and Landy (1977). It is based on Kleinman's explanatory model framework, to provide a combined *emic* and *etic* cross-cultural comparison of theories of illness causation. Eisenbruch (1990) distinguished between Western and non-Western causal beliefs of mental distress by taxonomising a wide range of beliefs into four causative categories. Stress and Western physiological causes were postulated as being more dominant in Western cultures, and supernatural and non-Western physiological causes typified non-Western explanations of mental distress. In order to pick up greater nuances of responses, the scale, originally a five-point Likert scale was adjusted to a seven-point Likert format with responses to each item ranging from 'highly likely' to 'highly unlikely'. The internal reliabilities calculated for the three groups are given in Table 2 and appear satisfactory.

Procedure

Participants were given an information sheet about the research and each participant was asked to sign a consent form. Before giving each participant a set of questionnaires, the following statement was read by the respondent:

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

The written instructions given with the OSPH scale were:

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

A demographic data questionnaire, which requested ethnicity, age, sex, marital status, religion, mother tongue, education obtained, income and length of stay in the United Kingdom, was also completed.

Table 2 Alpha reliabilities of the Mental Distress Explanatory Model Questionnaire (MDEMQ) causative categories for British Asians, Westerners and Pakistanis

	British Asians	Westerners	Pakistanis
Stress causes	0.92	0.91	0.77
Western physiological causes	0.85	0.78	0.78
Supernatural causes	0.95	0.95	0.91
Non-Western physiological causes	0.77	0.80	0.71

Results

A hierarchical multiple regression analysis of the sum total of the scores from the OSPH was performed in order to investigate whether culture was a predictor of a positive attitude towards seeking professional help for mental distress. The demographic variables entered in this analysis were sex, age, education, religion and culture. Culture was entered as the last variable, the increase in variance explained by the latter over and above that of other variables being the test of significance of culture. Results indicated that culture, as a variable, was not statistically significant in a positive attitude towards seeking professional help (Table 3).

Significant predictors in this sample of a positive attitude to seeking help were sex, level of education and religion. Means indicated that men had a less positive attitude to seeking professional help than women (males' mean = 124.5, SD = 18.6; females' mean = 132.8, SD = 20.1). Means also indicated that those with no education or only primary education had a less positive attitude than those with secondary education (no/primary education mean = 127.1, SD = 17.3; higher education mean = 132.6, SD = 20.4). Muslims had a

Table 3 Culture as a predictor of a positive attitude to seeking professional help for mental distress: results of a hierarchical multiple regression analysis of the sum total of the scores from the orientations for Seeking Professional Help (OSPH) questionnaire[a]

	B	β	*T*
Sex	8.36	0.20	3.34***
Age	0.78	0.08	1.34
Education	−3.28	0.13	−2.22*
Religion	2.14	0.20	3.42***
Culture	0.42	0.03	−0.66
	$F = 8.89$***; multiple $R = 0.30$; $R^2 = 0.09$; adjusted $R = 0.08$		

***$P < 0.001$; **$P < 0.01$; *$P < 0.05$

[a] Total *N* was 295. *N* was reduced to 289 with the deletion of 6 cases because of missing data. Mean substitution was made for cases withone missing variable in a multi-variate variable. Adjustment was made for outliers. *N* was further reduced to 287 because of 2 cases with multivariate outliers, which were deleted from the data set

Table 4 Culture as a predictor of causal beliefs about mental distress: results of a hierarchical multiple regression analysis of the MDEMQ Scores[a]

	Stress			Western phys.			Supernatural			Non-Western phys.		
	B	*β*	*T*	*B*	*β*	*T*	*B*	*β*	*T*	*B*	*β*	*T*
Sex	−0.59	−0.02	−0.42	−9.7	−0.00	−0.10	−1.7	−0.04	−0.74	−0.25	−0.02	−0.38
Age	−0.98	−0.17	−2.9**	−0.59	−0.15	−2.6*	−1.6	−0.17	−2.9**	−0.26	−0.09	−1.6
Education	0.46	0.03	0.54	0.92	0.03	0.09	4.2	0.17	2.9**	0.73	0.10	1.8
Religion	0.26	0.04	0.72	4.8	0.01	0.84	−1.8	−0.18	−3.08**	−0.46	−0.16	−2.6**
Culture	4.9	0.34	5.8***	2.0	0.20	3.5**	4.5	0.18	3.15**	1.6	0.23	3.8***
	Multiple $R = 0.41$; $R^2 = 0.17$; Adjusted $R = 0.16$; $F = 26.83$***			Multiple $R = 0.28$; $R^2 = 0.08$; Adjusted $R = 0.07$; $F = 12.10$***			Multiple $R = 0.37$; $R^2 = 0.14$; Adjusted $R = 0.12$; $F = 10.11$***			Multiple $R = 0.39$; $R^2 = 0.09$; Adjusted $R = 0.08$; $F = 8.44$***		

***$P < 0.001$; **$P < 0.01$; *$P < 0.05$

[a] Total N of 295 was reduced to 287 with the deletion of 8 cases because of missing data. Mean substitution was made for those cases with just a single missing variable in a multi-variate variable. Adjustment was made for outliers, except for one variable (MDEMQ2) with more than 10 outliers on the one score. These scores were retained

less positive attitude to seeking professional help than Hindus, Sikhs, Christians and those with no religious affiliation (Muslim mean = 125.8, SD = 19.50; Hindu mean = 136.8, SD = 20.8; Sikh mean = 135.2, SD = 21.0; Christian mean = 133.1, SD = 17.7; no religious affiliation mean = 135.5, SD = 22.6).

The four causative categories of the MDEMQ were analysed using hierarchical multiple regression. The demographic variables entered in this analysis were sex, age, education, religion and culture. Culture was entered as the last variable. The increase in variance explained by culture, over and above that explained by other variables, was the test of significance of culture. Results indicated that culture, as a variable, was significant as a predictor of all four causative categories: stress, Western physiological, supernatural and non-Western physiological causes (Table 4).

Other significant predictors of the causative categories of mental distress were age for the categories of stress and supernatural causes, education for supernatural causes and religion for supernatural and non-Western physiological causes. Means indicated that younger subjects (those under the age of 35 years) had greater beliefs in both stress and supernatural causes than those over 35 years of age, which is a counter-intuitive finding. Those with no education or only primary education had more beliefs in supernatural causes than those with higher education. Muslims had more beliefs in supernatural and non-Western physiological causes than Hindus, Sikhs, Christians and those with no religious affiliation (Table 5).

A simultaneous multiple regression was used to analyse the relationship between beliefs about causes of mental distress and a positive attitude to seeking professional help for the British Asian, Western and Pakistani groups separately. As a whole, causal attributions of mental distress were significant predictors of attitude to seeking professional help for the two Asian samples but not for the Western sample. They accounted for 12% of the variance for the British Asian sample (multiple $r = 0.35$, $r^2 = 0.12$) and for 25% of the variance for the Pakistani sample (multiple $r = 0.50$, $r^2 = 0.25$). Specifically, beliefs about Western physiological causes were significant predictors for a positive attitude to

Table 5 Means (SD) for MDEMQ causal categories for **A** culture and **B** religion

A Cultural groups

Causal beliefs	British Asian	Westerners	Pakistanis
Stress causes	45.80 (12.9)	51.01 (11.1)	56.53 (8.2)
Western physiological causes	31.38 (8.8)	33.74 (6.7)	35.90 (6.9)
Supernatural causes	47.35 (19.8)	44.55 (18.2)	57.80 (18.57)
Non-Western physiological causes	15.16 (5.6)	14.78 (5.1)	18.47 (5.00)

B Religion

Causal beliefs	Muslim	Hindu	Sikh	Christian	No religious affiliation
Stress causes	50.18 (12.3)	47.44 (12.0)	48.14 (10.2)	51.29 (11.4)	53.65 (11.1)
Western physiological causes	33.15 (8.6)	32.06 (7.7)	34.85 (10.1)	33.83 (6.6)	34.59 (7.02)
Supernatural causes	51.87 (20.9)	48.00 (16.5)	46.71 (15.9)	47.43 (17.9)	46.08 (17.6)
Non-Western physiological causes	16.45 (5.5)	16.25 (5.4)	14.00 (4.47)	15.81 (5.4)	15.08 (5.3)

Table 6 Regression of beliefs of the causal attribution of mental distress on a positive attitude towards seeking professional help for mental distress

Causal beliefs	British Asians			Westerners			Pakistanis		
	B	*β*	*T*	*B*	*β*	*T*	*B*	*β*	*T*
Stress	0.20	0.12	0.79	0.42	0.26	1.67	0.01	0.00	0.02
Supernatural	−0.30	−0.29	−1.88	−0.15	−0.15	−0.89	−0.41	−0.41	−3.21**
Western physiology	0.31	0.12	0.76	−0.01	−0.00	−0.03	0.95	0.35	2.20*
Non-western physiology	−0.76	−0.20	−1.37	−0.11	−0.03	−0.17	0.64	0.17	1.16
	Multiple $R = 0.35$; $R^2 = 0.12$; Adjusted $R^2 = 0.09$; $F = 3.55$***			Multiple $R = 0.21$; $R^2 = 0.04$; Adjusted $R^2 = 0.00$; $F = 0.92$***			Multiple $R = 0.50$; $R^2 = 0.25$; Adjusted $R^2 = 0.20$; $F = 4.88$***		

***$P < 0.001$; **$P < 0.01$; *$P < 0.05$

seeking professional help, while supernatural causes were significant predictors for a negative attitude towards seeking professional help for the Pakistani sample only (Table 6).

Discussion

The results indicated that culture was not a significant predictor of attitudes towards seeking professional help for mental distress. This result goes against the prediction that the Asian groups would have a less positive attitude towards seeking professional help for mental distress than the Western group, though it could reflect sampling problems. It also does not support evidence or assumptions, in the case of the British Asians, of inhibitions regarding seeking professional help for mental distress.

This finding, however, is not altogether surprising. In the Indo-subcontinent, a varied range of help seeking for mental distress increasingly includes Western therapies, as Ramesh and Hyma (1981) have noted. More recently, with the growing globalisation of the media, the 'psychologisation' of many aspects of life and health and the increasing acceptability of seeking psychotherapeutic solutions could account for more positive attitudes to seeking professional help.

Although differences in a positive attitude to seeking professional help, measured as a undimensional measure between the three cultural groups, are not evident, the meaning attached to a positive attitude to seeking help could, nevertheless, be different for each of the groups. In a culture where the range of treatment for any disorder has traditionally been more pluralistic when seeking help for illness than in the West, positive attitudes to treatment could cover a variety of pathways to treatment, not all of them leading to a medically trained professional. For those Asians residing in Pakistan, where medical pluralism is the norm, seeking professional help might entail a range of therapies, professional and otherwise. In the British Asian community, an individual with mental health problems would possibly consider it more appropriate to talk to someone from his/her social network, such as an elder in the community or a priest, rather than a professional, who might be considered more appropriate by a Westerner.

On the other hand, British Asians are probably influenced by the values and beliefs systems of the culture of society in which they reside, as well as the prevalent health system. In the United Kingdom, where the norm is health-care services under the National Health Service, attitudes to seeking help for psychological problems are probably mediated by the fact that the medical model of treatment is more widely available than other forms of treatment, as well as being free.

Religion was a significant predictor of attitudes to seeking help. This finding confirms the emphasis given by Littlewood and Lipsedge (1997) on an aspect of culture that provides people with ways of interpreting and understanding mental distress, and may be giving a truer picture of people's traditional values. In looking at the mean scores, Muslims have the lowest scores and those with no religious affiliation have the highest scores for a positive attitude to seeking professional help. This is in keeping with findings from the Milltown survey (Hatfield et al. 1996) that the value of Islamic prayer was seen as an important way of seeking help for mental illness.

Although the emphasis in this research has been on the effect of culture, other demographic variables shape cultural perceptions of mental distress. The two variables that are significant predictors for a positive attitude to seeking help are sex and education. Men have a much less positive attitude to seeking professional help, as do those individuals with a lower level of education. The finding that the lower the level of education, the less positive the attitude to seeking professional help (if the latter term is perceived as one referring to seeking Western medical treatment), may have been expected. However, the difference found between men's and women's attitudes towards seeking help does not support findings of other research.

In the case of the British Asians, research has shown women in this ethnic minority group to be more inhibited in seeking help (Fenton and Sadiq 1993; Currer

1986). While the sample sizes of these qualitative studies make their findings difficult to generalise, the high rates of suicides amongst Asian women in the United Kingdom (Raleigh 1996) is perhaps a testimony to an unmet need for help. However, men often find it difficult to express the need for seeking help, and self reliance is, therefore, considered important in dealing with mental distress.

Analysis of causal beliefs of mental distress showed that culture was significant in all four causative categories of mental distress hypothesised by Eisenbruch (1990). These results support the assertion of many theorists (Marsella and White 1982; Weiss et al. 1986; Eisenbruch 1990) that non-Western cultures have a different conceptualisation of mental distress from Western cultures. The lower mean scores of the British Asian group compared with those of the Western group in the categories of stress and Western physiological causes confirmed Eisenbruch's hypothesis of the distinction between Western and non-Western beliefs. However, an analysis of the pattern of responses across all three cultural samples did not show a Western/non-Western distinction between higher scores for the Western group on the one hand and lower scores for the British Asian and Pakistani groups on the other.

Pakistanis, rather than Westerners, had higher scores for these two Western categories, with the British Asians scoring the lowest of all three cultural groups. Indeed, Pakistanis had higher scores in all categories of causal beliefs. These results may be truly reflective of the medically pluralistic setting of Pakistanis, in which all four causative categories exist within the aetiologies of allopathic, humoral and sacred medicine (Leslie 1976). The 'assimilative character of medically pluralistic settings', in which people from the sub-continent view the medical systems as more or less interchangeable, is different from the compartmentalisation evident in Western cultures (Bhattacharya 1986). In the case of the British Asian group, however, it seems that in residing in another culture and within a Western medical system, this broadly holistic medical outlook has been modified over time.

The two Asian samples had higher scores for the non-Western categories of supernatural and non-Western physiological causes. This result is an indication of the adherence of the more traditional cultures to cultural beliefs about health and illness, particularly in the case of the migrant British Asian group. Not unsurprisingly, religion also is a significant predictor for the two non-Western categories of supernatural causes and non-Western physiological causes. Again, means show that Muslims had by far the highest score for belief in supernatural causes compared to all other religions, while those with no religious affiliation have the lowest scores in supernatural causes of mental distress. More than indicating a difference between religions, this finding shows the effect of religiosity in different cultural groups. While 35% of the Western group were of no religious affiliation, only 1.5% of the British Asian group had no religious affiliation and none in the Pakistani group. This result again supports the findings of Hatfield et al. (1996), who found, in a survey carried out in Milltown, that 'the will of God' was cited as one of the three main causes of mental illness by Asians.

However there were two other interesting findings with respect to beliefs in supernatural causes of mental illness. First, as is noticeable in Table 4, younger people tended to believe in supernatural beliefs more than older people (those over 35 years). This is a counter-intuitive finding against previous research that indicates that younger people tend to reject supernatural explanations. This may be due to sampling restrictions or possibly a manifestation of an anti-scientific attitude among young people, many of whom seem disillusioned with modern medicine and psychiatry and turn to many alternative therapies (Vincent and Furnham 1997). A second finding was that Pakistanis were considerably more likely to believe in supernatural causes than British Asians and Westerners. This may be attributable to their religion (Islam) and the fact that they are probably more exposed to supernatural explanations for everyday events compared to those living in the West. Furnham et al. (1999) also found that the view that supernatural factors play a causative role in both health and illness was the factor that most powerfully differentiated between those living in the first and third world.

Muslims also have the highest score for non-Western physiological causes, although the differences between all the groups are much smaller than for supernatural causes. This category incorporates many items that could be interpreted as aspects of beliefs in alternative healing systems (e.g. body being out of balance). This might account for the fact that younger people in this sample had higher scores in this category. However, the level of education was again a significant predictor for this category, with higher scores for those with lower levels of education. These two separate, perhaps contradictory findings, illustrate the difficulty of separating *emic* (unique to one culture) and *etic* (common across cultures) concepts.

Although culture was not a significant predictor for attitudes towards seeking professional help for mental distress, the findings showed that cultural causal beliefs about mental distress were significant predictors of attitudes to seeking help for the two Asian samples and not for the Western sample. This finding indicates the strength of the values and beliefs of the more traditional cultures. When analysed more specifically, it is only in the Pakistani group that particular categories of beliefs predicted attitudes to seeking help. The more traditional beliefs of supernatural causes predicted a less positive attitude, while beliefs in Western physiological causes predicted a more positive attitude to seeking professional help.

It is to be expected that individuals with more beliefs in the supernatural or in non-Western physiological explanations as causes of mental distress would not have a positive attitude to seeking help for psychological

problems, but this relationship was significant only for Pakistanis. The contrast between the Pakistani and the British Asian sample indicates possibly the effect of acculturation on a migrant community, as the strength of association between beliefs and attitudes is eroded. On the other hand, although these traditional beliefs and attitudes are deeply held, a migrant community might have more difficulty in expressing these beliefs. If that is true, and since British Asians' expressed attitudes towards seeking professional help did not differ significantly from the Westerners, their under-utilisation of health services may be explained in their more traditional conceptions of the causal attributions of mental distress.

The taxonomies of beliefs proposed by Eisenbruch (1990) are useful ways of understanding people's beliefs rather than distinct categories. The problems in classifying a wide range of beliefs have become apparent in this study – a point that had also been made by Eisenbruch (1990) in his original study. He found the dichotomy between natural and supernatural causes to be an artificial one – a criticism that had been made by Landy (1977) earlier. This point is illustrated by some of the items of the MDEMQ, which could be classified as both a Western or non-Western belief (e.g. being born this way). In addition, clear distinctions become blurred in a multicultural setting. As an example, ' body being out of balance or harmony' can assume two quite separate meanings, as can terms such as 'a person's karma'. Coupled with the present day resurgence of the more holistic beliefs, these categories are no longer dichotomous between cultures.

The ambiguous nature of some of the questions of the OSPH could also have contributed to the findings that showed culture as not significant in predicting a positive attitude to seeking help. For example, 'I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family', might have a very different meaning for the cultural groups. Furthermore, answering negatively to the some of items of the OSPH might lead to a higher total score but would not, necessarily, mean a more positive attitude to seeking *professional* help for psychological problems. Examples are: 'Emotional difficulties, like many things, tend to work out by themselves'; 'Keeping one's mind on a job is a good solution for avoiding personal worries and concerns'; 'It is probably best not to know everything about oneself'; 'There are experiences I would not discuss with anyone'.

The findings in this study are limited in their generalisability because of the high level of education in all three groups. There are considerable problems in generalising results to the general population, since, in an effort to standardise samples, real socio-cultural differences have been minimised. However, the level of education was comparable to those of the Western group and these results could indicate real cultural differences in the causal attributions of mental distress. If that is assumed to be the case, rather than applying 'culture' as a mere label in the form of an independent variable, these findings illustrate, as Ware and Kleinman (1992) have suggested, that cultural beliefs about health and illness can provide a useful way of operationalising culture.

Further research is needed to investigate the conceptions of mental distress of Asians, particularly those who reside in the United Kingdom. The reported under-utilisation of mental health services by the British Asians in this country, in addition to research that has shown higher levels of mental distress in this community than had been previously supposed, indicate a need for further investigation of cultural differences in conceptions of mental illness. Future research should seek a more representative sample of this minority group, particularly those who form the more disadvantaged sub-groups within the community, in socio-economic terms.

If such research supports the association between the causal beliefs of mental distress and attitudes towards help seeking, it may help to illustrate ways of developing and providing more culturally appropriate services for this ethnic minority group in the United Kingdom.

References

Bal SS (1987) Psychological symptomology and health beliefs of Asian patients. In: Dent H (ed) Clinical psychology: research and development. Croom and Helm, London, pp 101–110

Ballard R (ed) (1994) Desh Pardesh: the South Asian presence in Britain. Routledge, London

Bhattacharya D (1986) Pagalami: ethnopsychiatric knowledge in Bengal. Maxwell School of Citizenship and Public Affairs, Syracuse

Clarke C, Peach C, Vertovec S (1990) South Asians overseas: migration and ethnicity. Cambridge University Press, Cambridge

Cochrane R, Stopes-Roe M (1981) Psychological symptom levels in Indian immigrants to England: a comparison with native English. Psychol Med 11: 319–327

Currer C (1986) Concepts of mental well- and ill-being: the case of Pathan mothers in Britain. In: Currer C, Stacey M (eds) Concepts of health, illness and disease. Berg, Leamington Spa, pp 181–199

Eisenbruch M (1990) Classification of natural and supernatural causes of mental distress: development of a mental distress explanatory model questionnaire. J Nerv Ment Dis 178: 712–719

Fenton S, Sadiq A (1993) The Sorrow in my Heart: sixteen Asian women speak about depression. Commision for Racial Equality, Bristol

Fischer EH, Turner JL (1970) Orientations to seeking psychological help: development and research utility of an attitude scale. J Consult Clin Psychol 35: 79–90

Foster GM (1976) Disease etiologies in non-western medical systems. Am Anthropol 78: 773–776

Furnham A, Akande D, Baguma P (1999) Beliefs about health and illness in three countries: Britain, South Africa and Uganda. Psychol Health Med 4: 189–201

Gillam SJ, Jarman B, White P, Law R (1989) Ethnic differences in general practice consultations. BMJ 299: 958–960

Greenfield SF, Borkan J, Yodfat Y (1987) Health beliefs and hypertension: a case control study in a Moroccan Jewish community in Israel. Cult Med Psychiatry 11: 79–95

Hall LE, Tucker CM (1985) Relationships between ethnicity, conceptions of mental distress and attitudes associated with seeking psychological help. Psychol Rep 57: 907–916

Hatfield B, Mohamad H, Rahim Z, Tanweer H (1996) Mental health and the Asian communities: a local survey. Br J Soc Work 26: 315–336

Helman CG (1985) Psyche, soma, and society: the social construction of psychosomatic disorders. Cult Med Psychiatry 9: 1–26

Helman CG (1990) Culture, health and illness: an introduction for health professionals. London: Wright

Henley A (1979) Asian patients in hospital and at home. Kings Fund, London

Herzlich C, Pierret J (1987) Illness and self in society. Johns Hopkins University Press, Baltimore

Hofstede G (1980) Culture's consequences. Sage, Beverly Hills

Joshi MS (1998) Adherence in ethnic minorities: the case of South Asians in Britain. In: Myers L, Midence K (eds) Adherence to treatment in medical conditions. Harwood, Amsterdam

Kakar S (1982) The inner world: a psycho-analytic study of childhood and society in India. Oxford University Press, Delhi

Kleinman A (1978) Concepts and a model for the comparison of medical systems as cultural systems. Soc Sci Med 12: 85–93

Kleinman A (1980) Patients and healers in the context of culture. University of California Press, Berkeley

Kleinman A (1987) Anthropology and psychiatry: the role of culture in cross-cultural research on illness. Cult Med Psychiatry 151: 447–454

Landrine H, Klonoff E (1992) Culture and health-related shemas: a review and proposal for inter disciplinary integration. Health Psychol 11: 267–276

Landrine H, Klonoff E (1994) Culture diversity in causal attributions for illness: the role of the supernatural. J Behav Med 71: 181–193

Landy D (1977) Medical systems in transcultural perspective. In: Landy D (ed) Culture, disease and healing: studies in medical anthropology. Macmillan, New York

Leslie C (1976) Asian medical systems: a comparative study. University of California Press, Berkeley

Littlewood R, Lipsedge M (1997) Aliens and alienists. Penguin, Harmondsworth

Lonner W (1980) The search for psychological universals. In: Triandis H, Lambert W (eds) Handbook of cross-cultural psychology: perspectives, vol 1. pp 143–204

Marsella AJ, White GM (eds) (1982) Culture and mental health: an overview. Cultural conceptions of mental health and therapy. Reidel, Dordrecht

Murdock GP, Wilson SF, Frederick V (1978a) Cultural distress and health. Anthropological studies, no. 9. American Anthropologcial Association, Washington, D.C.

Murdock GP, Wilson SF, Frederick V (1978b) World distribution of theories of distress. Ethnology 17: 449–470

Murray J, Williams P (1986) Self-reported distress and general practice consultations in Asian-born and British-born residents of West London. Soc Psychiatry 21: 139–145

Nichter M (1980) The layperson's perception of medicine as perspective into the utilisation of multiple therapy systems in the Indian context. Soc Sci Med 14B: 225–233

Rack P (1982) Race, culture and mental disorder. Tavistock, London

Raleigh SV (1996) Suicide patterns and trends in people of Indian subcontinent and Carribean origin in England and Wales. Ethnicity Health 1: 55–63

Ramesh A, Hyma B (1981) Traditional Indian medicine in practice in an Indian metropolitan city. Soc Sci Med 15D: 69–81

Raviv A, Raviv A, Yunovitz R (1989) Radio psychology and psychotherapy: comparison of client attitudes and expectations. Prof Psychol Res and Pract 20: 67–72

Schofield J (1987) Behind the veil: the mental health of Asian women in Britian. 1–3. Health Visitor 54: 138–141; 183–186; 248–251

Surgenor LJ (1985) Attitudes towards seeking professional psychological help. NZJ Psychol 14: 27–33

Tuckett D, Williams A (1984) Approaches to the explanation and information-giving in medical consultation: a review of empirical studies. Soc Sci Med 18: 571

Vincent C, Furnham A (1997) Complementary medicine: a research perspective. Wiley, Chichester

Ware NC, Kleinman A (1992). Culture and somatic experience : the social course of illness in neurasthenia and chronic fatigue syndrome. Psychosom Med 54: 546–560

Webb-Johnson A (1991) A cry for change: an Asian perspective on developing quality mental health care. Confederation of Indian Organisations, London

Weiss P (1996) Explanatory Models Interview Catalogue: framework for the comparative study of illness experience. Transcult Psychiatry 34: 235–263

Weiss MG, Sharma SD, Gaur RK, Sharma JS, Desai A, Doongaji DR (1986) Traditional concepts of mental disorder among Indian psychiatric patients; apreliminary report of work in progress. Soc Sci Med 23: 379–386

Weiss MG, Doongaji DR, Siddhartha S, Wypij D, Pathare S, Bhatawdhekar M, Bhave A, Sheth A, Fernandes R (1992) The Explanatory Model Interview Catalogue (EMIC): contribution to cross-cultural research methods from a study of leprosy and mental health. Br J Psychiatry 160: 819–830

Young A (1976a) Internalising and externalising medical belief systems: an Ethiopian example. Soc Sci Med 19: 147–156

Young A (1976b) Some implications of medical beliefs and practices for social anthropology. Am Anthropol 78: 5–24