# Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)

**A Survey carried out on behalf of the Department of Health by:**


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**Editors' acknowledgements**

1. **Introduction** *James Nazroo and Kerry Sproston*

1.1 Population surveys of psychiatric morbidity
1.2 Surveys on ethnic differences in mental health
1.3 The Study of Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)
1.4 The quantitative survey
1.5 The qualitative study
1.6 Ethical clearance
1.7 Overview of survey design
1.8 Profile of the sample
1.9 Data analysis
1.10 Availability of published data
1.11 The content of the report
Tables

2. Common mental disorders *Scott Weich and Sally McManus*

2.1 Introduction
2.2 Measures
2.3 Prevalence of the common mental disorders
2.4 Prevalence of ICD-10 diagnostic categories
2.5 Conclusions
Tables

3. Pyschosis symptoms and estimated rates *James Nazroo and Michael King*

3.1 Introduction
3.2 Measures
3.3 Prevalence of psychosis symptoms by gender
3.4 Estimated rates of psychosis by gender
3.5 Demographic factors
3.6 Socioeconomic position
3.7 Area of residence
3.8 Conclusions
Tables

4. Social function, chronic strains and personality difficulties *Peter Tyrer, Saffron Karlsen and Mike Crawford*

4.1 Introduction

4.2 Measures
4.3 Specific domains of social function, chronic strains and difficulties getting on with people and mean scores by sex
4.4 Social functioning, chronic strains and diffulties getting on with people by age and
marital status
4.5 Social functioning, chronic strains and difficulties getting on with people by socio-
economic characteristics
4.6 Social functioning, chronic strains and difficulties getting on with people and psychiatric disorder
4.7 Conclusions
Tables

5. Physical health, caring and mental health *Saffron Karlsen and Martin Blanchard*

5.1 Introduction
5.2 Measures
5.3 Physical health and the receipt of informal care
5.4 Limitation of physical activities
5.5 Emotional well-being
5.6 Limitation of social activities
5.7 Physical health and sex
5.8 Physical health and social position
5.9 Physical and mental health
5.10 Caring
5.11 Conclusions
Tables

6. Use of services *Keith Lloyd and Elizabeth Fuller*

6.1 Introduction
6.2 Measures
6.3 Recent doctor consultations
6.4 Type of doctor seen
6.5 Reasons for seeing a doctor
6.6 Other health problems
6.7 Use of other health services
6.8 Conclusions
Tables

7. Social support and networks *Stephen Stansfeld and Kerry Sproston*

7.1 Introduction
7.2 Measures
7.3 Social support
7.4 Social networks
7.5 Conclusions
Tables

8. Context, cause and meaning: qualitative insights *James Nazroo, Steve Fenton, Saffron*

*Karlsen and William O'Connor*

8.1 Introduction
8.2 Culture-bound syndromes
8.3 The qualitative approach
8.4 Findings
8.5 Conclusions
Tables

9. Methods

9.1 Overview of research
9.2 Sampling
9.3 The questionnaire
9.4 Obtaining ethical approval
9.5 Provision for non-English speaking informants
9.6 Fieldwork procedures
9.7 Data preparation
9.8 Survey response
9.9 Weighting
9.10 Age standardisation and risk ratios
9.11 Estimating standard errors: design factors
Tables

Appendices

A Questionnaire
B CIS-R and common mental disorders measurement

**Cover Page**

# 1 Introduction

*James Nazroo and Kerry Sproston*

## 1.1 Population surveys of psychiatric morbidity

Over the past decade a series of surveys on the mental health of the population of Great Britain has been commissioned by the Department of Health, Scottish Executive and the National Assembly for Wales (or their predecessors). The series began in 1993, with a survey of the adult population aged between 16 and 64 living in private households in Great Britain.[1] Since then, additional surveys have covered children aged 5 to 15 living in private households,[2] and prisoners in England and Wales.[3] The study reported here was conducted alongside a second survey of the adult population covering those aged between 16 and 74 and living in private households throughout Great Britain,[4] but this survey has as its focus five of the main ethnic minority groups in England (Bangladeshi, Black Caribbean, Indian, Irish and Pakistani people), together with a general population White group to provide a point of comparison.

The need for such surveys is clear. The recent survey of psychiatric morbidity among adults indicated that almost one in six people have a neurotic disorder (depression, anxiety, mixed anxiety and depression disorder, phobia, obsessive-compulsive disorder and panic disorder).[4] While the 1993 survey and the recent survey of adult psychiatric morbidity suggested that one in 250 people suffer from a psychotic illness.[1,4] It is also apparent that the prevalence of mental illness varies across population groups. For example, women have higher overall rates of neurotic disorders than men, similar rates of psychotic disorders and lower rates of alcohol and drug dependence,[1,4] and the prevalence of mental illness also appears to be related to socioeconomic position and ethnicity.[5,6,7]Understanding how the prevalence of mental illness might be changing over time and how it varies across populations is of importance both for policy development and an understanding of aetiology.

## 1.2 Surveys on ethnic differences in mental health

The relative prevalence of mental illness among different ethnic groups in Britain is both a controversial and complex field of inquiry.[8] Existing research evidence suggests that, as with physical health, there are important and possibly large differences in mental health across ethnic groups. Two key findings in the literature are the apparently high rates of schizophrenia and other forms of psychosis among African Caribbean people, and apparently low rates of mental illness generally among South Asian people.[9] However, findings are not entirely consistent across different studies,[10] and there have been few population surveys of ethnic differences in the prevalence of mental illness, with most work focusing on rates of contact with services for those with psychotic disorders.[11,12,13,14] This is largely because of the difficulty in including sufficiently large numbers of

ethnic minority informants in general population surveys. In fact, only one national survey (covering England and Wales) has previously been conducted,[7] and this had a fairly limited coverage of common mental (or neurotic) disorders.

An additional difficulty with conducting population surveys on ethnic differences in mental health is the possibility that there are important cultural differences in the way in which people experience and express mental illness.[15,16,17] This means that the research tools used in surveys, which are based on western psychiatric practice, may be more appropriate (and, consequently, more effective at case finding) for some ethnic groups than others.

This study was commissioned by the Department of Health to begin to address these issues.

## 1.3 The Study of Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)

As described above, this study was conducted alongside a survey of the adult population of Great Britain, and had a focus on some of the main ethnic minority groups in England. It consisted of two elements, a quantitative survey of rates of mental illness among different ethnic groups in England and a qualitative study investigating ethnic and cultural differences in the context, experience and expression of mental distress.

## 1.4 The quantitative survey

In order to overcome the difficulty of obtaining a large representative sample of ethnic minority groups, EMPIRIC used the existing 1999 Health Survey for England (HSE) to draw its ethnic minority sample.[18]

### 1.4.1 The 1999 Health Survey for England: sample and coverage

The HSE comprises a series of annual surveys commissioned by the Department of Health and designed to provide information on aspects of the population's health that cannot be obtained from other sources. The 1999 survey was the ninth in the series of surveys and the first to increase the representation of ethnic minority groups, boosting the sample of adults and children from Black Caribbean, Indian, Pakistani, Bangladeshi, Chinese and Irish communities.

To achieve the boosted sample of Black Caribbean, Indian, Pakistani, Bangladeshi and Irish people (Chinese people were sampled using a different strategy, which will be described shortly) a stratified sample of 64,000 addresses within 340 postal sectors were initially selected. These were then visited to establish whether there were any residents from the selected ethnic minority groups (in postal sectors with a low density of ethnic minority residents the technique of focused enumeration was used in order to screen a larger number of addresses cost-effectively). At households that contained residents from the selected ethnic minority groups up to four adults were randomly selected for inclusion in the HSE.

The boosted sample of Chinese people in the 1999 HSE was obtained by following up informants identified for inclusion in a 1998 study on the health of Chinese people.[19] As that sample had already been through two waves of attrition (the 1998 and the 1999 surveys), it was not included in EMPIRIC.

Further details of the sampling and screening procedures used in the 1999 HSE are provided in Chapter 14 of the report.[18]

Topic coverage of the 1999 HSE for the ethnic minority sample was similar to that for the 1998 HSE

general population sample. The special topics for both of these years of the HSE included cardiovascular disease, physical activity, eating habits, psychosocial health, and social support. The 'core' topics included smoking, alcohol consumption, general health, prescribed medication and the use of services. In addition to a questionnaire-based assessment of health, informants underwent a number of physical and blood tests.[18] As topic coverage for the 1999 HSE ethnic minority sample and the 1998 general population sample was similar, the White general population sample included in EMPIRIC was drawn from the 1998 HSE sample.

### 1.4.2 **Topic coverage**

Measures of mental health included in EMPIRIC were designed to be administered by a survey interviewer and to be used in a fully structured interview. EMPIRIC did not include a follow-up clinical interview administered by a trained clinician, as was the case for the other general population surveys,[1,4] and the previous population survey of ethnic minority people.[7] Topics that were covered, and the instruments used to cover them, were:

1. Common mental disorders, using the Revised Clinical Interview Schedule.[20,21,22]
2. Psychotic symptoms, using the Psychosis Screening Questionnaire.[23]
3. Physical health, using the SF12 questionnaire,[24,25] and questions on long-standing illness that were very similar to those used in the 1991 Census.
4. Social functioning and chronic strains using the Social Functioning Questionnaire,[26] and questions on strains used in the Whitehall II Study of British Civil Servants.
5. Social Support, using the Close Persons Questionnaire, developed in the Whitehall II Study of British Civil Servants. [28]
6. Access to services, using questions abstracted from the Short Explanatory Model Interview.[29]

## 1.5 **The qualitative study**

There is a large body of evidence suggesting that the idioms for mental distress vary across different ethnic groups.[15,16,17] The implication of possible cultural differences in symptomatic experience is that standardised research instruments will perform inconsistently across different ethnic groups, greatly restricting the validity of conclusions based on their use in surveys such as EMPIRIC. Indeed, detailed analysis of the Fourth National Survey suggested that these problems limited the conclusions that could be drawn on ethnic differences in mental health in that survey.[7,30,31]

To investigate cross-cultural validity in EMPIRIC, a qualitative study was conducted using a purposively drawn sub-sample of those included in the quantitative survey. The intention of this study was to conduct a detailed examination of ethnic differences in the way in which people both experience and express mental distress, in order to provide information on the nature of possible ethnic differences in the idioms and experience of mental distress, and the implications of this for our quantitative assessments of ethnic differences in prevalence.

As with other qualitative work, the aim was not to produce results that are statistically representative of the wider population, but to have a sample that was sufficiently heterogeneous to ensure that the full range of key issues were covered. The purposive sample was drawn to ensure that it covered each of the ethnic groups included in the quantitative survey and, within each ethnic group, to ensure that it covered different gender, age, migration history and socioeconomic groups. In addition to this, the sample was drawn to include those who had either a significant level of symptoms according to the measure of common mental disorders used in the quantitative survey, or those who did not have

symptoms, but who reported having significant difficulties in their lives according to the social functioning and chronic strain measures. Further details of the qualitative sampling strategy are given in Chapter 8.

The qualitative study used in-depth unstructured exploratory interviews, guided by a list of the topics to be covered. These included current events and difficulties in the informant's life, experiences of mental distress, and, where such difficulties or mental distress existed, responses to them and views about the causes of the difficulty or distress experienced. Again further details can be found in Chapter 8.

The interviews were conducted in the first language of the informant, tape-recorded and transcribed verbatim, after having been translated into English, if necessary, by the interviewer.

## 1.6 Ethical clearance

Ethical approval for EMPIRIC was obtained from the North Thames Multi-centre Research Ethics Committee (MREC) and ratified by all Local Research Ethics Committees (LRECs) in England.

## 1.7 Overview of survey design

The EMPIRIC survey included all HSE 1999 informants aged 16-74, who agreed, during the HSE interview, to be re-contacted, from the Black Caribbean, Indian, Pakistani, Bangladeshi and Irish groups. All those who answered 'no' to this question (about 8%) were excluded from the sample for the EMPIRIC study. The White general population sample was taken from the Health Survey for England 1998, and again, only those aged between 16 and 74 and who had agreed to recontact were eligible for inclusion. Age was calculated from the HSE data, so that the selected sample was aged between 16 and 74 at the time of the EMPIRIC interview. Those who were found, upon re-contact, to be out of this age range, were coded as 'ineligible for interview'.

Each sampled individual was sent a letter in advance of an interviewer visit. All survey materials, including the letter and the interview, were translated into five languages: Hindi, Gujarati, Punjabi, Urdu and Bengali. Informants were sent a letter written in the language that they had been interviewed in for the HSE survey. The letter explained the aims of the survey and that an interviewer would shortly be visiting. The interviewer sought the agreement of each sampled adult and then carried out an interview using Computer Assisted Personal Interviewing (CAPI). Informants who could not carry out an interview in English were provided with an interviewer who could speak the appropriate language.

Interviews were achieved with a total of 4281 adults (aged between 16 and 74) a response rate of 68.2% of in-scope individuals. Weighting has been applied to the data in all report tables. HSE weights were retained, and, in addition, weights were applied to all cases to adjust for non-response at the follow-up stage (see later).

## 1.8 Profile of the sample

The socio-demographic characteristics of the different ethnic minority populations varied. It is important to bear in mind that such differences might be associated with differences in psychiatric morbidity and health. In Tables 1.1 to 1.9 the profile of the different ethnic groups in the sample are compared across a number of socio-demographic variables. These tables do not include age standardised risk ratios.

### 1.8.1 **Age**

The South Asian, especially Bangladeshi and Pakistani, groups had a substantially younger age profile than the White group. Around six in ten Bangladeshi and Pakistani informants were aged below 34 years, compared with around three in ten of the White group. The oldest age group included around one in ten Bangladeshi and Pakistani informants, compared with a quarter of the White group. The age distribution of the Black Caribbean and Irish groups was more similar to that of the White group. These differences in age distribution should be taken into account when interpreting non-age standardised tables in the report, since age is associated with some health measures.

### 1.8.2 **Marital status**

The South Asian groups were more likely to be married, and less likely to be divorced than the other groups. Seven in ten South Asian informants were either married or cohabiting, compared with 62% and 63% of White and Irish informants respectively. Around one in ten White, Irish and Black Caribbean informants were divorced or separated, compared with 5% or less of the South Asian groups. Black Caribbean informants were the most likely to be single and never married (45% compared with 20-25% among the other groups). The marital status distribution of the South Asian groups was very similar for men and women, whereas the profile for the Black Caribbean group differed in that half of the male sample and only a third of the female sample were married or cohabiting.

### 1.8.3 **Tenure**

Housing circumstances differed greatly between ethnic groups. Three quarters of Irish and White and 85% of Indian informants were owner occupiers, compared with just over half of the Black Caribbean group and less than a third of the Bangladeshi group. Just 26% of Bangladeshi women and 38% of Bangladeshi men lived in a property their household owned or were buying. The Bangladeshi and Black Caribbean groups were the most likely, and Indian informants were the least likely, to rent their home.

### 1.8.4 **Social class**

There was considerable difference between the ethnic groups in terms of their occupational class profile, a difference that is likely to be related to differences in health measures. The South Asian groups, especially Bangladeshi and Pakistani, included higher proportions of manual households than the other groups. The highest proportion of non-manual households was found among the White group (56%) and the lowest among the Bangladeshi group (16%).

### 1.8.5 **Employment status**

The differences between the groups in terms of the informant's employment status were marked, and echoed the social class findings. The Bangladeshi group included the highest proportion of economically inactive informants (66%) and the Irish and White groups the lowest (17% and 19% respectively). Conversely, the proportion of employed respondents was highest among the White (75%) and Irish (78%) informants and lowest among the Bangladeshi (31%) and Pakistani (45%) groups.

There were marked differences between men and women that varied across ethnic group. Although on the whole men were considerably more likely to be in employment than women, this difference was particularly marked for the Pakistani and Bangladeshi group, and was not present for the Black Caribbean group, where the rates for men and women were similar.

### 1.8.6 **Educational qualifications**

The distribution of qualifications echoed the findings on social class and employment status. The

proportion of informants with no qualifications was highest among the Bangladeshi (59%) and Pakistani (44%) groups and lowest among the White, Irish and Black Caribbean groups. The proportion with at least a degree level qualification was highest among the Indian group (30%) and lowest among the Bangladeshi group (10%).

### 1.8.7 **Urbanisation**

Enormous variation by ethnic group existed in the urbanisation profile of the sample. A large majority of Bangladeshi individuals (87%) lived in an urban or inner city environment, with the next most urbanised groups being Black Caribbean (50%) and Pakistani (39%). The proportion of the Indian group living in an urban area was closer to that of the White sample than to the other south Asian groups, and Irish individuals (14%) were the least likely to be living in an urban area. Only White and Irish informants had any significant numbers living in rural areas, with the rest of the non-urban sample being suburban.

### 1.8.8 **Household composition**

While three-quarters of Bangladeshi informants lived in homes where a child was present, this was the case for only a third of White informants. The proportion of Black Caribbean and Irish informants living in homes with a child was similar to that of the White sample, while Pakistani informants approached the same proportion as that of the Bangladeshi group.

### 1.8.9 **Migration status**

The migration status of informants varied greatly with ethnic group. About half of all south Asian informants migrated to the UK after the age of ten, in contrast with one in six Irish and Black Caribbean informants. Migration status was similar for men and women within ethnic group. This question was not asked of the White group.

### 1.8.10 **Summary**

These tables have showed marked variation across ethnic groups in important demographic factors. These factors are important because they are likely to be associated with mental health within ethnic groups, and because they are also likely to be related to, and 'confound', ethnic differences in mental health outcomes. Consequently, throughout the rest of this report these factors are considered alongside ethnicity when examining differences in the prevalence of mental health outcomes both within and across ethnic groups.

## 1.9 Data analysis

### 1.9.1 **Introduction**

EMPIRIC was a cross-sectional survey of the population. It allows the examination of association between mental health states and demographic characteristics, including ethnic group, but such associations do not necessarily imply causality. In particular, the factors that underlie associations between demographic characteristics and mental health can not be detailed within the remit of a descriptive report such as this, and should not be assumed.[32]

### 1.9.2 **Weighting the sample**

Weighting has been applied to the EMPIRIC data in the following way. If weights had been applied to a particular case at the HSE stage, these were retained. Details of the weighting strategy for the 1998 and 1999 HSE surveys can be found in the reports of those surveys.[18,32] In addition, weights were

applied to all cases to adjust for non-response at the follow-up stage.

In order to correct for bias by non-response to the follow-up, we took full advantage of the HSE data (available for both respondents and non-respondents to the follow-up) to analyse the nature of non-response. Logistic stepwise regression modelling was utilised to identify significant predictors of non-response. Response to the study (binary variable) was modelled as the dependent variable. A number of HSE variables were included as possible predictors (independent variables). These included demographic indicators (eg age, sex, marital status, ethnicity, etc) health-related variables (eg self-assessed health, long-standing illness, smoking, blood pressure, etc.) as well as PSU (eg NHS region) and household level indicators (eg social class of head of household, household income, household type etc). To identify (and subsequently correct for) different response patterns by different minority ethnic groups, interactions with ethnicity were also included in the model.

### 1.9.3 **Weighted and unweighted bases in the report tables**

All of the data in the tables of this report are weighted (excluding Tables 9.1 and 9.2 examining response rates). Both unweighted and weighted bases are shown for all tables. The unweighted bases show the number of informants involved. The weighted bases show the relative sizes of the various sample elements after weighting. Scaling factors have been applied in order that the weighted size of each sample should reflect its population size. Thus the weighted base for the general population sample is very large relative to the ethnic minority group samples. The weighted sample sizes should be interpreted solely as indicating relative size. This is useful if, for example, it is desired to combine data from different columns in their correct proportions.

### 1.9.4 **Age standardisation and risk ratios**

On the whole, the ethnic minority groups had a considerably younger age profile than the White group, as shown in Table 1.1. Because of this, the risk ratios that are shown in some of the tables have been calculated after age standardisation, which adjusts for any age contribution to differences between groups.

As with the Health Survey for England reports,[18] the direct standardisation method has been used. And, as in the 1999 HSE report, the age-standardised data are presented in the form of relative risks that compare each ethnic minority group with the equivalent general population figure. In the case of a prevalence, the age-standardised 'risk ratio' is shown. If prevalence in sub-group h is $p_h$ and that in the general population $p_g$, then the risk ratio is $p_h/p_g$. Both elements are age-standardised before the ratio is computed, so that the ratio itself is age-standardised. (The age distribution to which all sub-populations are standardised is an artificial distribution that was designed to minimise the percentage increase in standard errors that the standardised weights introduce.) The same procedure was adopted for means, but the resulting ratios are referred to as 'ratios of means' not as risk ratios.

Given that the White ethnic group is taken as the base value of '1', a group with a risk ratio of, say, 1.5 is half again as likely (after allowing for age differences) to have that outcome as the population in general. Similarly, a risk ratio of 0.7 means that, after allowing for age differences, the prevalence of the condition is 30% lower in that group than in the population as a whole. The standard errors of the risk ratios (or ratios of means) are shown in the tables.

## 1.10 **Availability of published data**

A copy of the EMPIRIC data will be deposited at the Data Archive at the University of Essex. Copies of anonymised data files can be made available for specific research projects through the Archive (telephone 01206 872001).

## 1.11 **The content of the report**

Each chapter in the report dealing with the quantitative data (Chapters 2-7) reports on a broad grouping of the outcomes covered by the survey. These are:

Chapter 2 Common mental disorders.

Chapter 3 Psychosis  symptoms and estimated rates.

Chapter 4 Social function, chronic strains and personality difficulties.

Chapter 5 Physical health, caring and mental health.

Chapter 6 Use of services.

Chapter 7 Social support and networks.

In addition, Chapter 8 reports on the qualitative investigation into possible ethnic differences in the nature, experience and reporting of mental distress. This provides some context to the findings reported in Chapters 2 to 7, and, in the light of possible ethnic variation in the experience and reporting of symptoms (described earlier), an insight into how far these may have influenced the quantitative measures reported in earlier chapters.

Chapter 9 provides a detailed description of the methodology used in the survey.

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# 1 Introduction

*James Nazroo and Kerry Sproston*

## Tables

Table 1.1

**Age**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | Black | | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| 16 to 34 | 32 | 25 | 42 | 52 | 36 | 52 |
| 35 to 54 | 43 | 48 | 29 | 31 | 44 | 33 |
| 55 to 74 | 26 | 27 | 29 | 18 | 19 | 15 |
| **Female** | | | | | | |
| 16 to 34 | 31 | 31 | 37 | 64 | 40 | 61 |
| 35 to 54 | 42 | 46 | 41 | 27 | 42 | 30 |
| 55 to 74 | 27 | 22 | 22 | 9 | 18 | 9 |
| **Total** | | | | | | |
| 16 to 34 | 31 | 28 | 39 | 58 | 38 | 57 |
| 35 to 54 | 43 | 47 | 36 | 29 | 43 | 32 |
| 55 to 74 | 26 | 24 | 25 | 13 | 19 | 11 |
| *Bases (weighted)* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Male* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Female* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Female* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 1.2

**Marital status**

**Ethnic group**

| | | | Black | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| Married/cohabiting | 64 | 65 | 50 | 68 | 72 | 72 |
| Divorced/separated | 7 | 8 | 9 | 1 | 5 | 2 |
| Widowed | 2 | 3 | 3 | 0 | 0 | 1 |
| Single never married | 26 | 24 | 39 | 30 | 23 | 25 |
| **Female** | | | | | | |
| Married/cohabiting | 60 | 61 | 34 | 69 | 71 | 68 |
| Divorced/separated | 10 | 13 | 15 | 4 | 5 | 5 |
| Widowed | 6 | 4 | 3 | 8 | 5 | 3 |
| Single never married | 23 | 23 | 49 | 19 | 18 | 24 |
| **Total** | | | | | | |
| Married/cohabiting | 62 | 63 | 40 | 69 | 72 | 70 |
| Divorced/separated | 9 | 11 | 12 | 3 | 5 | 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Widowed | 4 | 3 | 3 | 4 | 3 | 2 |
| Single never married | 25 | 23 | 45 | 24 | 20 | 24 |
| *Bases (weighted)* | | | | | | |
| *Male* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Female* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Female* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 1.3

**Tenure**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| Owns or buying | 79 | 73 | 57 | 38 | 83 | 76 |
| Rents or part rents and part buys | 21 | 25 | 43 | 60 | 15 | 24 |
| Other | 1 | 1 | 0 | 2 | 2 | 1 |
| **Female** | | | | | | |
| Owns or buying | 72 | 73 | 49 | 26 | 84 | 70 |
| Rents or part rents and part buys | 27 | 27 | 51 | 71 | 14 | 29 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Other | 1 | 0 | 0 | 2 | 2 | 1 |
| **Total** | | | | | | |
| Owns or buying | 75 | 73 | 52 | 32 | 84 | 73 |
| Rents or part rents and part buys | 24 | 26 | 48 | 65 | 15 | 27 |
| Other | 1 | 1 | 0 | 2 | 2 | 1 |
| *Bases (weighted)* | | | | | | |
| *Male* | *32865* | *1359* | *327* | *128* | *536* | *330* |
| *Female* | *44068* | *1766* | *472* | *131* | *563* | *361* |
| *Total* | *76933* | *3125* | *799* | *259* | *1099* | *691* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *329* | *310* | *271* | *294* | *301* | *323* |
| *Female* | *421* | *383* | *399* | *320* | *312* | *370* |
| *Total* | *750* | *693* | *670* | *614* | *613* | *693* |

'Other' includes those who are living rent free.

Table 1.4

**Social class of Head of Household**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| Non manual | 53 | 45 | 36 | 19 | 43 | 33 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Manual | 47 | 55 | 64 | 81 | 57 | 67 |
| **Female** | | | | | | | |
| | Non manual | 59 | 51 | 47 | 14 | 46 | 36 |
| | Manual | 41 | 49 | 53 | 86 | 54 | 64 |
| **Total** | | | | | | | |
| | Non manual | 56 | 49 | 43 | 16 | 45 | 34 |
| | Manual | 44 | 51 | 57 | 84 | 55 | 66 |
| *Bases (weighted)* | | | | | | | |
| | *Male* | *36696* | *1430* | *318* | *124* | *554* | *319* |
| | *Female* | *48215* | *1837* | *463* | *112* | *563* | *311* |
| | *Total* | *84911* | *3267* | *781* | *236* | *1117* | *629* |
| *Bases (unweighted)* | | | | | | | |
| | *Male* | *364* | *324* | *267* | *283* | *308* | *311* |
| | *Female* | *460* | *401* | *393* | *272* | *315* | *326* |
| | *Total* | *824* | *725* | *660* | *555* | *623* | *637* |

Table 1.5

**Employment status**

| | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Black | | |
| | | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Male** | | | | | | | |
| | Employed | 85 | 84 | 70 | 54 | 76 | 70 |
| | ILO unemployed | 0 | 1 | 1 | 1 | 1 | 1 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Retired | 4 | 2 | 3 | 4 | 1 | 3 |
| Other economically inactive | 11 | 14 | 26 | 42 | 22 | 25 |
| **Female** | | | | | | |
| Employed | 67 | 73 | 61 | 10 | 58 | 23 |
| ILO unemployed | 1 | 2 | 5 | 1 | 4 | 3 |
| Retired | 6 | 5 | 4 | 0 | 2 | 1 |
| Other economically inactive | 26 | 20 | 30 | 89 | 36 | 73 |
| **Total** | | | | | | |
| Employed | 75 | 78 | 65 | 31 | 67 | 45 |
| ILO unemployed | 1 | 2 | 3 | 1 | 2 | 2 |
| Retired | 5 | 4 | 4 | 2 | 1 | 2 |
| Other economically inactive | 19 | 17 | 29 | 66 | 29 | 50 |
| *Bases (weighted)* | | | | | | |
| *Male* | *31927* | *1211* | *254* | *110* | *509* | *302* |
| *Female* | *41858* | *1575* | *391* | *122* | *509* | *342* |
| *Total* | *73785* | *2785* | *645* | *232* | *1017* | *643* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *320* | *272* | *213* | *257* | *280* | *293* |
| *Female* | *399* | *339* | *335* | *301* | *278* | *347* |
| *Total* | *719* | *611* | *548* | *558* | *558* | *640* |

ILO unemployed includes those who are not currently in employment, available to start work within 2 weeks, and either looked for work in the last 4 weeks or waiting to start a new job.

Table 1.6

**Highest educational qualification**

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | | | Black | | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| NVQ 4/5, degree or above | 33 | 31 | 26 | 13 | 37 | 21 |
| NVQ 1/2/3, CSE, O level, GCSE, A level | 44 | 36 | 39 | 29 | 33 | 36 |
| Overseas qualification, other | 2 | 3 | 3 | 3 | 4 | 5 |
| No qualification | 21 | 29 | 32 | 55 | 26 | 39 |
| **Female** | | | | | | |
| NVQ 4/5, degree or above | 22 | 25 | 26 | 7 | 24 | 15 |
| NVQ 1/2/3, CSE, O level, GCSE, A level | 45 | 46 | 43 | 27 | 38 | 33 |
| Overseas qualification, other | 5 | 7 | 5 | 2 | 5 | 4 |
| No qualification | 29 | 23 | 26 | 63 | 34 | 49 |
| **Total** | | | | | | |
| NVQ 4/5, degree or above | 27 | 28 | 26 | 10 | 30 | 18 |
| NVQ 1/2/3, CSE, O level, GCSE, A level | 44 | 42 | 41 | 28 | 35 | 34 |
| Overseas qualification, other | 4 | 5 | 5 | 3 | 5 | 4 |
| No qualification | 25 | 26 | 28 | 59 | 30 | 44 |
| *Bases (weighted)* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Male* | *35899* | *1423* | *320* | *128* | *533* | *337* |
| *Female* | *47076* | *1774* | *472* | *131* | *584* | *350* |
| *Total* | *82975* | *3197* | *791* | *259* | *1118* | *687* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *357* | *324* | *271* | *300* | *304* | *330* |
| *Female* | *450* | *395* | *403* | *326* | *325* | *364* |
| *Total* | *807* | *719* | *674* | *626* | *629* | *694* |

Table 1.7

**Degree of urbanisation**

**Ethnic group**

| | White | Irish | Black Caribbean | Black Bangladeshi | Indian | Pakistani |
|---|---|---|---|---|---|---|
| | % | % | % | % | % | % |
| **Male** | | | | | | |
| Inner city | 7 | 5 | 31 | 61 | 10 | 18 |
| Other dense urban/town centre | 14 | 7 | 18 | 27 | 17 | 23 |
| Suburban residential | 57 | 74 | 50 | 11 | 72 | 59 |
| Rural residential/village centre | 18 | 13 | 1 | 0 | 1 | 0 |
| Rural agricultural | 3 | 1 | 0 | 0 | 0 | 0 |
| **Female** | | | | | | |
| Inner city | 7 | 6 | 32 | 63 | 14 | 16 |
| Other dense urban/town centre | 14 | 9 | 20 | 22 | 19 | 21 |
| Suburban residential | 56 | 76 | 48 | 15 | 66 | 63 |
| Rural residential/village centre | 20 | 9 | 0 | 0 | 1 | 0 |
| Rural agricultural | 3 | 0 | 0 | 0 | 0 | 0 |
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Inner city | 7 | 6 | 31 | 62 | 12 | 17 |
| Other dense urban/town centre | 14 | 8 | 19 | 25 | 18 | 22 |
| Suburban residential | 56 | 75 | 49 | 13 | 69 | 61 |
| Rural residential/village centre | 19 | 11 | 0 | 0 | 1 | 0 |
| Rural agricultural | 3 | 1 | 0 | 0 | 0 | 0 |
| *Bases (weighted)* | | | | | | |
| *Male* | *33081* | *1371* | *327* | *128* | *540* | *331* |
| *Female* | *44068* | *1774* | *474* | *131* | *568* | *365* |
| *Total* | *77150* | *3145* | *801* | *259* | *1108* | *696* |
| *Bases (unweighted)* | | | | | | |
| *Male* | *330* | *312* | *271* | *294* | *302* | *323* |
| *Female* | *421* | *384* | *400* | *320* | *314* | *373* |
| *Total* | *751* | *696* | *671* | *614* | *616* | *696* |

Table 1.8

**Children in household**

| | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Black | | | |
| | | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Male** | | | | | | | |
| | No children in household | 71 | 68 | 68 | 27 | 54 | 35 |
| | Children in household | 29 | 32 | 32 | 73 | 46 | 65 |
| **Female** | | | | | | | |
| | No children in household | 64 | 57 | 56 | 22 | 55 | 30 |
| | Children in | 36 | 43 | 44 | 78 | 45 | 70 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | household | 56 | 43 | 44 | 78 | 43 | 70 |
| **Total** | | | | | | | |
| | No children in household | 67 | 62 | 61 | 25 | 55 | 32 |
| | Children in household | 33 | 38 | 39 | 75 | 45 | 68 |
| *Bases (weighted)* | | | | | | | |
| | *Male* | *37069* | *1358* | *322* | *134* | *561* | *341* |
| | *Female* | *49222* | *1696* | *473* | *139* | *580* | *379* |
| | *Total* | *86291* | *3053* | *795* | *273* | *1141* | *720* |
| *Bases (unweighted)* | | | | | | | |
| | *Male* | *366* | *302* | *271* | *311* | *312* | *334* |
| | *Female* | *468* | *364* | *400* | *338* | *323* | *387* |
| | *Total* | *834* | *666* | *671* | *649* | *635* | *721* |

Table 1.9

**Age on migration**

| | **Ethnic group** | | | | |
|---|---|---|---|---|---|
| | | Black | | | |
| | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % |
| **Male** | | | | | |
| UK born or less than 11 | 85 | 85 | 50 | 52 | 53 |
| 11 or older | 15 | 15 | 50 | 48 | 47 |
| **Female** | | | | | |
| UK born or less than 11 | 83 | 81 | 46 | 50 | 57 |

| | | | | | |
|---|---|---|---|---|---|
| 11 or older | 17 | 19 | 54 | 50 | 43 |
| **Total** | | | | | |
| UK born or less than 11 | 84 | 83 | 48 | 51 | 55 |
| 11 or older | 16 | 17 | 52 | 49 | 45 |
| *Bases (weighted)* | | | | | |
| *Male* | *1066* | *237* | *111* | *455* | *295* |
| *Female* | *1439* | *385* | *126* | *487* | *347* |
| *Total* | *2505* | *622* | *237* | *942* | *641* |
| *Bases (unweighted)* | | | | | |
| *Male* | *235* | *194* | *249* | *250* | *288* |
| *Female* | *304* | *324* | *303* | *272* | *351* |
| *Total* | *539* | *518* | *552* | *522* | *639* |

# 2 Common mental disorders

*Scott Weich and Sally McManus*

## 2.1 Introduction

The most common mental disorders (CMD), anxiety and depression, have a combined prevalence rate of about 15% in the community.[1,2] They account for one-third of days lost from work due to ill health and one-fifth of all consultations with general practitioners in the UK.[3] Those affected experience increased mortality[4] and impairments in physical and social functioning as severe as those associated with chronic physical disorders.[5] The public health importance of these disorders, even in mild form, is further demonstrated by the finding that low levels of depression resulted in 51% more days lost from work than major depression.[6] Ten years ago the annual cost of CMD in the UK was estimated to exceed £6 billion.[7] While this figure certainly represents an underestimate of the current societal costs associated with these disorders, the finding that two-thirds of this sum was due to lost productivity is likely to remain valid.

Although 'major' psychiatric disorders such as schizophrenia (which has a community prevalence of less than 1%) are certainly more disabling for individual sufferers, and more distressing for their families and carers, their rarity means that these conditions place less of a burden on the public health than CMD. Despite this, the dearth of studies of CMD among members of ethnic minorities in Britain contrasts with an extensive literature on differences in rates of psychotic disorders.[8,9,10,11] The lack of evidence about rates of CMD in ethnic minority groups in the UK is thrown into sharper relief by the burgeoning literature on socio-economic inequalities in the prevalence and outcome of these disorders.[12,13] As Nazroo[14] pointed out, the hypothesis that the higher rate of psychosis among Black Caribbean individuals in England and Wales is due to 'social exclusion' (including harassment and discrimination) should also predict increased rates of CMD in this group, and among other ethnic groups who are similarly disadvantaged, such as those of Pakistani and Bangladeshi extraction. Although previous research indicated that Black Caribbean and Irish groups have higher rates of psychiatric admissions, and South Asian groups lower rates than the White population, such findings were likely to have been prone to bias, particularly by factors that differentially affect access to treatment. The absence of a robust, population-based evidence base in this area represents a major lacuna in our understanding of the processes that contribute to the aetiology and outcome of the most common psychiatric disorders.

In common with the Black Caribbean population, very little is known about the epidemiology of the common mental disorders among South Asian groups, who comprise over 3% of the UK population. In the Fourth National Survey of Ethnic Minorities,[14] Pakistani informants had similar rates of depression to the White group, while rates among Indian and Bangladeshi informants were lower than both of these groups. The latter group had especially low rates of depression, among both men and women. When the study findings were disaggregated by gender, it was found that Pakistani women

had lower rates of depression than their White counterparts, while Pakistani men were more likely than White informants to be depressed. All of the South Asian groups, both men and women, had lower rates of anxiety than White informants. Irish informants had consistently, and significantly, higher rates of depression and anxiety than all other groups, with the exception of Black Caribbean men and women. One important limitation of this study was the finding that the psychometric performance of the case-finding methodology varied between ethnic groups. In particular, South Asian informants who scored positively on the brief depression screening items were significantly less likely than their White, Irish and Black Caribbean counterparts to meet diagnostic criteria for an anxiety or depressive disorder using a standardised clinical interview. The reasons for this remain unknown, but may have included the choice of Revised Clinical Interview Schedule (CIS-R) items used to screen for depression, and the decision to omit items concerning somatic symptoms.

There is also a dearth of population-based studies of psychiatric disorder among those born in Ireland (and those of Irish descent) living in Britain, despite the fact that these groups may constitute up to 5% of the UK population.[15] The latter is perhaps due in part to the tendency to equate ethnicity with skin colour,[15,16] and the difficulty of establishing valid criteria for defining ethnicity among members of this group, some of whom may have lived in this country for several generations. Understanding differences in health outcomes and the experiences of living in the UK within, as well as between, 'South Asian', 'Black Caribbean' and 'White' groups is vital, and underlines the need to view ethnicity as a complex social, economic and cultural matrix.[17]

Two notable recent surveys were carried out in a national sample,[15] and among a random sample of individuals registered with General Practitioners in Manchester.[16] While the latter was smaller (n=612) and restricted to Black Caribbean and White individuals, the former was the first to simultaneously compare rates of psychotic and non-psychotic psychiatric morbidity among White, Irish, Black Caribbean, Indian, Pakistani, Bangladeshi and Chinese groups in the UK. The study by Nazroo (1997) was limited, however, by the use of an abbreviated two-stage assessment procedure, in which a number of questions were omitted from the CIS-R, making direct comparisons with other studies difficult. Both studies concluded that the prevalence of anxiety and depression among Black Caribbean informants was broadly similar to that found among the White group. Both studies went on to report small, post hoc differences between these groups, in that depression was slightly more common, and anxiety less common, in the Black Caribbean group. A further limitation of the study by Shaw et al (1999) was the inclusion of Irish and other White European informants in the same group as White British people.[18] It was notable also that the two samples differed in their demographic characteristics, a finding that probably reflects the difference in geographical coverage of the two studies. Interestingly, the national survey by Nazroo (1997) found that the excess in depression among Black Caribbean informants was confined largely to those who were married or cohabiting.

In an epidemiological survey of individuals living in a multi-ethnic, inner city area in the West Midlands, Commander et al (1997)[19] found significantly higher rates of the common mental disorders among Asian residents compared with those of White or Black ethnicity. The elevated prevalence of these disorders among Asian residents (nearly twice that found in the other two groups) was observed in both community (37%) and primary care settings (30%). Although Bhui (2001)[20] found a similar case rate (41%) among Punjabi patients attending General Practices in a single electoral ward in South London, the prevalence of these disorders was almost identical (39%) among English controls. A very similar prevalence was reported from a study of Pakistani primary care attenders in Manchester.[21]

An interesting area of enquiry is the contrast between rates of the common mental disorders among ethnic minority groups living in the UK, and rates observed in their countries of origin.[22] Although

none of the studies can claim to be representative of the general population of any of the countries in question, there are a number of interesting findings from South Asia. In Goa, one of the richest states in India, Patel et al (1998)[23] reported that 46% of primary care attenders were cases of the common mental disorders using the CIS-R. Even higher rates have been observed in different settings in Pakistan, and in rural areas in particular.[24,25,26,27] While nearly all studies from around the world report that women experience roughly double the prevalence of the common mental disorders found among men, this difference was nearer to three-fold in rural Pakistan. In a rural setting in the Punjab, Mumford and his colleagues (1997) found that 66% of women were suffering from the common mental disorders.

The assessment of psychiatric morbidity in groups of differing ethnicity and culture has been beset by philosophical debate about the appropriateness of applying diagnostic and conceptual models of disorder across settings and populations. This issue is highlighted among individuals of South Asian origin, who are said to sometimes 'somatise' psychological distress, by expressing this in the form of physical complaints.[25] As Bhui (1999) and others have pointed out, this is an extremely complex matter, and may reflect differences in the ways societies and cultures conceptualise the relationship between mind and body, as well as differences in the perceived stigma associated with mental illness.[28] It is also likely that the manner in which psychological distress is expressed will be influenced by the configuration of services, and the most effective or pragmatic means of seeking help in a given setting. Finally, although most attention has been paid to the excess of somatic complaints among South Asian individuals who experience psychological distress, it is also widely recognised that the psychological idioms of distress may also differ across cultures. It is therefore possible that rates of the common mental disorders may be underestimated in cross-cultural research not only by failing to give sufficient weight to somatic symptoms, but also by overlooking different types of psychological symptoms.[22] The qualitative study reported in chapter 8 attempted to address these issues.

The present study represents the most comprehensive investigation of the mental health of ethnic groups in the UK to date. This chapter will consider the main study findings concerning the prevalence of the common mental disorders.

## 2.2 Measures

Psychiatric morbidity was assessed using the Revised Clinical Interview Schedule (CIS-R).[29,30,31] The original Clinical Interview Schedule (CIS) was the first standardised interview designed specifically to assess common mental disorders in community settings, among informants who may not see themselves as psychiatrically disturbed.[32] The original was revised for use by lay interviewers,[29] by removing all but the systematic and highly standardised items inquiring about non-psychotic psychiatric symptoms. Lewis and Williams (1989)[33] found that these changes did not alter the validity of the CIS. More recently, the CIS-R was successfully administered to over 10,000 informants in the UK National Survey of Psychiatric Morbidity.[1,2,34,35,36]

The CIS-R enquires about the presence and severity of fourteen different non-psychotic psychiatric symptoms during the week prior to interview. These are: somatic complaints associated with low mood or anxiety, fatigue, problems with memory and/or concentration, sleep disturbance, irritability, worry about physical health, depressed mood, depressive thoughts, non-health related worry, generalised anxiety, phobic anxiety, panic attacks, compulsive behaviours, and obsessional thoughts. Item scores for each of these symptoms range from 0 to 4 (except depressive thoughts, which ranges from 0 to 5), resulting in a measure with a potential score ranging from 0 to 57. The CIS-R score may be analysed

in two ways: as a continuous measure of psychiatric morbidity, along a single continuum of severity (range 0 to 57), or as a dichotomous variable ('case' v 'non-case'). The latter is defined using a case threshold of 11/12, identified by the authors of the instrument in their validation study.[29] See Appendix B for the items used to calculate CIS-R symptom and total scores.

In addition, individuals scoring above the case threshold on the CIS-R were allocated ICD-10 diagnoses according to an algorithm for the CIS-R based on ICD-10 criteria,[37,38] written by one of the authors of this chapter[39] (Weich 2001), and adopted by ONS for use in the two National Psychiatric Morbidity Surveys of Great Britain.[1,40] The algorithms are shown in Appendix A. The ten ICD-10 categories derived from responses to the CIS-R were: Mild Depressive Episode, with and without somatic symptoms (F32.0), Moderate Depressive Episode, with and without somatic symptoms (F32.1), Severe Depressive Disorder (F32.2), Agoraphobia, with and without panic disorder (F40.0), Social Phobias (F40.1), Specific (isolated) Phobias (F40.2), Panic Disorder (F41.0), Generalised Anxiety Disorder (GAD) (F41.1), Mixed Anxiety and Depressive Disorder (MADD) (F41.2), and Obsessive-Compulsive Disorder (F42). Each diagnosis was recorded as present or absent. A diagnosis of MADD was allocated to all individuals who scored above the case threshold on the CIS-R but who did not meet criteria for any other diagnosis. Hence, although MADD could not be comorbid with any other disorder, the method for allocating diagnoses meant that it was possible for other ICD-10 disorders (apart from Panic Disorder and Phobias) to co-occur in the same individuals.

It should be noted that the ONS surveys applied the diagnostic algorithms in a slightly different way from this survey, and did not include the CIS-R case threshold of 12 or more in the criteria for any diagnosis other than MADD. In keeping with the original formulation of these criteria,[40] we chose to include the criterion of CIS-R score of 12 or more, to ensure that our case estimates were consistent whether using the CIS-R case threshold or ICD-10 diagnoses. Furthermore, this avoided the anomaly of individuals who were not eligible for a diagnosis of MADD meeting criteria for other disorders, such as GAD or a mild depressive episode.

While there may be individuals who have a relatively greater disturbance on the dimension of anxiety than on the dimension of depression (and vice versa),[41] there is consistent evidence that the symptoms of anxiety and depression co-occur, particularly in community settings.[3] These symptoms occur in the same individuals both consecutively and concurrently, to a degree far in excess of that predicted by chance alone. Failure of the main classificatory systems to agree on a common set of diagnostic criteria for the common mental disorders reflects the genuine difficulty of imposing points of cleavage where none would appear to exist in nature. There is increasing evidence from sophisticated studies of comorbidity that individuals commonly meet criteria for multiple lifetime diagnoses, and move between categories of disorder at different times in their lives.[3] The main categories of the non-psychotic psychiatric disorders also share many aetiological risk factors, most notably a genetic predisposition that appears to be non-specific with respect to symptoms of anxiety and depression. A recent study using CIS-R data collected in four countries (including a sample of Indian informants living in the UK) found scores in each sample were equally well explained by one- and two-factor models, and that both models fitted well with each of the four datasets.[42] The term 'common mental disorders' (CMD),[40] defined in this study as a score of 12 or more on the CIS-R,[1,29] will therefore be used to denote those conditions most commonly encountered in primary care and community settings, considered as a single dimension. Findings concerning the prevalence of the common mental disorders as a whole will be described, before considering individual diagnostic categories.

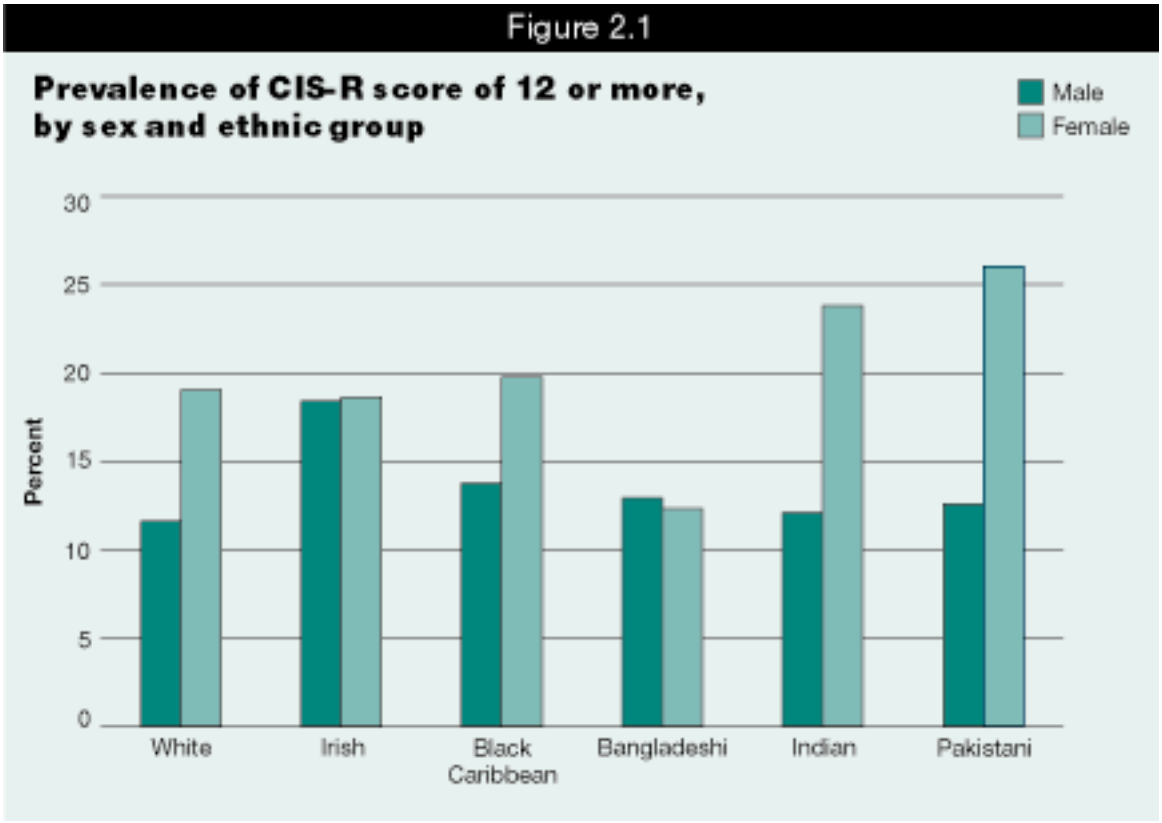
Finally, to explore the possibility that the CIS-R may have under-estimated the prevalence of the common mental disorders among South Asian groups, separate analyses were undertaken to compare

scores on the somatic symptoms section of the CIS-R across ethnic groups. This section (range 0 to 4) asks about the severity and frequency of somatic complaints (such as aches and pains) that were 'brought on or made worse because you were feeling low, anxious or stressed'. The score on this section was compared across ethnic groups, before and after adjusting for the score on the rest of the CIS-R.

## 2.3 **Prevalence of the common mental disorders**

The figure and inset table below, along with Table 2.1, show the proportions of informants in each ethnic group who scored above the case threshold for CMD on the CIS-R, before adjusting for age or any other potential confounders. Among men, the prevalence of CMD was very similar in all groups apart from the Irish, for whom this rate was increased to a statistically significant degree compared with the White group. Among women, the pattern was somewhat more complex, with similar rates in the White, Irish and Black Caribbean groups, but significantly higher rates among Indian and Pakistani women, and a very low rate among Bangladeshi women. Of these differences, only those for Bangladeshi and Pakistani women reached statistical significance, before adjusting for age.

Figure 2.1




As described in the introductory chapter to this volume, the age structure of the ethnic groups differed considerably. In particular, Pakistani and Bangladeshi men and women, and Black Caribbean men, were significantly younger than those from other ethnic groups. However, Table 2.2 shows that there was relatively little variation in the association between CMD and age across ethnic groups. Among White, Irish, Black Caribbean and Indian men, the prevalence of CMD did not vary with age to a significant degree. By contrast, CMD increased with age to a significant extent among Pakistani and Bangladeshi men, predominantly because of the very low rates observed among those aged 16-34 in these groups. Among women, the rate of CMD only varied with age among Indian informants, for whom these disorders became more common with advancing age.

After adjusting for the differences in age structure between these groups, the excess in cases of the common mental disorders among Irish men (compared with White men) no longer reached statistical significance (Table 2.1). Table 2.1 also shows that only the lower prevalence of CMD among Bangladeshi women (compared with White women) remained statistically significant after adjusting for differences in age structure between ethnic groups.

**Prevalence of CIS-R score of 12 or more, by ethnic group within gender (see Table 2.1) , before adjusting for age**

| | Observed % | Unadjusted RR (95% CI) | P |
|---|---|---|---|
| **Men** | | | |
| White | 11.6 | 1.00 | |
| Irish | 18.4 | 1.59 (1.11-2.28) | 0.02 |
| Black Caribbean | 13.8 | 1.19 (0.80-1.79) | 0.46 |
| Bangladeshi | 12.9 | 1.10 (0.73-1.64) | 0.74 |
| Indian | 12.1 | 1.03 (0.69-1.56) | 0.97 |
| Pakistani | 12.6 | 1.07 (0.72-1.59) | 0.84 |
| **Women** | | | |
| White | 19.0 | 1.00 | |
| Irish | 18.6 | 0.98 (0.74-1.29) | 0.95 |
| Black Caribbean | 19.8 | 1.04 (0.80-1.37) | 0.82 |
| Bangladeshi | 12.3 | 0.65 (0.47-0.92) | 0.02 |
| Indian | 23.8 | 1.25 (0.96-1.64) | 0.12 |
| Pakistani | 26.0 | 1.37 (1.07-1.77) | 0.02 |

## 2.4 Prevalence of ICD-10 diagnostic categories

Table 2.1 shows the distribution of ICD-10 diagnoses by ethnic group and gender. In all ethnic groups,

the most common ICD-10 diagnosis was Mixed Anxiety Depressive Disorder (MADD), which accounted for 60% to 70% of all diagnoses on average, ranging from a low of 56% (Pakistani men) to a high of 80% (Indian men).

### 2.4.1 **Depressive episodes**

Among men, White and Pakistani informants reported depressive episodes most often, although the prevalence of (any) depressive episodes did not vary between ethnic groups to a statistically significant degree. Interestingly, although the Irish group had the highest prevalence of CMD, only 10% of Irish men with any ICD-10 diagnosis met criteria for a depressive episode, compared with 14% to 21% of other informants. (Table 2.1)

Among women, depressive episodes were most common among Indian and Pakistani informants, and least common in the Bangladeshi and Black Caribbean groups. Among Indian and Pakistani women, around one-quarter of all cases met criteria for depressive episodes, compared with 12% of Bangladeshi and Black Caribbean women. (Table 2.1)

Like episodes of CMD, the gender difference in the prevalence of depressive episodes was greatest among Indian (RR 3.65, 95% CI 1.38-9.66) (p=0.009) and Pakistani groups (RR 2.58, 95% CI 1.18-5.67)(p=0.02). There was no gender difference in other groups. Thus, in contrast to CMD, the gender difference in the prevalence of depressive episodes did not vary to a statistically significant degree for either the White or Black Caribbean groups.

### 2.4.2 **Anxiety disorders**

In contrast to depressive episodes, the highest rate of anxiety disorders among men was found in the Irish group. It was also notable that the rate in the Indian group was significantly lower than that observed in all but White and Bangladeshi men. Like Irish men and depression, a very small proportion of Indian men (11%) with any ICD-10 diagnosis met the criteria for an anxiety disorder, compared with 25% to 35% in other groups.
(Table 2.1)

The pattern of ICD-10 anxiety disorders among women was similar to that observed for depressive episodes. The lowest rate was found among Bangladeshi women, and the highest rates among Indian, Pakistani and Irish women. Although the prevalence of anxiety episodes among ethnic minority informants did not differ from that observed among White women to a statistically significant degree, the rates in the Indian, Pakistani and Irish groups were all significantly higher than among Bangladeshi women. (Table 2.1)

In general, gender differences in the prevalence of anxiety disorders were much smaller than for depressive episodes, and were non-significant. The one exception to this was among Indian informants, for whom the rate in women far exceeded that in men (RR 5.76, 95% CI 2.02-16.42) (p=0.0004).

### 2.4.3 **Mixed anxiety depressive disorder (MADD)**

Among men, the lowest rates of MADD were found in the White and Pakistani groups. The variation across ethnic groups in the prevalence of MADD among men was not statistically significant.

Like the other types of disorder, MADD was least common in the Bangladeshi group compared with other women. While the rate of MADD in ethnic minority groups did not differ from the White group to a statistically significant degree, the rate among Pakistani women was significantly higher than in the Bangladeshi group. (Table 2.1)

### 2.4.4 **Somatic symptoms**

Among men, the somatic symptom scores were increased to a statistically significant degree only in the Bangladeshi group, even after adjusting for score on the rest of the CIS-R (difference in mean score compared to White group 0.19, 95% CI 0.09-0.29)($p<0.001$).

Among women, somatic symptom scores were elevated among all three South Asian groups, and were greatest among Pakistani women. This difference (compared with White women) did not reach statistical significance among the Bangladeshi group after adjusting for score on the rest of the CIS-R. The adjusted differences in mean somatic symptom scores (compared with the White group) were 0.16 (95% CI 0.04-0.28)($p=0.008$) for Indian women, and 0.23 (95% CI 0.11-0.35)($p<0.001$) for Pakistani women (data not shown in tables).

### 2.4.5 **Gender**

The ratio of women: men who were cases of CMD approached unity for the Irish and Bangladeshi groups, was a little (but not significantly) higher for the Black Caribbean group, and was about 60% higher among the White group and twice as high for the Indian and Pakistani groups. The differences for the White, Indian and Pakistani groups were all statistically significant.

### 2.4.6 **Marital status**

Table 2.3 shows the relationship between marital status and CMD. Too few informants were separated, divorced or widowed to fully explore the association between this risk factor and the prevalence of the common mental disorders. As described in the introductory chapter to this volume, South Asian informants (and particularly South Asian men) were particularly unlikely to be separated, divorced or widowed, while few Black Caribbean men were married. As anticipated in the light of previous research, the highest rates of CMD were generally found among those who were divorced, separated or widowed, although the precision with which these rates have been estimated was of course limited by the small sample size. Among both men and women, the lowest rates of CMD were generally found among those who were married and cohabiting, a finding that was most marked among Black Caribbean men. The notable exceptions to this trend were Pakistani men and women, and Bangladeshi men, for whom the lowest rates of CMD were observed among those who had never married.

### 2.4.7 **Socio-economic status**

There were marked differences in the housing circumstances of the different ethnic groups. Apart from Black Caribbean (54%) and Bangladeshi informants (28%), more than 70% of informants in all groups were owner-occupiers. However, the size of the association between living in rented accommodation and the prevalence of CMD varied from RR 2.10 (95% CI 1.11-3.91)($p=0.04$) and 2.73 (95% CI 1.76-4.29)($p<0.0001$) among White men and women, respectively, to near unity for Bangladeshi men and women (Table 2.4). Indeed, this association only reached statistical significance for White men and women, and Pakistani women (RR 1.61, 95% CI 1.16-2.27)($p=0.009$).

Using other measures of socio-economic status produced slightly different results. Although a significantly higher proportion of Bangladeshi informants (73%) were living in households where the occupational social class of the head of the household was classified as 'manual', compared with other groups no statistically significant associations were found between this variable and the prevalence of CMD (Table 2.5). Apart from Black Caribbean men, the prevalence of CMD was lowest among informants whose head of household was classified as 'non-manual'. Although this pattern was reversed among Black Caribbean men, the social class gradient in this group was not statistically significant (RR 0.50, 95% CI 0.25-1.12)($p=0.12$).

As with marital status, the sample was too homogenous in terms of employment status to permit the effects of this variable to be studied in detail. In particular, rates of unemployment were very low, and precluded robust estimates of associations with the prevalence of CMD. As described previously, Bangladeshi men and women were the least likely, and White men the most likely to be employed (Table 2.6).

The proportion of informants without any educational qualifications was broadly similar across groups, with the exception of the Bangladeshi and Pakistani samples. Among women, around 25% to 30% of informants had no such qualifications, rising to 52% and 68% of Pakistani and Bangladeshi women, respectively. The figures were similar among men (Table 2.7). There were few statistically significant associations between education and CMD. Black Caribbean men without any educational qualifications had a significantly elevated rate of CMD (RR 2.01, 95% CI 1.13-3.57)(p=0.03). Among Bangladeshi women, the lowest prevalence of CMD (just 7%) was found among those without educational qualifications.

### 2.4.8 **Household composition**

The composition of households varied with ethnic group. Although Table 2.8 does not contain information about household size, it shows marked differences in the proportions of households with children, ranging from around 30% among White, Irish and Black Caribbean informants to 70% to 80% of Pakistani and Bangladeshi informants, respectively. In general, the presence of children at home was associated with a lower rate of CMD among men (but not women), although this gradient was not statistically significant for any ethnic group. The presence of children at home was associated with a significantly lower rate of disorder among Indian women (RR 0.58, 95% CI 0.38-0.90)(p=0.02), but with a higher rate of CMD among White (RR 1.59, 95% CI 1.09-2.30)(p=0.02) and Pakistani (RR 1.54, 95% CI 1.02-2.33)(p=0.04) women.

### 2.4.9 **Age at migration**

The migratory status of informants varied across ethnic groups, with 82% of both Irish and Black Caribbean individuals and around half of South Asian individuals being born in the UK or having migrated here before the age of 11. Migratory status was similar for men and women within each ethnic group. To reduce the effects of confounding by age, the findings in Table 2.9 have been restricted to those obtained from informants aged 16 to 54 at the time of interview. Among women, with the exception of the Black Caribbean group, higher rates of CMD were found among those who were born in the UK or who came to this country very early in life, although this difference was only significant for Bangladeshi women (RR 3.15, 95% CI 1.61-6.16)(p=0.0007). The pattern among men was somewhat harder to interpret, in part because of small numbers of informants who had emigrated to the UK after the age of 10. Perhaps the most notable finding was the lower prevalence of CMD among Bangladeshi men who were born in the UK or who came here before the age of 11, an association which differed in its direction compared with that found among Bangladeshi women.

### 2.4.10 **Comparison with the National Survey of Psychiatric Morbidity**

We compared findings in the White group with the results of the two National Surveys of Psychiatric Morbidity in the UK, carried out by ONS. Although the two ONS surveys included members of ethnic minorities, these individuals comprised less than 5% of the sample.[1,2] The first of these surveys was conducted in 1993, while the second was contemporaneous with the present survey. Since there were few significant differences between the findings of the two ONS surveys, comparisons were made with the most recent findings.

The prevalence of CMD in the most recent ONS survey was very similar to that found in the White

group in the present survey.[2] In the national survey, 12.4% of men and 18.1% of women aged 16-74 scored 12 or more on the CIS-R, compared with 11.6% of men and 19.0% of women in the present study. Although closer examination revealed modest differences in the age structure of the two samples, adjusting for this did not appear to significantly alter these rates. Very few differences were found in rates of specific ICD-10 diagnoses, although it should be noted that the ONS surveys applied the diagnostic algorithms in a slightly different way from this survey, and did not require a minimum CIS-R score of 12 or more for any diagnosis other than MADD. The only substantial differences that were observed from the present study were the slightly lower rates of Generalised Anxiety Disorder (GAD) among men (1.5%) and women (1.4%), compared with the national survey (4.6% and 4.3%, respectively).

Although the National Survey sample was predominantly white (96%), the investigators reported findings for three self-identified ethnic groups: a white group, a black group and a South Indian group comprising individuals who described themselves as being of Indian, Pakistani or Bangladeshi origin. The National Survey did not distinguish between Irish and other White informants. The proportions of White men (12%) and women (18%) scoring 12 or more on the CIS-R were almost identical to the results for the sample as a whole.

Among men, similar case rates for the common mental disorders were found among the White (12%) and Black (11%) groups, as in the present survey. In contrast to the present findings, the National Survey found a slightly higher case rate (16%) among South Asian men, although this did not differ from other ethnic groups to a statistically significant degree.

Among women, the National Survey found similar case rates for the common mental disorders among White (18%) and Black informants (18%). There was also evidence of a moderately increased case rate among South Asian women (23%), although this gradient was not statistically significant. Since our own findings suggest that case rates among women may vary considerably between the different South Asian cultural groups, direct comparison between studies is likely to be problematic.

#### 2.4.11 **Comparison with the Fourth National Survey**

Direct comparison with the Fourth National Survey[14] is also difficult, particularly given the different measures used to assess common mental disorders. However, the present findings were consistent with the results of this survey in a number of respects. The most striking similarities were the consistently low rates of the common mental disorders among Bangladeshi informants, and the high rates of anxiety disorders among Irish men and women.

In contrast to the Fourth National Survey, we found no evidence of increased rates of depression among Black Caribbean or Pakistani men. Similarly, the present survey found no evidence of lower rates of either anxiety or depression among Indian or Pakistani informants. Indeed, our results suggest that Indian and Pakistani women had rates of both disorders that were significantly higher than those found among Bangladeshi and, to a lesser extent, White women. Finally, it is worth noting that Black Caribbean men who were married or cohabiting in the present study had very low rates of CMD, in contrast to the findings from the Fourth National Survey.

## 2.5 **Conclusions**

The present findings represent probably the most comprehensive assessment to date of the prevalence of the common mental disorders (CMD) among ethnic minority groups in the UK. Although our study was restricted to England, rates of CMD in our White group were very similar to those reported by both UK National Surveys of Psychiatric Morbidity,[1,2] the last of which was carried out

contemporaneously with this survey. Overall, our findings indicate relatively modest differences in the rates of these disorders between individuals of White, Irish, Black Caribbean, Bangladeshi, Indian and Pakistani ethnicity. In general, the clearest ethnic differences in the prevalence of non-psychotic psychiatric disorders were observed when the common mental disorders (CMD) were considered as a whole. We found that there were small but statistically significant variations in the prevalence of common mental disorders (CMD) across ethnic groups. Compared with White informants of the same gender, Irish men and Pakistani women had significantly higher, and Bangladeshi women lower rates of CMD. Although only the lower prevalence of CMD among Bangladeshi women reached statistical significance after adjusting for age, this may have been due to the relatively small sample sizes within each ethnic group.

Among men, no statistically significant differences were found between ethnic groups when individual ICD-10 diagnoses were considered. Using these categories, we found a very low prevalence of anxiety disorders among the Indian group, while Irish men had the highest rate of anxiety disorders but the lowest rate of depressive episodes. Among women, the prevalence of all types of ICD-10 disorder were least common in the Bangladeshi group, while depressive episodes and anxiety disorders were most common among Indian and Pakistani women.

There was evidence that somatic symptom scores were elevated among Bangladeshi men, and South Asian women (especially those of Indian and Pakistani origin), after adjusting for the severity of symptoms elicited in the rest of the CIS-R. While this does not constitute direct evidence of a tendency for these groups to express psychological distress by means of somatic symptoms, failure to give added weight to these symptoms may have resulted in under-estimates of the prevalence of the common mental disorders among some South Asian groups. Since this finding was not observed to the same extent among Bangladeshi women, it could not explain the very low prevalence of these disorders in this group, compared with other South Asian women.

Interesting differences were found between ethnic groups in both the distribution of social and economic risk factors for the common mental disorders, and in patterns of association with this outcome. In general, Bangladeshi informants were the most socially disadvantaged, although associations between standard indices of socio-economic deprivation and CMD were often weakest in this group. These findings require further investigation.

The variation in the gender difference in the prevalence of CMD across ethnic groups was also notable. We found that the risk ratio for CMD associated with female gender varied considerably, from 1.5-2.0 among White, Black Caribbean, Indian and Pakistani groups, to near unity for Irish and Bangladeshi informants. This finding certainly warrants further investigation, particularly given previously consistent evidence of a significantly higher prevalence of these disorders among women, using different measures of depression, and across a range of settings. It should be noted, however, that previous studies have been almost exclusively restricted to (predominantly) White samples.

Interpretation of these findings is challenging. Although there were significant differences in the demographic and socio-economic characteristics of the different ethnic groups, preliminary statistical adjustment for these made relatively little difference to our findings. Given the very high levels of socio-economic deprivation among the Bangladeshi group in particular, these findings would appear to run counter to the hypothesis that members of this ethnic minority group should, as a consequence, experience higher rates of severe mental illness than less deprived groups.[17] It is possible, however, that employment status, education and housing tenure fail to capture the most stressful aspects of life among the different ethnic minority groups in the UK. Conversely, it may be that the effects of these types of socio-economic deprivation are offset by other, unmeasured, factors such as social support or community social capital.

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# 2 Common mental disorders

*Scott Weich and Sally McManus*

## Tables

Table 2.1

| **Prevalence of ICD-10 diagnostic categories, by sex** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Any neurotic disorder in** | | **Ethnic group** | | | | | |
| **past week** | | | | Black | | | |
| | | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Men** | | | | | | | |
| **Any neurotic disorder in past week** | | | | | | | |
| **(CIS-R score 12+)** | 11.6 | 18.4 | 13.8 | 12.9 | 12.1 | 12.6 | |
| Any depressive episode | 2.4 | 1.8 | 2.2 | 2.1 | 1.7 | 2.4 | |
| Any anxiety disorder | 3.0 | 5.9 | 4.7 | 3.6 | 1.4 | 4.4 | |
| | OCD | 0.3 | 0.6 | 0.6 | 1.0 | 0.6 | 2.1 |
| | All phobias | 1.8 | 1.9 | 0.9 | 1.0 | 0.3 | 2.5 |
| | Panic disorder | 0.5 | 2.0 | 1.8 | 1.7 | 0.7 | 0.6 |
| | GAD | 1.5 | 2.9 | 2.0 | 0.5 | 0.2 | 1.4 |
| Mixed anxiety depressive disorder | 7.4 | 11.5 | 8.3 | 8.7 | 9.7 | 7.1 | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Women** | | | | | | | |
| **Any neurotic disorder in past week** | | | | | | | |
| **(CIS-R score 12+)** | 19.0 | 18.6 | 19.8 | 12.3 | 23.8 | 26.0 | |
| Any depressive episode | 3.3 | 3.5 | 2.5 | 1.6 | 5.7 | 6.3 | |
| Any anxiety disorder | 3.9 | 5.4 | 4.0 | 1.9 | 7.3 | 5.4 | |
| | OCD | 1.4 | 1.2 | 1.2 | 0.9 | 1.7 | 1.4 |
| | All phobias | 1.7 | 2.3 | 1.9 | 0.4 | 1.3 | 1.7 |
| | Panic disorder | 0.5 | 1.5 | 1.0 | 0.9 | 3.5 | 1.8 |
| | GAD | 1.4 | 3.0 | 0.8 | 0.6 | 2.0 | 1.3 |
| Mixed anxiety depressive disorder | 13.7 | 11.7 | 14.5 | 9.4 | 14.1 | 17.0 | |
| **Total** | | | | | | | |
| **Any neurotic disorder in past week** | | | | | | | |
| **(CIS-R score 12+)** | 15.8 | 18.5 | 17.3 | 12.6 | 18.1 | 19.6 | |
| Any depressive episode | 2.9 | 2.8 | 2.4 | 1.9 | 3.8 | 4.5 | |
| Any anxiety disorder | 3.5 | 5.6 | 4.3 | 2.8 | 4.4 | 4.9 | |
| | OCD | 0.9 | 1.0 | 1.0 | 1.0 | 1.2 | 1.7 |
| | All phobias | 1.8 | 2.1 | 1.5 | 0.7 | 0.8 | 2.1 |
| | Panic disorder | 0.5 | 1.7 | 1.3 | 1.3 | 2.1 | 1.2 |
| | GAD | 1.4 | 3.0 | 1.3 | 0.6 | 1.2 | 1.4 |
| Mixed anxiety depressive disorder | 10.9 | 11.6 | 12.0 | 9.0 | 11.9 | 12.3 | |
| **Age standardised risk ratio for any** | | | | | | | |
| **neurotic disorder** | | | | | | | |
| Men | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Risk ratio | 1 | 1.37 | 1.13 | 1.12 | 1.03 | 1.12 | |
| | Standard error | | | 0.27 | 0.25 | 0.25 | 0.22 | 0.23 |
| Women | | | | | | | | |
| | Risk ratio | 1 | 0.95 | 0.98 | 0.64 | 1.20 | 1.37 | |
| | Standard error | | | 0.14 | 0.14 | 0.12 | 0.17 | 0.19 |
| Total | | | | | | | | |
| | Risk ratio | 1 | 1.13 | 1.07 | 0.83 | 1.10 | 1.24 | |
| | Standard error | | | 0.14 | 0.13 | 0.11 | 0.13 | 0.14 |
| *Bases (weighted)* | | | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* | | |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* | | |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* | | |
| *Bases (unweighted)* | | | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* | | |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* | | |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* | | |

Table 2.2

**Prevalence of CIS-R score of 12 or more, by age and sex**

| **CIS-R score of 12 or more** | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Black | | |
| | | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Men** | | | | | | | |
| | 16 to 34 | 14 | 15 | 13 | 8 | 12 | 7 |
| | 35 to 54 | 10 | 21 | 12 | 17 | 11 | 21 |
| | 55 to 74 | 11 | 17 | 17 | 20 | 16 | [13] |
| **Women** | | | | | | | |
| | 16 to 34 | 19 | 18 | 17 | 11 | 17 | 25 |
| | 35 to 54 | 25 | 23 | 26 | 16 | 27 | 27 |
| | 55 to 74 | 10 | 11 | 12 | [8] | 33 | [29] |
| **Total** | | | | | | | |
| | 16 to 34 | 17 | 17 | 15 | 10 | 14 | 17 |
| | 35 to 54 | 18 | 22 | 22 | 17 | 19 | 24 |
| | 55 to 74 | 11 | 14 | 14 | 16 | 24 | 19 |
| *Bases (weighted)* | | | | | | | |
| *Men* | | | | | | | |
| | *16 to 34* | *10820* | *359* | *139* | *70* | *205* | *180* |
| | *35 to 54* | *16290* | *707* | *97* | *41* | *250* | *115* |
| | *55 to 74* | *9963* | *393* | *98* | *24* | *110* | *51* |
| *Women* | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | *16 to 34* | *14599* | *584* | *182* | *89* | *237* | *232* |
| | *35 to 54* | *21063* | *855* | *204* | *37* | *249* | *115* |
| | *55 to 74* | *13559* | *416* | *105* | *13* | *104* | *32* |
| *Total* | | | | | | | |
| | *16 to 34* | *25420* | *943* | *321* | *158* | *442* | *412* |
| | *35 to 54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| | *55 to 74* | *23522* | *808* | *203* | *37* | *214* | *83* |
| *Bases (unweighted)* | | | | | | | |
| *Men* | | | | | | | |
| | *16 to 34* | *102* | *71* | *108* | *153* | *102* | *171* |
| | *35 to 54* | *166* | *164* | *86* | *96* | *148* | *117* |
| | *55 to 74* | *100* | *94* | *86* | *63* | *65* | *49* |
| *Women* | | | | | | | |
| | *16 to 34* | *126* | *108* | *140* | *209* | *125* | *232* |
| | *35 to 54* | *205* | *196* | *184* | *94* | *147* | *119* |
| | *55 to 74* | *138* | *100* | *90* | *35* | *56* | *36* |
| *Total* | | | | | | | |
| | *16 to 34* | *228* | *179* | *248* | *362* | *227* | *403* |
| | *35 to 54* | *371* | *360* | *270* | *190* | *295* | *236* |
| | *55 to 74* | *238* | *194* | *176* | *98* | *121* | *85* |

Table 2.3

**Prevalence of CIS-R score of 12 or more, by marital status and sex**

| **CIS-R score of 12 or more[a]** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Men** | | | | | | | |
| Married/cohabitating | 11 | 18 | 9 | 13 | 11 | 13 | |
| Divorced/separated | b | [25] | b | b | b | b | |
| Single and never been married | 13 | 20 | 16 | 8 | 15 | 7 | |
| **Women** | | | | | | | |
| Married/cohabitating | 17 | 16 | 19 | 12 | 22 | 27 | |
| Divorced/separated | [28] | 17 | 14 | b | b | b | |
| Single and never been married | 22 | 25 | 22 | 13 | 19 | 19 | |
| **Total** | | | | | | | |
| Married/cohabitating | 14 | 17 | 14 | 13 | 16 | 20 | |
| Divorced/separated | 25 | 20 | 20 | b | [37] | b | |
| Single and never been married | 18 | 23 | 20 | 10 | 17 | 13 | |
| *Bases (weighted)* | | | | | | | |
| *Men* | | | | | | | |
| *Married/cohabitating* | *24385* | *955* | *166* | *92* | *407* | *248* | |
| *Divorced/ separated* | *2859* | *115* | *28* | *2* | *27* | *8* | |
| *Single and never been married* | *8947* | *345* | *132* | *40* | *128* | *87* | |
| *Women* | | | | | | | |
| *Married/cohabitating* | *30483* | *1127* | *167* | *95* | *421* | *259* | |
| *Divorced/ separated* | *5219* | *238* | *71* | *6* | *31* | *18* | |
| *Single and never been married* | *10486* | *421* | *240* | *26* | *108* | *89* | |
| *Total* | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Married/cohabitating* | *54868* | *2082* | *333* | *188* | *829* | *506* |
| *Divorced/separated* | *8079* | *353* | *100* | *8* | *58* | *26* |
| *Single and never been married* | *19434* | *766* | *371* | *66* | *236* | *176* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |
| *Married/cohabitating* | *248* | *224* | *141* | *221* | *238* | *239* |
| *Divorced/separated* | *26* | *30* | *25* | *4* | *12* | *6* |
| *Single and never been married* | *85* | *63* | *106* | *86* | *63* | *89* |
| *Women* | | | | | | |
| *Married/cohabitating* | *295* | *256* | *145* | *237* | *241* | *272* |
| *Divorced/separated* | *45* | *53* | *68* | *13* | *18* | *12* |
| *Single and never been married* | *98* | *75* | *188* | *58* | *57* | *86* |
| *Total* | | | | | | |
| *Married/cohabitating* | *543* | *480* | *286* | *458* | *479* | *511* |
| *Divorced/separated* | *71* | *83* | *93* | *17* | *30* | *18* |
| *Single and never been married* | *183* | *138* | *294* | *144* | *120* | *175* |

[a] The sample base for widowed informants is too small for results to be shown.

[b] The sample base for these categories is too small for results to be shown.

Table 2.4

**Prevalence of CIS-R score of 12 or more, by housing tenure and sex**

| **CIS-R score of 12 or more[a]** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Black | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| Own/ mortgage | 10 | 16 | 10 | 12 | 11 | 12 |
| Rent/ part rent-part buy | 21 | 26 | 18 | 13 | [17] | 14 |
| **Women** | | | | | | |
| Own/ mortgage | 13 | 18 | 19 | 12 | 23 | 23 |
| Rent/ part rent-part buy | 35 | 23 | 22 | 12 | [25] | 37 |
| **Total** | | | | | | |
| Own/ mortgage | 11 | 17 | 15 | 12 | 17 | 17 |
| Rent/ part rent-part buy | 30 | 24 | 20 | 12 | 21 | 27 |
| *Bases (weighted)* | | | | | | |
| *Men* | | | | | | |
| *Own/ mortgage* | *26590* | *994* | *186* | *49* | *446* | *249* |
| *Rent/ part rent-part buy* | *6001* | *345* | *141* | *77* | *81* | *78* |
| *Women* | | | | | | |
| *Own/ mortgage* | *32320* | *1296* | *233* | *35* | *475* | *252* |
| *Rent/ part rent-part buy* | *11372* | *470* | *238* | *93* | *79* | *106* |
| *Total* | | | | | | |
| *Own/ mortgage* | *58909* | *2291* | *419* | *83* | *921* | *501* |
| *Rent/ part rent-part buy* | *17373* | *815* | *380* | *170* | *160* | *184* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Own/ mortgage* | *275* | *234* | *158* | *96* | *258* | *254* |
| *Rent/ part rent-part buy* | *52* | *73* | *113* | *195* | *39* | *67* |
| *Women* | | | | | | |
| *Own/ mortgage* | *331* | *290* | *203* | *77* | *269* | *267* |
| *Rent/ part rent-part buy* | *87* | *93* | *196* | *240* | *39* | *100* |
| *Total* | | | | | | |
| *Own/ mortgage* | *606* | *524* | *361* | *173* | *527* | *521* |
| *Rent/ part rent-part buy* | *139* | *166* | *309* | *435* | *78* | *167* |

[a] The sample base for informants reporting 'other' tenure is too small for results to be shown.

Table 2.5

**Prevalence of CIS-R score of 12 or more, by social class of Head of Household and sex**

| **CIS-R score of 12 or more[a]** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| Manual | 12 | 19 | 16 | 14 | 13 | 11 |
| Non-manual | 12 | 19 | 8 | [11] | 11 | 16 |
| **Women** | | | | | | |
| Manual | 18 | 19 | 20 | 14 | 23 | 21 |
| Non-manual | 20 | 19 | 20 | [8] | 21 | 31 |
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Manual | 17 | 19 | 16 | 10 | 16 | 23 |
| Non-manual | 15 | 19 | 18 | 14 | 18 | 16 |
| *Bases (weighted)* | | | | | | |
| *Men* | | | | | | |
| *Manual* | *16870* | *786* | *202* | *101* | *314* | *214* |
| *Non-manual* | *19826* | *644* | *116* | *23* | *241* | *105* |
| *Women* | | | | | | |
| *Manual* | *19885* | *894* | *244* | *96* | *305* | *198* |
| *Non-manual* | *28330* | *944* | *219* | *16* | *257* | *112* |
| *Total* | | | | | | |
| *Manual* | *36755* | *1680* | *446* | *197* | *619* | *412* |
| *Non-manual* | *48156* | *1588* | *335* | *39* | *498* | *217* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |
| *Manual* | *161* | *177* | *171* | *236* | *165* | *210* |
| *Non-manual* | *203* | *147* | *96* | *47* | *143* | *101* |
| *Women* | | | | | | |
| *Manual* | *180* | *206* | *210* | *238* | *160* | *217* |
| *Non-manual* | *280* | *195* | *183* | *34* | *155* | *109* |
| *Total* | | | | | | |
| *Manual* | *341* | *383* | *381* | *474* | *325* | *427* |
| *Non-manual* | *483* | *342* | *279* | *81* | *298* | *210* |

[a] Informants whose Head of Household works for armed forces, has never worked or about whose work there is insufficient information and informants who have moved since they were interviewed for HSE, are excluded from this table.

Table 2.6

**Prevalence of CIS-R score of 12 or more, by employment status and sex**

| **CIS-R score of 12 or more[a]** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| In employment | 9 | 15 | 10 | 9 | 9 | 9 |
| Retired | 7 | [8] | 13 | [23] | [21] | b |
| Other economically inactive | b | [49] | [28] | 18 | [20] | 22 |
| **Women** | | | | | | |
| In employment | 20 | 19 | 18 | b | 18 | 21 |
| Retired | 9 | 9 | [18] | b | b | b |
| Other economically inactive | 23 | 26 | 22 | 10 | 28 | 27 |
| **Total** | | | | | | |
| In employment | 14 | 17 | 14 | 12 | 13 | 12 |
| Retired | 8 | 8 | 15 | [22] | 28 | [10] |
| Other economically inactive | 25 | 33 | 24 | 12 | 25 | 26 |
| *Bases (weighted)* | | | | | | |
| *Men* | | | | | | |
| *In employment* | *27407* | *1037* | *186* | *64* | *387* | *214* |
| *Retired* | *5190* | *178* | *62* | *13* | *52* | *28* |
| *Economically inactive* | *2976* | *168* | *55* | *39* | *89* | *68* |
| *Women* | | | | | | |
| *In employment* | *28285* | *1176* | *262* | *13* | *317* | *82* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Retired* | *8585* | *257* | *54* | *1* | *36* | *12* |
| *Economically inactive* | *10552* | *339* | *118* | *116* | *197* | *259* |
| *Total* | | | | | | |
| *In employment* | *55692* | *2213* | *448* | *76* | *704* | *296* |
| *Retired* | *13774* | *434* | *116* | *14* | *88* | *41* |
| *Economically inactive* | *13528* | *508* | *173* | *155* | *286* | *327* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |
| *In employment* | *275* | *235* | *156* | *144* | *218* | *201* |
| *Retired* | *53* | *44* | *56* | *32* | *31* | *26* |
| *Economically inactive* | *27* | *35* | *45* | *86* | *48* | *72* |
| *Women* | | | | | | |
| *In employment* | *273* | *248* | *225* | *28* | *189* | *83* |
| *Retired* | *85* | *58* | *48* | *4* | *22* | *13* |
| *Economically inactive* | *93* | *81* | *101* | *286* | *97* | *267* |
| *Total* | | | | | | |
| *In employment* | *548* | *483* | *381* | *172* | *407* | *284* |
| *Retired* | *138* | *102* | *104* | *36* | *53* | *39* |
| *Economically inactive* | *120* | *116* | *146* | *372* | *145* | *339* |

[a] The sample base for ILO unemployed informants is too small for results to be shown.

[b] The sample base for these categories is too small for results to be shown.

Table 2.7

**Prevalence of CIS-R score of 12 or more, by educational attainment and sex**

| **CIS-R score of 12 or more[a]** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| NVQ4/5 / HE / Degree or above | 11 | 21 | 8 | [16] | 12 | 7 |
| NVQ1/2/3 / CSE / GCSE / A level | 11 | 17 | 13 | 14 | 10 | 15 |
| No qualifications | 15 | 19 | 22 | 12 | 12 | 11 |
| **Women** | | | | | | |
| NVQ4/5 / HE / Degree or above | 25 | 12 | 18 | b | 17 | [23] |
| NVQ1/2/3 / CSE / GCSE / A level | 18 | 24 | 23 | 20 | 23 | 35 |
| No qualifications | 17 | 18 | 16 | 7 | 26 | 24 |
| **Total** | | | | | | |
| NVQ4/5 / HE / Degree or above | 17 | 17 | 14 | 20 | 14 | 14 |
| NVQ1/2/3 / CSE / GCSE / A level | 15 | 21 | 19 | 17 | 17 | 25 |
| No qualifications | 16 | 19 | 19 | 10 | 20 | 19 |
| *Bases (weighted)* | | | | | | |
| *Men* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *12133* | *444* | *83* | *16* | *195* | *71* |
| *NVQ1/2/3 / CSE / GCSE / A* | *15166* | *519* | *124* | *37* | *175* | *120* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *level* | *15166* | *519* | *124* | *37* | *173* | *120* |
| *No qualifications* | *7668* | *416* | *102* | *70* | *141* | *130* |
| *Women* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *10504* | *440* | *123* | *10* | *139* | *52* |
| *NVQ1/2/3 / CSE / GCSE / A level* | *20577* | *809* | *201* | *35* | *220* | *114* |
| *No qualifications* | *13537* | *409* | *123* | *83* | *196* | *171* |
| *Total* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *22637* | *884* | *206* | *26* | *334* | *122* |
| *NVQ1/2/3 / CSE / GCSE / A level* | *35743* | *1328* | *325* | *72* | *395* | *234* |
| *No qualifications* | *21205* | *825* | *224* | *154* | *337* | *301* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *125* | *103* | *67* | *37* | *124* | *63* |
| *NVQ1/2/3 / CSE / GCSE / A level* | *152* | *118* | *105* | *72* | *98* | *123* |
| *No qualifications* | *72* | *92* | *90* | *181* | *73* | *130* |
| *Women* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *101* | *99* | *107* | *17* | *86* | *48* |
| *NVQ1/2/3 / CSE / GCSE / A level* | *200* | *169* | *169* | *84* | *128* | *121* |
| *No qualifications* | *126* | *99* | *109* | *219* | *99* | *180* |
| *Total* | | | | | | |
| *NVQ4/5 / HE / Degree or above* | *226* | *202* | *174* | *54* | *210* | *111* |
| *NVQ1/2/3 / CSE / GCSE / A* | *352* | *287* | *274* | *156* | *226* | *244* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *level* | *332* | *287* | *274* | *130* | *220* | *244* |
| *No qualifications* | *198* | *191* | *199* | *400* | *172* | *310* |

[a] Informants with foreign or other qualifications are not included in this table because the sample base is too small.
[b] The sample base for this category is too small for results to be shown.

Table 2.8

**Prevalence of CIS-R score of 12 or more, by presence of children in household and sex**

| **CIS-R score of 12 or more** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| Children in household | 7 | 19 | 10 | 12 | 11 | 10 |
| No children in household | 13 | 17 | 16 | 17 | 13 | 17 |
| **Women** | | | | | | |
| Children in household | 25 | 19 | 21 | 12 | 17 | 29 |
| No children in household | 16 | 17 | 20 | 15 | 29 | 19 |
| **Total** | | | | | | |
| Children in household | 18 | 19 | 17 | 12 | 14 | 21 |
| No children in household | 14 | 17 | 18 | 16 | 21 | 18 |
| *Bases (weighted)* | | | | | | |
| *Men* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Children in household* | *10737* | *439* | *102* | *97* | *255* | *223* |
| *No children in household* | *26332* | *919* | *220* | *37* | *305* | *119* |
| *Women* | | | | | | |
| *Children in household* | *17739* | *726* | *208* | *108* | *262* | *267* |
| *No children in household* | *31483* | *969* | *265* | *30* | *319* | *112* |
| *Total* | | | | | | |
| *Children in household* | *28477* | *1166* | *310* | *206* | *517* | *490* |
| *No children in household* | *57814* | *1888* | *485* | *67* | *624* | *231* |
| *Bases (unweighted)* | | | | | | |
| *Men* | | | | | | |
| *Children in household* | *109* | *102* | *86* | *228* | *134* | *215* |
| *No children in household* | *257* | *200* | *185* | *83* | *178* | *119* |
| *Women* | | | | | | |
| *Children in household* | *159* | *148* | *176* | *265* | *141* | *265* |
| *No children in household* | *309* | *216* | *224* | *73* | *182* | *122* |
| *Total* | | | | | | |
| *Children in household* | *268* | *250* | *262* | *493* | *275* | *480* |
| *No children in household* | *566* | *416* | *409* | *156* | *360* | *241* |

Table 2.9

**Prevalence of CIS-R score of 12 or more, by age at migration and sex**

*Base: aged 16 to 54*

| **CIS-R score of 12 or more** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | Black | | | |
| | Irish | Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | |
| **Men** | | | | | | |
| Migrated aged < 11 or born in UK | 17 | 13 | 8 | 14 | 12 | |

| | | | | | |
|---|---|---|---|---|---|
| Migrated aged 11 or more | [26] | a | 14 | 8 | 13 |
| **Women** | | | | | |
| Migrated aged < 11 or born in UK | 22 | 20 | 20 | 26 | 29 |
| Migrated aged 11 or more | 15 | 28 | 6 | 18 | 22 |
| **Total** | | | | | |
| Migrated aged < 11 or born in UK | 20 | 17 | 14 | 20 | 21 |
| Migrated aged 11 or more | 19 | 23 | 10 | 13 | 18 |
| *Bases (weighted)* | | | | | |
| *Men* | | | | | |
| *Migrated aged < 11 or born in UK* | *904* | *202* | *56* | *236* | *157* |
| *Migrated aged 11 or more* | *162* | *35* | *55* | *219* | *138* |
| *Women* | | | | | |
| *Migrated aged < 11 or born in UK* | *1191* | *312* | *58* | *242* | *198* |
| *Migrated aged 11 or more* | *248* | *73* | *68* | *244* | *149* |
| *Total* | | | | | |
| *Migrated aged < 11 or born in UK* | *2095* | *514* | *114* | *478* | *355* |
| *Migrated aged 11 or more* | *409* | *108* | *123* | *464* | *286* |
| *Bases (unweighted)* | | | | | |
| *Men* | | | | | |
| *Migrated aged < 11 or born in UK* | *196* | *165* | *121* | *131* | *158* |
| *Migrated aged 11 or more* | *39* | *29* | *128* | *119* | *130* |
| *Women* | | | | | |
| *Migrated aged < 11 or born in UK* | *244* | *259* | *127* | *139* | *198* |
| *Migrated aged 11 or more* | *60* | *65* | *176* | *133* | *153* |
| *Total* | | | | | |
| *Migrated aged < 11 or born in UK* | *440* | *424* | *248* | *270* | *356* |
| *Migrated aged 11 or more* | *99* | *94* | *304* | *252* | *283* |

[a] The sample base for this category is too small for results to be shown.

# 3 Pyschosis symptoms and estimated rates

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## 3.1 Introduction

Psychotic illnesses involve a fundamental disruption of thought processes, in which the individual suffers from a combination of distressing delusions and hallucinations. Delusions often involve convictions that one is being watched or persecuted or that some external force is controlling one's thoughts. Hallucinations typically involve hearing voices talking about or to the individual, but may also involve visual experiences or smells. Individuals often lose insight into the nature of the illness, particularly during an acute episode. These disorders, which include schizophrenia and other delusional disorders (International Classification of Mental and Behavioural Disorders, Edition 10, F20-F29), are relatively infrequent. Recent prevalence estimates suggest that annually they affect around 1 person in 200 in the UK,[1] but often result in severe disability.

Most research on ethnic differences in psychotic illnesses has been based on treatment rates, because of their relative infrequency in the population, the difficulty with measuring them and because the majority of people affected are thought to make contact at some stage with treatment services. Over the past three decades such studies in Britain have consistently shown elevated rates of schizophrenia among Black Caribbean people compared with the White population. Black Caribbean people are typically reported to be three to five times more likely than White people to be admitted to hospital with a first diagnosis of schizophrenia.[2,3,4,5,6,7] These findings have been repeated in studies that have included first contact with any form of treatment, rather than just hospital services,[8] although the rates in one such study were only twice those of the White population.[9] Some of the more recent of these studies have also included people of African ethnicity and have reported similarly raised rates of psychotic illness in this group.[7,8] Explorations of the demographic characteristics of Black people admitted to hospital with a psychotic illness suggest that these illnesses are particularly common among young men,[6] and some studies have suggested that the rates are very high among young Black Caribbean people who were born in Britain (although these data, like most work in this area are dependent on a very small number of identified cases). For example, one study reported that the rates of first contact with psychiatric services for psychotic illness among Black Caribbean people born in Britain are 18 times those of the general population.[4]

In contrast to studies based on contact with treatment services, the only other national community based study of mental illness among ethnic minority groups, the Fourth National Survey of Ethnic Minorities (FNS), produced rather different findings. Overall, the group defined as Caribbean in that survey (using a question on 'family origins') did have a raised prevalence of psychotic symptoms in comparison with the White British group, but not to the level reported elsewhere. For Caribbean people the annual prevalence (that is the number of people affected at some point in a year) was 14 per

thousand, in comparison with the rate of 8 per thousand for the White group (that is 75 per cent higher in the Caribbean group). And when differences were considered across gender, age and migration status, it was found that the prevalence of psychotic symptoms was not particularly high among young Caribbean men or those born in Britain. In fact, the difference between Caribbean and White people in estimated prevalence of psychotic illness in the FNS was largely accounted for by the relatively high prevalence among Caribbean women.[10]

Findings on rates of psychotic illness among South Asian people are even more mixed. A study of hospital-based treatment suggested that rates of admission for psychotic illness among South Asian people are similar to those among White people.[6] A more comprehensive prospective study of first contact for schizophrenia with all treatment services in one area of London (whose South Asian population is predominantly of Indian origin) confirmed this.[9] However, an earlier study, using the same methods in another London district in which the South Asian population (of Indian and Pakistani origin) was smaller and more dispersed, suggested that rates of psychotic illness were raised to similar levels among South Asian people to those found among Black Caribbean people.[8] Indeed, this study suggested that rates of psychotic illness among all ethnic minority groups, as defined by the 1991 Census categories, were similarly raised in comparison with a White group. In addition, the study found that the majority of White people identified as having a first onset of psychotic illness was not of British origin.[8] Elsewhere the authors state that: 'Most [patients] were from an ethnic minority background, including those people defined as White according to the 1991 OPCS census'.[11] A study on rates of treatment in hospital similarly showed a high rate of psychosis among the largest White migrant group  Irish people.[6]

In contrast to the findings for contact with treatment services, the community based FNS prevalence study suggested that rates of psychotic symptoms might be lower among South Asian people, particularly Bangladeshi people, than among White British people.[10] However, when these findings were examined by migration status, it seemed that the lower rates only applied to those South Asian people who had migrated to Britain, with non-migrants having rates that were identical to the White British rates. In support of the conclusions drawn by King et al[8] and Cole et al,[11] the FNS also reported a high rate of psychosis among White people who were not of British origin (they were predominantly, though not exclusively, of Irish origin), for whom the rate was 75 per cent higher rate than that for the White British group.

## 3.2 **Measures**

The Psychosis Screening Questionnaire (PSQ) was used to assess psychotic symptoms in this study.[12] This was designed as a screening instrument to identify whether there was any possibility of the informant suffering from a psychotic illness. For example, when used in a sample of psychiatric in-patients, psychiatric out-patients and GP attendees, only 2 out of 124 informants who screened negative on the PSQ were found to have a psychotic illness during a full diagnostic interview (using the Schedules for Clinical Assessment in Neuropsychiatry  the SCAN).[12] However, the use of such an instrument, while minimising the possibility of false negative assessments, does increase the false positive rate. The authors of the instrument estimated that if it were used in a population with a typical one per cent prevalence of psychotic illness, only one in every six cases identified as positive by the PSQ would be a true case.[12]

The PSQ as used here (and in the OPCS/ONS series of surveys and the FNS) covers five broad categories of symptoms: hypomania; thought interference; delusions of persecution; a feeling that something 'strange' is taking place that is hard to explain; and auditory hallucinations. Two or three

questions are used for each symptom category, a general introductory stem question and one or two more targeted questions for those who answer 'yes' to the introductory questions. The informant must have answered 'yes' to all questions within a symptom category in order to screen positive on that item. The actual questions used are:

1. Over the past year, have there been times when you felt very happy indeed without a break for days on end?

   a) Was there an obvious reason for this?
   b) Did your relatives or friends think it was strange or complain about it?

2. Over the past year, have you ever felt that your thoughts were directly interfered with or controlled by some outside force or person?

   a) Did this come about in a way that many people would find hard to believe, for instance, through telepathy?

3. Over the past year, have there been times when you felt that people were against you?

   a) Have there been times when you felt that people were deliberately acting to harm you or your interests?
   b) Have there been times when you felt that a group of people were plotting to cause you serious harm or injury?

4. Over the past year, have there been times when you felt that something strange was going on?

   a) Did you feel it was so strange that other people would find it very hard to believe?

5. Over the past year, have there been times when you heard or saw things that other people could not?

   a) Did you at any time hear voices saying quite a few words or sentences when there was no one around that might account for it?

In the standard use of the PSQ, informants are not asked to continue the psychosis screening sequence once they have answered positively to one item, because a positive screen would route the informant into a more detailed clinical assessment. However, in this study, which did not conduct such clinical assessments, informants were asked all of the stem questions, regardless of their response to earlier ones. The FNS also asked all of the PSQ stem questions regardless of answers to previous items.[10] That study included a clinical validation interview using the Present State Examination (PSE),[13] which showed that the higher the number of positive PSQ items, the greater the risk of meeting the criteria for psychotic illness in the clinical interview. In the FNS this finding was used to calculate estimates of the rate of psychosis in a population, based on the number of positive PSQ items for individual informants.

In the current study, the use of the full PSQ for all informants and the existence of the FNS validation study, enabled two levels of analysis to be conducted. First, each of the broad symptom categories covered by the PSQ were mapped across the ethnic groups, and the prevalence of psychosis symptoms (as measured by the PSQ) were explored by demographic and socio-economic factors. Second, findings from the FNS validation study were used to calculate estimates of the annual prevalence of

psychotic illness, using the relationship between the number of positive PSQ items reported by the informant and the likelihood of meeting the criteria for a psychotic illness at a diagnostic interview (based on the strategy used in the FNS[10]). So, the size of this relationship was used to identify the probability for an informant of having a psychotic illness (from 0 to 1) for a given score on the PSQ screening items. This was then used to predict the number of people with a psychotic illness in a particular population.

It is worth describing how this works in detail. Table 3.1 shows the relationship in the FNS between PSQ score and diagnostic class at the PSE interview for informants from all ethnic groups (sample numbers were too small to do sub-group analyses). The final row of the table shows the relationship between PSQ score and chance of being allocated into the non-affective (that is excluding those relating to depression and mania) psychosis class. So, of those who scored on one PSQ item 10.5% were confirmed as having a psychotic illness at the diagnostic interview, and the figures for those who scored two and three or more were 16.4% and 17.4% respectively. To apply this, if a particular population had ten people scoring one, ten people scoring two, and ten people scoring three items on the PSQ, the estimated prevalence of psychosis in that population would be: (10*0.105) + (10*0.164) + (10*0.174) = 4.43 people. In the current study this calculation has been performed for each sub-population of interest (for example, ethnic group and particular occupational class group within ethnic group). In this approach we emphasise that:

1. We have not included affective psychoses in order to be comparable with the FNS, but including such psychosis would, because of the method of estimation used, simply uniformly increase the estimated annual prevalence of psychosis.
2. Despite a suggestion by Bebbington and Nayani[12] that items on thought interference detracted from the predictive value of cases of the overall questionnaire, we have included them, as they are used in the OPCS/ONS series of surveys, they were used in the FNS, and here they increase the number of items for estimation of rates of illness.
3. Although not used as criteria for follow-up clinical interview in the FNS, delusions of persecution are also used in the OPCS/ONS series of surveys and increase the number of items for estimation of the prevalence of psychosis, so are included here. Evidence presented later (see Table 3.2) suggests that this item had a similar variation of outcome across ethnic groups to other PSQ items, so its inclusion should not bias the findings reported here.
4. The formula used to estimate the prevalence of psychosis was derived using informants from all ethnic groups, because numbers were too small for group-specific analyses. This means that the estimates presented here do not account for possible ethnic differences in the relationship between PSQ score and diagnostic class at PSE interview.

This process is somewhat different from that used in the first and second National Psychiatric Morbidity Surveys.[1,14] The first counted as 'cases' of psychosis only those who had been validated in the follow-up clinical interview, or who had reported both taking anti-psychotic medication and having a psychotic illness. Those who were not successfully followed-up, or who did not report both a diagnosis of and treatment for psychosis, were excluded. Although, the second used slightly wider criteria to identify 'cases' of psychosis, the authors' still recognised that their approach to case finding was conservative and likely to lead to an underestimate of the number of people with psychoses.[1] In this context, it is worth noting that when the first National Psychiatric Morbidity Survey criteria were used for the FNS data, an almost identical general population rate for non-affective psychosis was recorded.[10] Similarly, when the first National Psychiatric Morbidity Survey criteria were used for the second National Psychiatric Morbidity Survey data, an almost identical general population rate for psychosis was recorded.[1] And, when a less conservative approach to 'case' finding was used with the second National Psychiatric Morbidity Survey data, the prevalence estimate was close to that found in

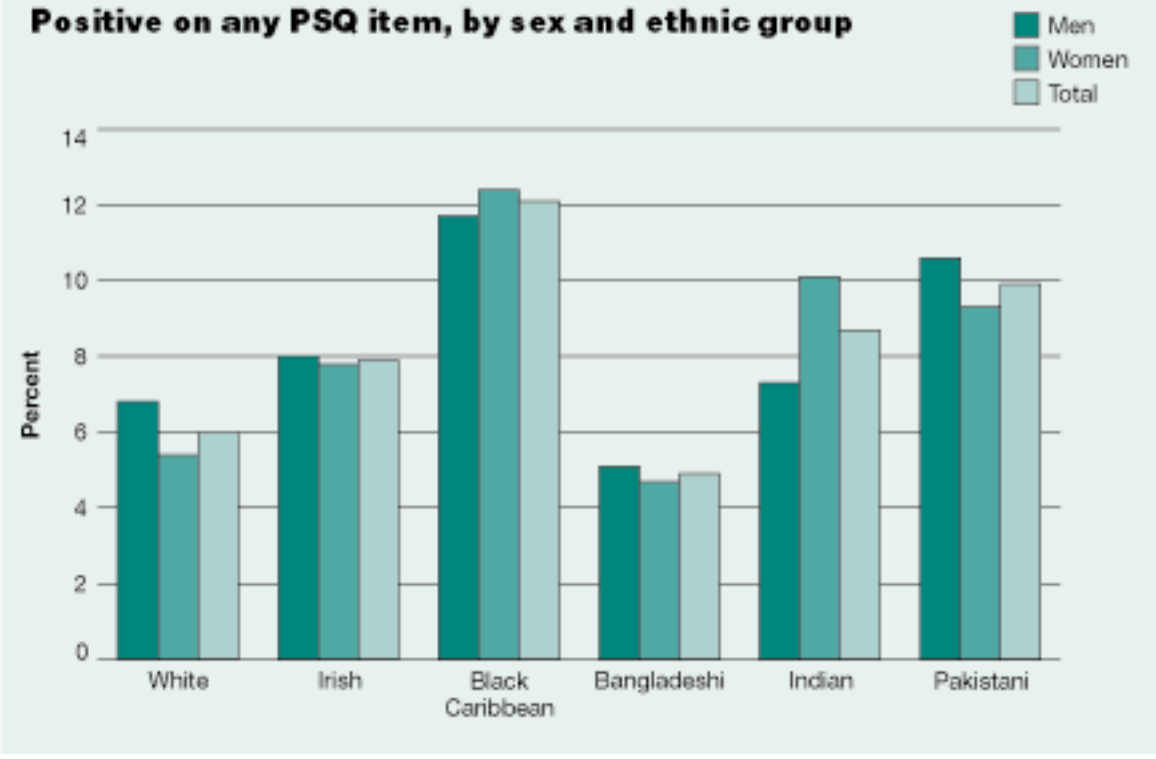
the FNS.[1] The implication of this is that while the three studies might have resulted in different estimates of prevalence of psychosis in the general population, the differences were the result of more or less conservative approaches to 'case' finding, rather than differences in the samples.

A disadvantage of the approach adopted in the current study is that the validation work was carried out on another survey in a different context, so it may not apply to the population used for this study, surveyed some six years later.

## 3.3 **Prevalence of psychosis symptoms by gender**

Table 3.2 shows responses to the PSQ questions by ethnic group and by gender within ethnic group. The first five sets of rows show the prevalence for each of the symptom categories covered by the PSQ, while the final set shows the prevalence of scoring positively on any item. This is also shown in Figure 3.1. The prevalence of scoring positively on any PSQ item ranged from a low of 5% for both men and women in the Bangladeshi group to a high of 12% for men and women in the Black Caribbean group. In comparison with the rate of 6% among White group (7% for men and 5% for women), the prevalence of scoring positively on any PSQ item appeared to be high in the Black Caribbean (12%), Pakistani (10%), Indian (9%) and Irish (8%) groups, and lower for the Bangladeshi (5%) group, although the age-adjusted relative risk ratios show that none of these differences were statistically significant. The only significant difference in the table is the two-fold greater prevalence for Black Caribbean women compared with White women.

Figure 3.1




For each of the symptom categories shown in the table the Black Caribbean group had a higher prevalence rate than that in the White group (between 40% higher, for thought interference, and twice as high, for delusions of persecution). Prevalence rates were also generally higher for the Pakistani group than the White group (with auditory hallucinations the one exception) and generally lower for the Bangladeshi group (with delusions of persecution the exception for this group). The pattern was

more mixed for the Irish and Indian groups.

Throughout the table there were only inconsistent gender differences. For some ethnic groups the rates for men and women were very similar (Black Caribbean, Bangladeshi and Pakistani). Where there appeared to be differences within ethnic groups, men had higher prevalence rates than women for some symptom categories, while for others prevalence rates were higher among women than men. And where there were gender differences within a symptom category, they were not consistent across different ethnic groups (see, for example, the pattern for hypomania).

## 3.4 Estimated rates of psychosis by gender

Table 3.3 uses the formula described in the measurement section of this chapter to show the estimated annual prevalence of psychosis in each ethnic group and by gender within ethnic group. The estimated annual prevalence ranged from a low of six per thousand for men and women in the Bangladesh group to a high of sixteen per thousand in the Black Caribbean group. The rate for the White group, eight per thousand, was the same as that reported for the FNS.[10] Although it is a little higher than that reported in the second National Psychiatric Morbidity Survey, as suggested above this is likely to be a consequence of a more conservative approach to case finding in that survey.[1]

As might be expected, the overall pattern of difference by ethnic group is similar to that shown in Table 3.2. In comparison with the White group, the rates were higher among the Black Caribbean group (at sixteen per thousand) and the Pakistani group (at thirteen per thousand) and lower among the Bangladeshi group (at six per thousand). The rates for the Irish group (at ten per thousand) and the Indian group (at eleven per thousand) were similar to those of the White group. However, none of these differences, including the two-fold greater estimated prevalence for the Black Caribbean group, were statistically significant.

Overall, the rates for men and women in the table were similar. The only exception was the higher rate for White men compared with White women, although again this difference was not statistically significant.

## 3.5 Demographic factors

This section describes differences in PSQ scores and in the estimated annual prevalence of psychosis by demographic factors: age, age on migration to the UK, and marital status.

Table 3.4 shows differences by age. For the White, Irish and Pakistani ethnic groups, prevalence rates were markedly lower in the oldest age group. For example, among 55 to 74 year old White people the estimated annual prevalence of psychosis was three per thousand, in comparison with a rate of ten per thousand among adults aged below 55. Among the Black Caribbean, Bangladeshi and Indian groups, the rates did not vary by age, or were inconsistent and not large.

Table 3.5 shows differences by age on migration for each of the ethnic minority groups. Each group is dichotomised between those who migrated aged 11 or older, and those who were born in the UK or migrated before the age of 11. In the analysis of the FNS data, a threshold age of 11 was chosen because of the differences in the age distributions between migrants and non-migrants.[10] Using this cut-off made the age groups more balanced; resulted in numbers in each group that were reasonable for analysis; and produced similar findings to thresholds of 0, 5 and 16 years. Thus, we followed that strategy here. The table is restricted to those aged under 55, to minimise age differences between the 'migrant' and 'non-migrant' groups.

There was a suggestion of a difference for all of the ethnic groups. For the Irish, Bangladeshi, Indian

and Pakistani groups the rate of screening positive on the PSQ was higher for the 'non-migrant' group than for the 'migrant' group. This pattern is consistent with findings from the FNS for the three South Asian groups.[10] For the Caribbean group there was a suggestion that the rate was higher among the 'migrant' group, although the difference was small. This pattern is also consistent with findings from the FNS,[10] but it is inconsistent with studies of treatment rates for psychotic illness among first and second generation Black Caribbean people,[3,4] which suggest that rates are particularly high for second generation Black Caribbean people.

Table 3.6 shows how the prevalence of screening positive on the PSQ and estimated annual prevalence of psychosis varied by marital status within ethnic groups. The table shows a consistent pattern across ethnic groups, with the lowest rate found in the married/cohabiting category for each ethnic group, a finding consistent with that of the second National Psychiatric Morbidity Survey.[1] For the three South Asian groups, reliable estimates could not be made for the divorced/separated group, because of small numbers of informants in this category, but for the White, Irish and Black Caribbean groups the prevalence rates were similar for the divorced/separated and never married categories.

## 3.6 **Socioeconomic position**

Three indicators of socio-economic position are used here, economic activity, occupational class of Head of Household, and housing tenure.

Table 3.7 shows the prevalence of screening positive on the PSQ and estimated annual prevalence of psychosis by economic activity within ethnic groups, with those who are employed compared with a combined group covering all of those who are economically inactive. For the White, Irish and Black Caribbean groups there were differences, which were large for the White and Black Caribbean groups, with higher prevalence rates among the economically inactive. Similar findings for the general population were found for the second National Psychiatric Morbidity Survey.[1] In contrast, there were no differences between the employed and economically inactive among the three South Asian groups.

Table 3.8 shows differences between those classified as manual and non-manual according to the occupation of the Head of the Household. Differences were present for the White, Black Caribbean and Pakistani groups. Among the White and Black Caribbean groups higher rates were found for the manual than the non-manual category, while the opposite was the case for the Pakistani group. The other groups showed no difference between the manual and non-manual groups. These findings are consistent with those from the FNS, which suggested a class gradient in psychosis for White and Caribbean people, but not for South Asian people.[10]

Table 3.9 shows differences in the prevalence of screening positive on the PSQ and estimated annual prevalence of psychosis by housing tenure. The findings echoed those for economic activity (see Table 3.7) in that there was a clear and large difference for the White, Irish and Black Caribbean groups, with those renting having higher rates than those who owned or were buying their homes. But there was no difference between tenure categories for the three South Asian groups. Again the findings for the White, Irish and Black Caribbean groups are compatible with those found in the second National Psychiatric Morbidity Survey for the general population.[1]

## 3.7 **Area of residence**

The areas where informants lived were categorised according to degree of urbanisation, using interviewer assessments. Table 3.10 shows how the prevalence of screening positive on the PSQ and estimated annual prevalence of psychosis varied by area of residence, comparing urban areas with

suburban/rural areas. For the White group the prevalence was higher for those living in urban areas, a finding similar to that for the second National Psychiatric Morbidity Survey.[1] For most of the other ethnic groups there were no differences in prevalence among those living in urban areas compared with those living in suburban/rural areas, though there is a suggestion of a higher rate among urban Pakistani people, and among suburban/rural Bangladeshi people. It is worth noting that the there were very few informants living in rural areas among the non-White ethnic minority groups, so the findings for suburban/rural people in these groups in fact reflect those living in suburban areas.

## 3.8 **Conclusions**

The literature on ethnic differences in psychotic illnesses suggests that rates of first contact with treatment services for such illnesses are three to five times higher for Black Caribbean people than the general population.[2,3,4,5,6,7] They are also possibly higher for the other ethnic minority groups in the UK, including White minorities,[8,11] though some have suggested that rates for South Asian people are similar to those for the general population.[6,9] One of the weaknesses of most work on ethnicity and mental illness is a reliance on data based on contact with treatment services. Contact with services, even when access is universal, as in the NHS, reflects illness behaviour (ie the way that symptoms are perceived, evaluated and acted upon), rather than illness per se.[15] This makes interpreting differences in treatment rates across ethnic groups difficult, particularly as illness behaviour is likely to be influenced by a number of factors that vary by ethnicity, such as socioeconomic position, health beliefs, expectations of the sick role and lay referral systems.[15] These problems become particularly important for psychotic illnesses, where contact with services might be against the patient's wishes. So, despite the consistency of research findings showing that Black Caribbean people have higher rates of treatment for psychosis, some commentators have not accepted the validity of the interpretation of these data and continue to suggest that a higher illness rate (rather than a higher treatment rate) remains unproven, because of the methodological flaws with the research that has been carried out. (See Sashidharan[16] and Iley and Nazroo[17] for comprehensive reviews of this.)

In contrast to studies on rates of contact with services, this national study of prevalence rates in the community indicated a twofold higher rate for Black Caribbean people compared with the White group, and this was only statistically significant for women at the level of reporting psychosis symptoms on the PSQ. It was not significant for men or the total Black Caribbean population and was not significant at the level of estimated rates of psychosis. This finding is consistent with the only other national community survey that has estimated the prevalence of psychotic illnesses among different ethnic groups, the FNS.[10] Also consistent with the FNS were the findings that rates for Black Caribbean people were not particularly elevated among men, the young, or 'non-migrant' people. This detail also contradicts some of the data from studies of treatment rates, which have suggested that the onset of psychotic illnesses is particularly high among young Black Caribbean men,[6] and among those born in the UK.[3,4] One finding that is consistent with both treatment based studies and the FNS is that the rate of psychotic illness in this study was, for the Black Caribbean (and White) group, related to socioeconomic position, with those who were in poorer economic positions appearing to have a higher risk. Those living in inner cities also appeared to have a higher risk.

For the Irish and South Asian groups the pattern was more mixed. Irish people had a similar rate of screening positive for psychosis on the PSQ and for the estimated prevalence of psychotic illness to that for the White group. The Indian and Pakistani groups had higher rates of screening positive for psychosis and for the estimated prevalence of psychotic illness than the White group, although none of these differences were statistically significant. In contrast, the Bangladeshi group had a lower rate than

the White group for both of these items, but not significantly so. Although rates of psychosis for South Asian people are usually reported in treatment studies as equal to or lower than rates for White people, at least one first contact study in the UK[8] and one in Holland[18] have reported elevated incidence rates. For the three South Asian groups covered here, the risk of screening positively on the PSQ was related to age on migration, with 'migrants' having lower rates than 'non-migrants', which is consistent with findings from the FNS.[10] This is discussed more fully in Chapters 1 and 8, where the possibility that this is a consequence of cultural differences in symptomatic experience, or idioms, of mental distress is explored. In particular, it is possible that the illness experiences of South Asian people are not adequately captured by Western instruments, something that, if it were the case, would be more evident among the 'migrant' group. Hence the lower rates of detected mental illness in 'migrant' as opposed to 'non-migrant' people when using survey measures derived from Western psychiatry approaches.

Findings for the Irish group, like the Black Caribbean and White groups, had a suggestion of a socioeconomic gradient in risk of psychotic symptoms and illness. However, such a gradient was not present for any of the South Asian groups and, if anything, was reversed for the Pakistani group.

Although research based on service contacts in the UK indicates that psychotic illnesses are considerably more common in Black Caribbean people than White people, epidemiological work in the Caribbean suggests that rates of first-contact with treatment services for non-affective psychoses in people of African ethnic background are not elevated above first-contact rates for the White population of the United Kingdom.[19,20,21]Furthermore, epidemiological data from the FNS, and now this survey, reveal that although non-affective psychoses are more common in people of Black Caribbean origin, the differential in rates is far less than that seen in most studies based on rates if contact with services. Since the concepts of 'western psychiatry' are common to all research approaches, this suggests that even if Black Caribbean people are more vulnerable to psychotic illnesses they are also treated differently in the UK. Possible explanations are racism by psychiatrists and in the community,[22,23] misunderstanding of cultural expressions of distress,[24,25] differential responses by police, social and treatment services,[24,26,27] and social inequality. However, why such factors should operate for Black Caribbean people as opposed to other ethnic minorities is not clear.

Course and outcome of an illness tells us something about its nature. It also determines the relationship between incidence and prevalence. Many of the comparisons in this chapter have been made between prevalence rates as determined by the PSQ and published data from first contact treatment studies, which are a proxy for incidence. However, comparing incidence and prevalence rates could be misleading if psychotic disorders had differential courses and outcomes between ethnic groups. For example, if the incidence of psychotic illness in Black Caribbean people were higher than in White people, but the outcome in Black Caribbean people was better, one would find less disparity in prevalence than in incidence between the two ethnic groups. However, it remains uncertain whether the course of these illnesses is similar in Black Caribbean and White patients. Although several studies have reported little difference in outcomes between ethnic groups,[27,29,30] one study has recently reported better outcomes for Black Caribbean patients.[31] Outcome of psychotic illness is a complex process that reflects the effects of stigma, social exclusion, degree of compliance with treatment, institutionalisation and treatment with anti-psychotic drugs, as well as the natural history of the illness itself.

Finally, we should consider the suggestion made in the early years of the twentieth century that selective migration of vulnerable people, rather than difficulties encountered post migration, may be an explanation.[32] However, the findings from this study and the FNS have suggested that for the Black

Caribbean group 'non-migrants' have similar rates of psychosis to 'migrants'. A study in Denmark showed that immigrants from other Scandinavian and European Union countries have higher rates of psychosis than immigrants from countries such as Turkey or Pakistan, for whom adjustment post migration would be likely to be more difficult.[33] Also, once again it is difficult to see how this might affect only some ethnic minority populations and not others.

One potential and important limitation to our findings is that people with psychotic disorders may be less likely to comply with a request to participate in surveys of this nature than those without such disorders. Such a systematic bias in participation is difficult to assess. Perhaps most importantly, however, there is little evidence that this potential error in estimation of prevalence is likely to be greater in any particular ethnic population.

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# 3 Pyschosis symptoms and estimated rates

*James Nazroo and Michael King*

## Tables

Table 3.1

**Number of positive PSQ items and PSE diagnostic (CATEGO) class, data from the Fourth National Survey**

| | | Number of positive PSQ items | | |
|---|---|---|---|---|
| | | One | Two | Three or more |
| | | % | % | % |
| PSE (CATEGO) diagnostic class | | | | |
| | None | 31.3 | 16.4 | 21.7 |
| | Neurotic | 56.0 | 62.3 | 56.5 |
| | Affective psychosis | 2.2 | 4.9 | 4.4 |
| | Non-affective psychosis | 10.5 | 16.4 | 17.4 |
| *Base* | *134* | | *61* | *23* |

Table 3.2

**Prevalence of psychosis symptoms (on the PSQ), by gender**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | Black | | | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Hypomania** | | | | | | |
| Men | < 1 | 1 | 2 | < 1 | 2 | 1 |
| Women | 1 | 1 | 2 | < 1 | 1 | 1 |
| Total | 1 | 1 | 2 | < 1 | 1 | 1 |
| **Thought interference** | | | | | | |
| Men | 3 | 1 | 3 | 1 | 1 | 2 |
| Women | 1 | 1 | 2 | 1 | 3 | 2 |
| Total | 2 | 1 | 3 | 1 | 2 | 2 |
| **Delusions of persecution** | | | | | | |
| Men | 3 | 2 | 4 | 2 | 1 | 3 |
| Women | 1 | 2 | 3 | 2 | 2 | 5 |
| Total | 2 | 2 | 3 | 2 | 1 | 4 |
| **Feeling that something 'strange' is taking place** | | | | | | |
| Men | 5 | 4 | 6 | 2 | 4 | 6 |
| Women | 3 | 5 | 8 | 2 | 7 | 5 |
| Total | 4 | 4 | 7 | 2 | 6 | 5 |
| **Auditory hallucinations** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Men | 2 | 2 | 3 | 1 | 1 | 1 |
| | Women | 1 | 1 | 2 | 1 | < 1 | 1 |
| | Total | 1 | 1 | 2 | 1 | 1 | 1 |
| **Positive on any PSQ item** | | | | | | | |
| | Men | 7 | 8 | 12 | 5 | 7 | 11 |
| | Women | 5 | 8 | 12 | 5 | 10 | 9 |
| | Total | 6 | 8 | 12 | 5 | 9 | 10 |
| **Age standardised risk ratio for** | | | | | | | |
| **positive on any PSQ item** | | | | | | | |
| Men | | | | | | | |
| | Risk ratio | 1 | 1.46 | 1.56 | 0.65 | 1.08 | 1.36 |
| | Standard error | 1 | 0.44 | 0.42 | 0.21 | 0.31 | 0.36 |
| Women | | | | | | | |
| | Risk ratio | 1 | 1.64 | 2.13 | 0.65 | 1.77 | 1.48 |
| | Standard error | 1 | 0.46 | 0.53 | 0.22 | 0.48 | 0.39 |
| Total | | | | | | | |
| | Risk ratio | 1 | 1.55 | 1.85 | 0.65 | 1.42 | 1.42 |
| | Standard error | 1 | 0.45 | 0.48 | 0.21 | 0.39 | 0.37 |
| *Bases (weighted)* | | | | | | | |
| | *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| | *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| | *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | | |
| | *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| | *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| | *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

**Estimated annual prevalence of psychosis, by gender**

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | | | Black | | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| Men | 1.0 | 1.0 | 1.6 | 0.6 | 0.9 | 1.4 |
| Women | 0.7 | 1.0 | 1.7 | 0.6 | 1.3 | 1.3 |
| Total | 0.8 | 1.0 | 1.6 | 0.6 | 1.1 | 1.3 |
| *Bases (weighted)* | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 3.4

**Screening positive on the PSQ and estimated annual prevalence of psychosis, by age**

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | | | Black | | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 16 to 34 | 8 | 16 | 13 | 6 | 10 | 9 |
| 35 to 54 | 7 | 7 | 12 | 3 | 7 | 14 |
| 55 to 74 | 2 | 0 | 12 | 4 | 8 | 2 |
| **Estimated prevalence of psychosis** | | | | | | |
| 16 to 34 | 1.0 | 2.1 | 1.7 | 0.7 | 1.3 | 1.3 |
| 35 to 54 | 1.0 | 0.9 | 1.6 | 0.3 | 0.9 | 1.9 |
| 55 to 74 | 0.3 | 0.0 | 1.6 | 0.5 | 1.1 | 0.2 |
| *Bases (weighted)* | | | | | | |
| *16 to 34* | *25420* | *943* | *321* | *158* | *442* | *412* |
| *35 to 54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| *55 to 74* | *23522* | *808* | *203* | *37* | *214* | *83* |
| *Bases (unweighted)* | | | | | | |
| *16 to 34* | *228* | *179* | *248* | *362* | *227* | *403* |
| *35 to 54* | *371* | *360* | *270* | *190* | *295* | *236* |
| *55 to 74* | *238* | *194* | *176* | *98* | *121* | *85* |

Table 3.5

**Screening positive on the PSQ and estimated annual prevalence of psychosis, by age on migration (informants aged 16 to 54 only)**

| | **Ethnic group** | | | | |
|---|---|---|---|---|---|
| | | Black | | | |
| | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | |
| Migrated aged < 11 or born in UK | [11] | 12 | 7 | 11 | 13 |
| Migrated aged 11 or older | 7 | 15 | 3 | 7 | 8 |
| **Estimated prevalence of psychosis** | | | | | |
| Migrated aged < 11 or born in UK | [1.4] | 1.6 | 0.8 | 1.4 | 1.8 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Migrated aged 11 or older | 0.9 | 2.1 | 0.4 | 0.8 | 1.1 | |
| *Bases (weighted)* | | | | | | |
| *Migrated aged < 11 or born in UK* | *180* | *66* | *59* | *136* | *86* | |
| *Migrated aged 11 or older* | *383* | *94* | *120* | *436* | *266* | |
| *Bases (unweighted)* | | | | | | |
| *Migrated aged < 11 or born in UK* | *37* | *58* | *138* | *86* | *86* | |
| *Migrated aged 11 or older* | *94* | *83* | *292* | *237* | | *265* |

Table 3.6

**Screening positive on the PSQ and estimated annual prevalence of psychosis,**

**by marital status**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |
| Married/cohabiting | 4 | 5 | 9 | 5 | 8 | 8 |
| Divorced/separated | 10 | 12 | 16 | [-] | [9] | [-] |
| Single and never been married | 10 | 15 | 14 | 7 | 12 | 13 |
| **Estimated prevalence of psychosis** | | | | | | |
| Married/cohabiting | 0.5 | 0.5 | 1.1 | 0.6 | 1.0 | 1.0 |
| Divorced/separated | 1.5 | 1.6 | 2.3 | [-] | [1.3] | [-] |
| Single and never been married | 1.3 | 2.1 | 2.0 | 0.8 | 1.5 | 1.8 |
| *Bases (weighted)* | | | | | | |
| *Married/cohabiting* | *54868* | *2082* | *333* | *188* | *829* | *507* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Divorced/separated* | *8079* | *353* | *100* | *8* | *58* | *26* |
| *Single and never been married* | *19434* | *766* | *371* | *66* | *236* | *176* |
| *Bases (unweighted)* | | | | | | |
| *Married/cohabiting* | *543* | *480* | *286* | *458* | *479* | *511* |
| *Divorced/separated* | *71* | *83* | *93* | *17* | *30* | *18* |
| *Single and never been married* | *183* | *138* | *294* | *144* | *120* | *175* |

Table 3.7

**Screening positive on the PSQ and estimated annual prevalence of psychosis,**

**by economic activity**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |
| Employed | 5 | 8 | 10 | 5 | 9 | 10 |
| Economically inactive | 10 | 11 | 20 | 4 | 9 | 10 |
| **Estimated prevalence of psychosis** | | | | | | |
| Employed | 0.6 | 1.0 | 1.3 | 0.6 | 1.1 | 1.3 |
| Economically inactive | 1.5 | 1.5 | 3.0 | 0.4 | 1.1 | 1.4 |
| *Bases (weighted)* | | | | | | |
| *Employed* | *55692* | *2213* | *448* | *76* | *704* | *296* |
| *Economically inactive* | *13528* | *508* | *173* | *155* | *286* | *327* |
| *Bases (unweighted)* | | | | | | |
| *Employed* | *548* | *483* | *381* | *172* | *407* | *284* |
| *Economically inactive* | *120* | *116* | *146* | *372* | *145* | *339* |

Table 3.8

**Screening positive on the PSQ and estimated annual prevalence of psychosis,**

**by social class of Head of Household**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |
| Non manual | 4 | 8 | 8 | 3 | 8 | 13 |
| Manual | 8 | 8 | 15 | 5 | 8 | 7 |
| **Estimated prevalence of psychosis** | | | | | | |
| Non manual | 0.5 | 1.0 | 1.0 | 0.5 | 1.0 | 1.8 |
| Manual | 1.2 | 1.0 | 2.0 | 0.6 | 1.1 | 1.0 |
| *Bases (weighted)* | | | | | | |
| *Non manual* | *48156* | *1588* | *335* | *39* | *498* | *217* |
| *Manual* | *36755* | *1680* | *446* | *197* | *619* | *412* |
| *Bases (unweighted)* | | | | | | |
| *Non manual* | *483* | *342* | *279* | *81* | *298* | *210* |
| *Manual* | *341* | *383* | *381* | *474* | *325* | *427* |

Table 3.9

**Screening positive on the PSQ and estimated annual prevalence of psychosis, by tenure**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |
| Owns/buying | 4 | 6 | 9 | 5 | 9 | 9 |
| Rent/part rent and part buy | 12 | 14 | 15 | 5 | 10 | 10 |
| **Estimated prevalence of psychosis** | | | | | | |
| Owns/buying | 0.5 | 0.6 | 1.1 | 0.7 | 1.1 | 1.3 |
| Rent/part rent and part buy | 1.7 | 1.9 | 2.2 | 0.5 | 1.2 | 1.4 |
| *Bases (weighted)* | | | | | | |
| *Owns/buying* | *58909* | *2291* | *419* | *83* | *921* | *501* |
| *Rent/part rent and part buy* | *17373* | *815* | *380* | *170* | *160* | *184* |
| *Bases (unweighted)* | | | | | | |
| *Owns/buying* | *606* | *524* | *361* | *173* | *527* | *521* |
| *Rent/part rent and part buy* | *139* | *166* | *309* | *435* | *78* | *167* |

Table 3.10

**Screening positive on the PSQ and estimated annual prevalence of psychosis, by degree of urbanisation**

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | | | | Black | | |
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Screening positive on the PSQ** | | | | | | |
| Urban | 11 | 7 | 12 | 4 | 9 | 13 |
| Suburban/rural | 5 | 8 | 12 | 7 | 9 | 8 |
| **Estimated prevalence of psychosis** | | | | | | |
| Urban | 1.5 | 0.9 | 1.5 | 0.5 | 1.2 | 1.8 |
| Suburban/rural | 0.6 | 0.9 | 1.7 | 1.0 | 1.1 | 1.1 |
| *Bases (weighted)* | | | | | | |
| *Urban* | *16261* | *436* | *405* | *225* | *331* | *271* |
| *Suburban/rural* | *60889* | *2709* | *396* | *34* | *776* | *424* |
| *Bases (unweighted)* | | | | | | |
| *Urban* | *137* | *142* | *324* | *539* | *165* | *282* |
| *Suburban/rural* | *614* | *554* | *347* | *75* | *451* | *414* |

# 4 Social function, chronic strains and personality difficulties

*Peter Tyrer, Saffron Karlsen and Mike Crawford*

## 4.1 Introduction

Social functioning, the way in which each of us acts and reacts in occupational, personal, social and leisure settings, has increasingly been recognised as one of the most important elements in mental health. It was first given a separate area of description in formal classifications in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III)[1] in which a new division (axis) of description was given over to social functioning (defined as 'the highest level of adaptive functioning in the past year'). Subsequently the International Classification of Diseases devoted the second axis of its classification to disability and social functioning.[2] The point of recording social functioning independently of other variables concerned with mental state perhaps needs to be stated. Someone who has, for example, symptoms of nervousness and anxiety, may cope with these well and, at least on the surface, show no apparent distress to other people, perhaps even functioning better than normal as a result of their increased vigilance. Yet another may have similar symptoms but be so incapacitated by worry that their ability to complete normal daily activities is affected.

The measurement of social functioning has been recorded over many years. The first scale for recording social functioning was introduced nearly 50 years ago[3] and since then there have been over 40 instruments introduced for this purpose. There has been some difference of opinion between those who measure social functioning according to how most people would feel or behave (so-called norm-based criteria) and those who feel that the individual concerned is him/herself best placed to decide whether their social functioning is good or poor.[4] With increasing attention being given to subject's own feelings about their functioning and symptoms the second of these approaches is currently regarded as more acceptable and now the term 'social function' has gradually replaced the original concept of 'social adjustment', which has enabled us to move away from assumptions that there is a 'standard level' of social functioning that can be applied universally.

What is generally agreed is that social functioning covers all activities of daily living, comprising eight main areas: functioning at work or task-related activity; the ability to organise self-care and finances; child care and relationships; other family relationships, including those with parents; sexual function; social contacts; the ability to get on with others in society; and use of spare or leisure time. At the highest level of social functioning all these areas are associated with good performance and with lack of stress, and at the lowest levels of functioning the sufferers are usually unable to look after themselves and are in institutional care.[5]

Chronic strains, the stress of living under persistent difficulties, describe external pressures that impact on individuals over long periods of time. Although chronic strains are linked to social functioning in

that those under greater strain may have poorer functioning, the two may also be independent, as some may either ignore strains or even thrive on them as a stimulus. Strains describe the stressors to which people are exposed, whereas social functioning is concerned with the response to such strains and a variety of other factors, including mental illness.

Personality, the habitual way in which we interact with the world, is also linked to social functioning. Those who have personality disorder or, the less severe, personality difficulty,[6] have problems arising from their personality structure which lead to impaired social function.[2] The difference between the impaired social functioning associated with personality disorder and that associated with other factors is that the former is long-term, and sometimes lifelong. In this chapter social dysfunction, chronic strains and personality difficulty, are described in different ethnic groups. There is little previous data on this subject in the UK, apart from some evidence that Caribbeans have fewer personality difficulties.[7] Findings from the latest ONS Survey of the general population[8] show the rate of personality disorder in the population (using the Structured Clinical Interview for DSM Personality Disorders) to be 4%, which is lower than that found in other epidemiological surveys.[9] However, as the EMPIRIC survey used a measure of personality difficulties, it is difficult to make direct comparisons.

## 4.2 Measures

There are over 40 instruments used to measure social function,[10,11] but most of these are rated by observers and not suited to general population surveys. The Social Adjustment Scale, Self-Report[12] is one of the most common self-rating scales used but takes at least 20 minutes to complete. The Social Functioning Questionnaire (SFQ)[13] was used in this survey because of the speed of its administration and its robustness in a wide range of settings. It correlates well with a much longer observer-rated schedule, the Social Functioning Schedule (SFS).[5,14] It consists of eight questions each scored on a four point scale (0-3), with higher scores indicating more dysfunction (maximum 24). In some cases, however, results have been presented with responses to each question dichotomised. In these instances, informants reporting 'severe', 'moderate' or 'occasional' problems have been coded together. The questions included in the SFQ explore: difficulties surrounding the completion of tasks at work and home; financial problems; problems with close relationships and sex life; relations with relatives; feelings of loneliness and isolation; and the enjoyment of spare time.

Chronic strains were measured using a set of questions used in the Whitehall II Study.[15] It consists of five questions asking about problems with relatives, with financial problems over providing necessities and payment of bills, housing problems, and difficulties in the local neighbourhood. All of these are scored on five point scales. Responses to each question were dichotomised to classify informants into those reporting themselves to 'always', 'often' or 'sometimes' experience these problems, and those who 'seldom' or 'never' experience these problems. These dichotomous scores were then summed to give an overall chronic strain score, with a range of 0 to 5, with a higher score indicating more problems.

Personality difficulties (covering the range from mild problems through to disorder) were assessed using only one question 'do you, in general, have difficulties getting on with other people?' scored on a four point scale, and (on the whole) again dichotomised to show those reporting any difficulties. Personality status is not an easy subject to record in epidemiological surveys and, when it is measured, it is usually carried out in two stages. In the first, a population at risk is identified with screening questions. Subsequently, a second phase of detailed enquiry allows detailed assessment to be made in those who respond positively to the screening.[16] The reason why two stages are necessary is that it is almost impossible to assess personality quickly and reliably, with the most satisfactory and robust

forms of assessment taking between 1 and 4 hours to complete. So, an assessment of personality disorder is usually made using a more extensive exploratory tool than that employed here, and it is unlikely that a single question is sufficient to assess personality status fully. Separate studies are currently being carried out to determine the relationship between the answers to brief personality questions of this nature and the results of a much fuller personality assessment.[17]

There are also differences between the way in which people assess their own personalities (subject assessment) and how they are assessed by others (informant assessment). Although it can be argued that only the individual can really assess his or her habitual attitudes and behaviour it is also true that we are blind to many of the elements in our personalities that are very apparent to others, best described in the words of Robert Burns: 'O what gift would the lordie gie us, to see ourselves as others see us'. Predictably, informants' and subjects' assessments of personality generally do not agree[18] and there is therefore a tendency for only one type of assessment to be included in studies. In the United States, where respect for individual perceptions and differences is paramount, almost all interviews for assessment of personality status are carried out with subjects, but in the United Kingdom informant assessments are more commonly selected and often preferred.[19,20] The nature of the EMPIRIC survey, where 'lay' interviewers were used, meant that it was possible to collect only the informant's own assessment of personality.

## 4.3 Specific domains of social function, chronic strains and difficulties getting on with people and mean scores, by sex

Table 4.1 shows the proportion of informants reporting any problems on the indicators comprising the social functioning score, by sex. There was a wide variation in the proportion of informants reporting problems across the different indicators, and by ethnic group. In general, the South Asian groups were the most likely to report problems on the different social functioning indicators, with the exception of the items on problems with sex life and finances. Bangladeshi and Black Caribbean informants were more likely to report financial difficulties, compared with other groups, with around two-thirds of these groups reporting problems. Across the ethnic groups, women were more likely to report feelings of loneliness and isolation, with the exception of the Bangladeshi group. On the other indicators, South Asian groups were more likely to show greater differences between the sexes. Pakistani women were more likely to report finding tasks at home and work very stressful, and Bangladeshi men and Indian women were more likely to report financial problems, compared with their counterparts from the same ethnic group. Bangladeshi men were also more likely to report problems with their close relationships and sex life. Indian and Black Caribbean women were more likely than their male counterparts to report not enjoying their spare time.

Table 4.2 shows the proportion of informants reporting any problems on the indicators comprising the chronic strains score, by sex. As in Table 4.1, Black Caribbean and Bangladeshi informants were the most likely to report financial problems, in terms of basic purchases and the payment of bills. Bangladeshi informants were also more likely to report housing problems and problems in the local neighbourhood. In general, there was some similarity between the sexes in the reporting of problems on the indicators comprising the chronic strains score. Women, in each ethnic group, were more likely to report problems or worries with relatives, compared with their male counterparts, with the exception of those from Bangladeshi or Indian groups. Black Caribbean and Pakistani women were more likely to report financial shortages that affected basic purchases compared with their male counterparts. Black Caribbean and Indian women were more likely to report problems in the local neighbourhood, compared with their male counterparts. White women were more likely than White men to report housing problems.

Figures 4.1, 4.2 and 4.3 and Table 4.3 show the summary chronic strains and social functioning scores, and proportions reporting any difficulties getting on with people. Table 4.3 also shows these findings divided by sex. Bangladeshi (and to a lesser extent Pakistani) informants showed a tendency towards higher mean scores (ie worse social functioning) than the other groups and Bangladeshi informants showed a tendency towards higher mean scores for (and therefore more problems with) chronic strains. Table 4.3 suggests that there were no marked differences in the proportions reporting difficulties getting on with people between the different ethnic groups. However, figure 4.3 suggests that, while non-white ethnic minority groups were slightly less likely to report any problems getting on with people, where problems were reported they were described as being more severe compared with those reportedly experienced by White or Irish informants. There were similarities in mean social functioning and chronic strain scores and getting on with people between the sexes, across the different ethnic groups, although Bangladeshi men had higher scores for social functioning. Irish men were more likely than Irish women to report problems getting on with people.

Figure 4.1

**Mean scores on the summary indicator of social functioning, by ethnic group**

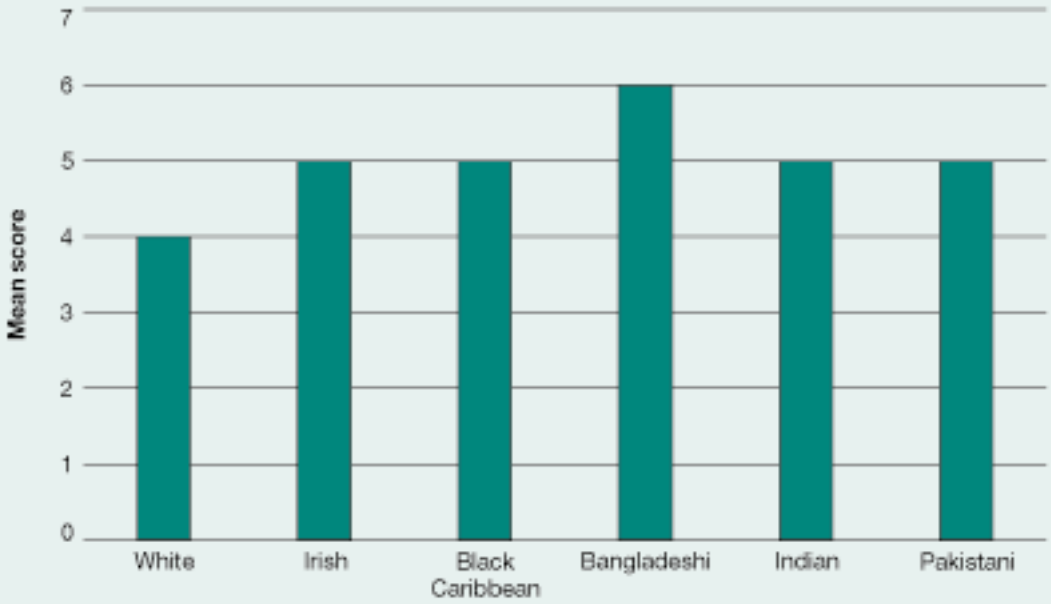
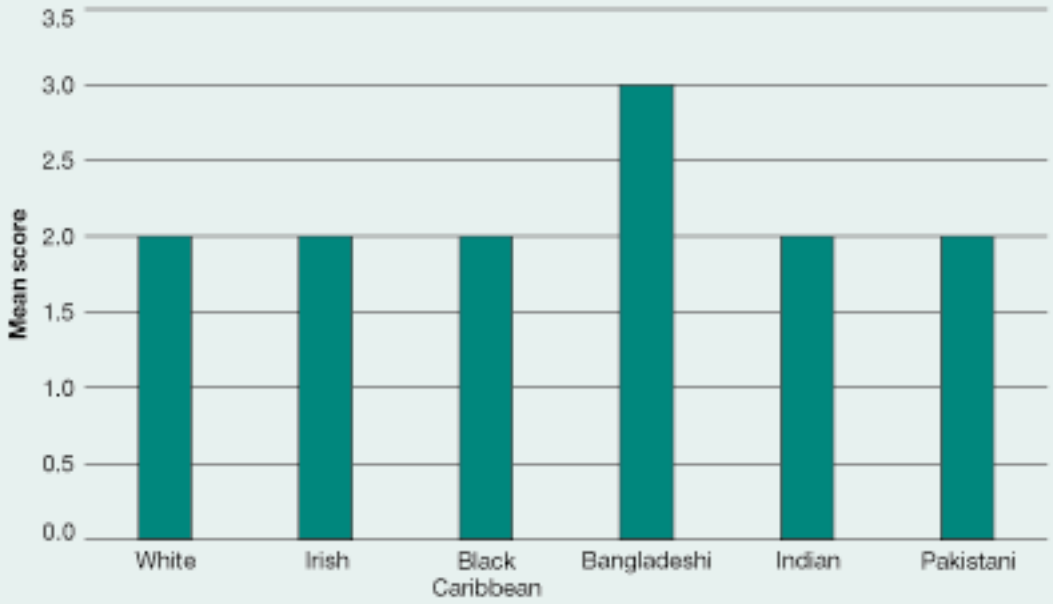


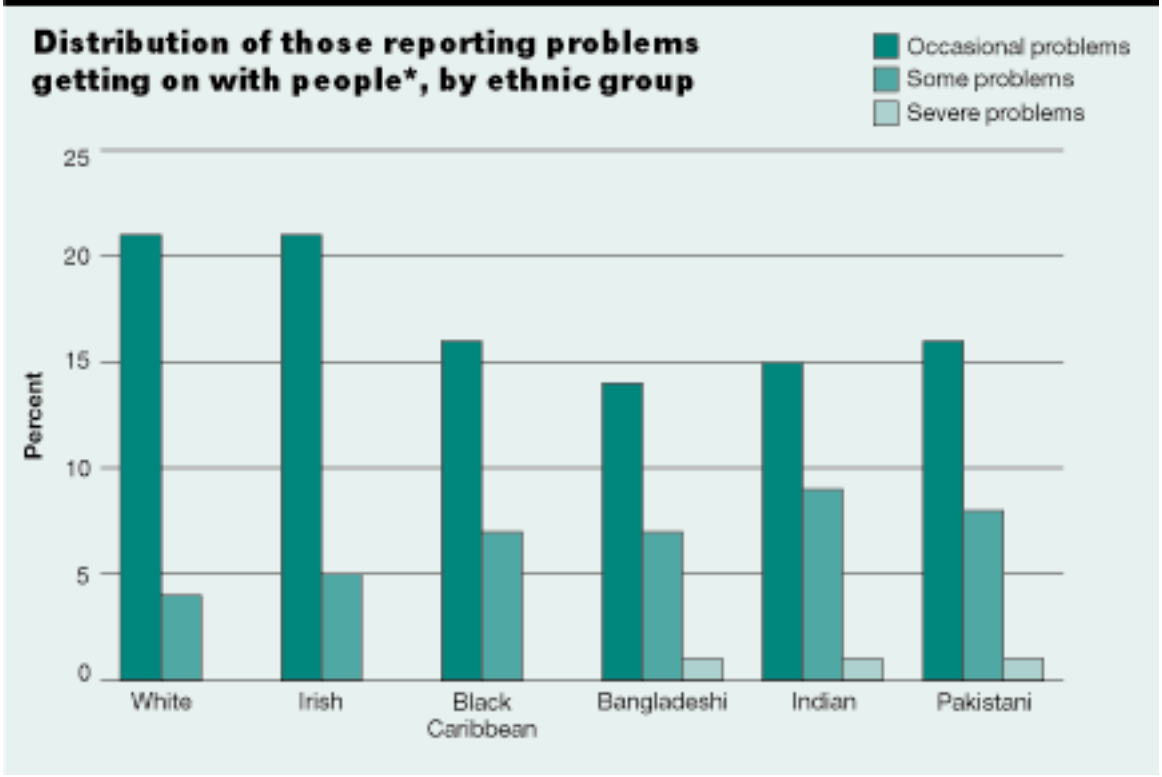
Figure 4.2

**Mean scores on the summary indicator of chronic strains, by ethnic group**




In interpreting the prevalence of personality difficulties it should be emphasised that the relationship between personality disorder, as defined in formal classifications of mental illness, and personality difficulties, as defined here, remain to be determined. As mentioned earlier, at best the findings from this study represent only a rough approximation to a formal personality measurement. Those reporting difficulties getting on with people had around double the mean score for problems with social functioning than those with no personality problems (Table 4.4). However, mean chronic strains scores were only about 10% greater in those reporting difficulties getting on with people, compared with others. There were no large differences between the ethnic groups in mean chronic strains scores by personality difficulty, although Bangladeshi, Pakistani and Black Caribbean people had higher mean scores, compared with people from other groups.

Figure 4.3




*Excluding those reporting no problems

## 4.4 Social functioning, chronic strains and difficulties getting on with people, by age and marital status

The comparison between chronic strains, social functioning and difficulties getting on with people is illustrated with respect to age and marital status in Tables 4.5 and 4.6. Although the differences between the different age groups were sometimes small, White and Irish people aged over 55 had better social functioning than their younger equivalents (Table 4.5). The reverse trend was shown with the Bangladeshi, Pakistani and, to a lesser extent, Indian groups. Chronic strains showed very small, if any, differences between the different age groups. Among White, Irish and Black Caribbean informants, the proportion of informants reporting difficulties getting on with people declined with age, from just under a third, to around 15%. There was little age-related variation among Pakistani and Bangladeshi informants.

Divorced and separated informants in all ethnic groups had higher mean scores (worse social function) on the summary indicator compared with those who were married or cohabiting (Table 4.6). Among White and Black Caribbean informants, divorced and separated informants also had higher mean scores compared with those who were single. The mean scores for divorced or separated South Asian informants have not been shown due to the small numbers of informants in these groups, which makes any statistical exploration unreliable. White, Irish and Black Caribbean informants showed some similarity in the chronic strains score, regardless of marital status. Between 16 and 19% of divorced or separated informants reported problems getting on with people in the White, Irish and Black Caribbean groups. Among the White and Irish groups, the divorced or separated were less likely to report personality difficulties compared with others. White, Irish, Black Caribbean and Indian single and never married people were more likely to report personality difficulties compared with their married or cohabiting counterparts.

## 4.5 Social functioning, chronic strains and difficulties getting on with people, by socio-economic characteristics

There were only small differences between the different ethnic groups in terms of social functioning, chronic strains or problems getting on with people, after allowing for household occupational class, although Bangladeshi people had higher mean scores on the social functioning and chronic strains scores compared with other groups included in the study (Table 4.7).

Those who were economically inactive had poorer social functioning than those in employment in all groups, with the exception of those from the Bangladeshi group (Table 4.8). Very similar results were found for chronic strains, although the differences between the economically active and inactive were smaller. Bangladeshi and Indian informants had similar levels of strain irrespective of employment status. There were no differences in the proportions reporting problems getting on with people by employment status among White, Irish and Bangladeshi informants.

Comparison by housing tenure showed that Black Caribbean, White and Irish groups in their own or mortgaged accommodation had lower scores, and therefore better social functioning and fewer chronic strains, than those in rented or part-buy accommodation (Table 4.9). This difference was smaller among Indian, Bangladeshi and Pakistani groups, for both indicators. However, there was a tendency for owner occupiers to report more difficulties getting on with people, compared with renters, although this did not hold for Black Caribbean or Indian informants.

## 4.6 Social functioning, chronic strains and difficulties getting on with people and psychiatric disorder

Other studies have found that social functioning is worse among those with psychiatric disorders compared with others and that severe psychiatric disorders create more dysfunction than less severe ones.[21,22,23] This finding is reinforced by the findings in this survey. Mean social functioning scores among those with CIS-R scores of 12 or over (ie those with significant psychiatric morbidity) were around twice those of people with a CIS-R score of between zero and eleven (Table 4.10). There were also greater chronic strains in those with high CIS-R scores. Those with CIS-R scores over 12 were also more likely to report difficulties getting on with people, although this was less true of the Indian and Pakistani groups. Among the White, Irish and Black Caribbean informants, the proportion reporting difficulties getting on with people was between 17 and 21% higher among those with CIS-R scores of over 12, compared with those with lower scores. Bangladeshi informants with CIS-R scores of over 12 were 32% more likely to report personality difficulties, compared with others.

## 4.7 Conclusions

The results show some consistency across the different ethnic groups as well as some differences. People of Bangladeshi and Pakistani origin have somewhat worse social functioning and people of Bangladeshi origin experience greater chronic strains compared with informants from the other ethnic groups. Social function, and to a lesser degree chronic strains, are also worse in those who are divorced or separated, in those who have personality difficulty and in those who show psychiatric morbidity (here, defined as a CIS-R score of 12 or over). While they were less likely to experience social functioning problems or chronic strains, owner occupiers were more likely to have personality difficulties than those in rented accommodation, apart from among the Black Caribbean and Indian groups. These findings concord with previous epidemiological studies[9,16,22] and give support to the validity of the measuring instruments included in this survey. However, findings from this survey also

suggest that indicators such as age, employment status and CIS-R score may have a different impact on social functioning, chronic strains and personality difficulties for South Asian (particularly Bangladeshi) groups, compared with the other ethnic groups included. For example, while, on the whole, the youngest age group reported more personality difficulties across the ethnic groups, and the chronic strains score showed great similarity across the age groups; in terms of social functioning, the age group functioning best varied by ethnicity: the middle age groups having more problems among white, Irish and Black Caribbean groups and the oldest age groups having more problems among the South Asian groups. Determining the cause of such variations will require further exploration.

Whilst acknowledging the problems associated with measuring personal difficulties (see Measures section), it is perhaps relevant that the only other epidemiological survey of personality difficulty in the United Kingdom[24] showed that 18% of those interviewed had some degree of personality disturbance (either disorder or difficulty).[6] In the EMPIRIC study, just under 25% of informants reported some difficulties getting on with people. This suggests that the separation of the results into those with and without difficulties in getting on with people, here, is at least within the same frame of prevalence as more formal tests, although much more information is needed from other studies before the validity of this information is accepted. There were also some ethnic differences within those reporting such difficulties which requires further investigation. Those reporting difficulties getting on with people had higher mean scores for (problems with) social functioning and chronic strains, compared with those with no personality problems. However, there were no large differences in the relationship between social functioning and chronic strains and personality difficulties between the ethnic groups, particularly for chronic strains.

On the whole the ethnic differences found here are not clear cut and also show some relationship with social class. There were only small differences between the different ethnic groups in terms of social functioning, chronic strains or problems getting on with people, after allowing for household occupational class. However, on the whole, those who were economically inactive had poorer social functioning and more chronic strains compared with those in employment, which would suggest the effect of social class goes beyond that of occupation. However some ethnic difference also remained. Also, it is not clear what impact racism will have had on the associations found here. But, as experience of racism has been found to have statistical associations with a variety of physical and mental health indicators,[25,26] and as social function, chronic strains and personality difficulties are all subject to a variety of external as well as internal influences, this too should be the focus of further investigation.

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# 4 Social function, chronic strains and personality difficulties

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## Tables

Table 4.1

**Proportions reporting any problems on the indicators comprising the summary social functioning score, by sex**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Not completing tasks at home and work satisfactorily** | | | | | | |
| Men | 26 | 34 | 41 | 47 | 38 | 42 |
| Women | 26 | 29 | 41 | 52 | 40 | 47 |
| Total | 26 | 31 | 41 | 49 | 39 | 45 |
| **Finding tasks at home and work very stressful** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Men | 68 | 65 | 58 | 70 | 65 | 57 |
| Women | 63 | 64 | 63 | 69 | 70 | 71 |
| Total | 65 | 65 | 61 | 70 | 67 | 64 |
| **Financial problems** | | | | | | |
| Men | 49 | 52 | 63 | 75 | 46 | 51 |
| Women | 48 | 54 | 69 | 68 | 53 | 56 |
| Total | 49 | 53 | 67 | 71 | 50 | 53 |
| **Problems with close relationships** | | | | | | |
| Men | 18 | 26 | 23 | 30 | 27 | 25 |
| Women | 18 | 18 | 24 | 23 | 25 | 30 |
| Total | 18 | 21 | 24 | 27 | 26 | 27 |
| **Problems with sex life** | | | | | | |
| Men | 21 | 25 | 22 | 17 | 15 | 13 |
| Women | 22 | 19 | 21 | 9 | 11 | 15 |
| Total | 21 | 22 | 21 | 13 | 13 | 14 |
| **Not having a positive relationship with their relatives** | | | | | | |
| Men | 40 | 35 | 36 | 65 | 40 | 41 |
| Women | 38 | 34 | 38 | 65 | 42 | 47 |
| Total | 39 | 34 | 37 | 65 | 41 | 44 |
| **Feelings of loneliness and isolation** | | | | | | |
| Men | 28 | 33 | 30 | 36 | 36 | 35 |
| Women | 37 | 36 | 42 | 31 | 49 | 50 |
| Total | 33 | 35 | 37 | 33 | 42 | 42 |
| **Not enjoying their spare time** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Men | 21 | 25 | 25 | 60 | 26 | 39 |
| Women | 25 | 22 | 32 | 59 | 39 | 42 |
| Total | 23 | 23 | 29 | 59 | 33 | 41 |
| *Bases (weighted)* | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 4.2

**Proportions reporting any problems on indicators comprising the summary chronic strains score, by sex**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Problems or worries with relatives** | | | | | | |
| Men | 45 | 47 | 38 | 36 | 52 | 39 |
| Women | 62 | 53 | 44 | 34 | 49 | 48 |
| Total | 54 | 50 | 41 | 35 | 50 | 43 |
| **Financial shortages that affect basic purchases** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Men | 24 | 32 | 42 | 56 | 30 | 34 |
| Women | 28 | 33 | 51 | 57 | 32 | 42 |
| Total | 26 | 32 | 47 | 56 | 31 | 38 |
| **Problems meeting the payment of bills** | | | | | | |
| Men | 16 | 25 | 36 | 50 | 23 | 25 |
| Women | 20 | 24 | 40 | 51 | 21 | 29 |
| Total | 19 | 24 | 38 | 51 | 22 | 27 |
| **Housing problems** | | | | | | |
| Men | 12 | 20 | 21 | 54 | 23 | 27 |
| Women | 19 | 19 | 29 | 53 | 22 | 29 |
| Total | 16 | 19 | 26 | 54 | 22 | 28 |
| **Problems in the local neighbourhood** | | | | | | |
| Men | 17 | 17 | 16 | 41 | 11 | 19 |
| Women | 23 | 18 | 26 | 39 | 19 | 18 |
| Total | 20 | 18 | 22 | 40 | 15 | 19 |
| *Bases (weighted)* | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 4.3

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by sex**

| | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| **Summary indicator of social functioning** | | | | | | | |
| Men | | | | | | | |
| | Mean | 4.0 | 4.7 | 4.6 | 6.0 | 4.8 | 5.0 |
| | Standard error of the mean | 0.15 | 0.21 | 0.20 | 0.20 | 0.21 | 0.22 |
| Women | | | | | | | |
| | Mean | 4.6 | 4.3 | 5.1 | 5.4 | 5.4 | 5.8 |
| | Standard error of the mean | 0.17 | 0.16 | 0.17 | 0.18 | 0.21 | 0.21 |
| Total | | | | | | | |
| | Mean | 4.3 | 4.5 | 4.9 | 5.7 | 5.1 | 5.5 |
| | Standard error of the mean | 0.12 | 0.13 | 0.13 | 0.13 | 0.15 | 0.15 |
| *Bases (weighted)* | | | | | | | |
| | Men | 33368 | 1299 | 304 | 128 | 481 | 298 |
| | Women | 42177 | 1614 | 442 | 134 | 513 | 332 |
| | Total | 75545 | 2914 | 746 | 261 | 994 | 629 |
| *Bases (unweighted)* | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Men | 331 | 287 | 252 | 297 | 266 | 295 |
| | Women | 397 | 351 | 372 | 323 | 287 | 342 |
| | Total | 728 | 638 | 624 | 620 | 553 | 637 |
| **Summary indicator of chronic strains** | | | | | | | |
| Men | | | | | | | |
| | Mean | 1.7 | 2.0 | 2.1 | 2.7 | 1.8 | 2.0 |
| | Standard error of the mean | 0.06 | 0.07 | 0.07 | 0.07 | 0.07 | 0.07 |
| Women | | | | | | | |
| | Mean | 2.0 | 2.0 | 2.4 | 2.7 | 2.1 | 2.2 |
| | Standard error of the mean | 0.06 | 0.06 | 0.07 | 0.07 | 0.08 | 0.07 |
| Total | | | | | | | |
| | Mean | 1.9 | 2.0 | 2.3 | 2.7 | 1.9 | 2.1 |
| | Standard error of the mean | 0.04 | 0.05 | 0.05 | 0.05 | 0.05 | 0.05 |
| *Bases (weighted)* | | | | | | | |
| | Men | 24174 | 1028 | 242 | 116 | 420 | 242 |
| | Women | 37950 | 1396 | 381 | 116 | 408 | 289 |
| | Total | 62124 | 2424 | 623 | 231 | 828 | 531 |
| *Bases (unweighted)* | | | | | | | |
| | Men | 244 | 225 | 204 | 270 | 237 | 244 |
| | Women | 357 | 301 | 327 | 286 | 235 | 298 |
| | Total | 601 | 526 | 531 | 556 | 472 | 542 |
| | | *%* | *%* | *%* | *%* | *%* | *%* |
| **Difficulties getting on with people** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Men | 26 | 32 | 24 | 23 | 24 | 27 |
| | Women | 23 | 21 | 22 | 21 | 25 | 22 |
| | Total | 25 | 26 | 23 | 22 | 24 | 24 |
| *Bases (weighted)* | | | | | | | |
| | Men | 37072 | 1459 | 335 | 135 | 565 | 345 |
| | Women | 48981 | 1853 | 490 | 139 | 591 | 379 |
| | Total | 86054 | 3311 | 824 | 274 | 1156 | 724 |
| *Bases (unweighted)* | | | | | | | |
| | Men | 368 | 329 | 280 | 312 | 315 | 337 |
| | Women | 467 | 403 | 413 | 338 | 328 | 387 |
| | Total | 835 | 732 | 693 | 650 | 643 | 724 |

Table 4.4

**Mean scores on the summary indicators of chronic strains and social functioning, by whether reported any problems getting on with people**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| **Summary indicator of social functioning** | | | | | | |
| No problems getting on with people | | | | | | |
| Mean | 3.5 | 3.7 | 4.2 | 5.1 | 4.3 | 4.5 |
| *Standard error of the mean* | 0.09 | 0.11 | 0.12 | 0.12 | 0.13 | 0.13 |
| Some problems getting on with people | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | 8.3 | 7.5 | 8.4 | 9.6 | 8.5 | 9.2 |
| | *Standard error of the mean* | 0.35 | 0.34 | 0.32 | 0.45 | 0.38 | 0.39 |
| *Bases (weighted)* | | | | | | | |
| *No problems getting on with people* | *55846* | *2107* | *560* | *201* | *723* | *465* | |
| *Some problems getting on with people* | *19698* | *806* | *186* | *60* | *271* | *165* | |
| *Bases (unweighted)* | | | | | | | |
| *No problems getting on with people* | *538* | *462* | *476* | *484* | *406* | *475* | |
| *Some problems getting on with people* | *190* | *176* | *148* | *136* | *147* | *162* | |
| **Summary indicator of chronic strains** | | | | | | | |
| No problems getting on with people | | | | | | | |
| | Mean | 1.8 | 1.9 | 2.2 | 2.7 | 1.9 | 2.0 |
| | Standard error of the mean | 0.05 | 0.06 | 0.06 | 0.06 | 0.06 | 0.06 |
| Some problems getting on with people | | | | | | | |
| | Mean | 1.9 | 2.2 | 2.4 | 2.9 | 2.0 | 2.3 |
| | Standard error of the mean | 0.10 | 0.09 | 0.11 | 0.11 | 0.11 | 0.09 |
| *Bases (weighted)* | | | | | | | |
| *No problems getting on with people* | 45129 | 1699 | 458 | 177 | 579 | 382 | |
| *Some problems getting on with people* | 16755 | 724 | 165 | 54 | 250 | 149 | |
| *Bases (unweighted)* | | | | | | | |
| *No problems getting on with* | 439 | 370 | 398 | 432 | 336 | 394 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *people* | 439 | 370 | 398 | 432 | 330 | 394 |
| *Some problems getting on with people* | 160 | 156 | 133 | 124 | 136 | 148 |

Table 4.5

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by age**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| **Summary indicator of social functioning** | | | | | | |
| 16-34 | | | | | | |
| Mean | 4.4 | 4.5 | 4.8 | 5.2 | 5.0 | 5.0 |
| Standard error of the mean | 0.20 | 0.20 | 0.20 | 0.16 | 0.22 | 0.17 |
| 35-54 | | | | | | |
| Mean | 4.6 | 4.9 | 5.3 | 6.2 | 5.1 | 6.0 |
| Standard error of the mean | 0.20 | 0.20 | 0.24 | 0.25 | 0.23 | 0.33 |
| 55-74 | | | | | | |
| Mean | 3.7 | 3.6 | 4.6 | 6.4 | 5.6 | 6.6 |
| Standard error of the mean | 0.20 | 0.25 | 0.24 | 0.41 | 0.36 | 0.44 |
| *Bases (weighted)* | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 16-34 | 24222 | 878 | 292 | 149 | 399 | 363 |
| | 35-54 | 33991 | 1403 | 283 | 77 | 429 | 198 |
| | 55-74 | 17331 | 632 | 170 | 35 | 166 | 69 |
| *Bases (unweighted)* | | | | | | | |
| | 16-34 | 216 | 168 | 226 | 340 | 205 | 358 |
| | 35-54 | 337 | 324 | 253 | 187 | 255 | 205 |
| | 55-74 | 175 | 146 | 145 | 93 | 93 | 74 |
| **Summary indicator of chronic strains** | | | | | | | |
| 16-34 | | | | | | | |
| | | Mean | 2.0 | 1.9 | 2.2 | 2.7 | 1.9 | 2.1 |
| | | Standard error of the mean | 0.08 | 0.08 | 0.08 | 0.07 | 0.09 | 0.06 |
| 35-54 | | | | | | | |
| | | Mean | 1.9 | 2.1 | 2.4 | 2.9 | 2.0 | 2.2 |
| | | Standard error of the mean | 0.07 | 0.07 | 0.09 | 0.09 | 0.08 | 0.09 |
| 55-74 | | | | | | | |
| | | Mean | 1.6 | 1.7 | 2.2 | 2.7 | 1.8 | 2.1 |
| | | Standard error of the mean | 0.07 | 0.11 | 0.11 | 0.15 | 0.12 | 0.17 |
| *Bases (weighted)* | | | | | | | |
| | 16-34 | 18742 | 728 | 250 | 132 | 292 | 297 |
| | 35-54 | 28838 | 1269 | 237 | 67 | 394 | 182 |
| | 55-74 | 14544 | 427 | 136 | 32 | 142 | 52 |
| *Bases (unweighted)* | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 16-34 | 168 | 139 | 195 | 303 | 158 | 295 |
| | 35-54 | 286 | 280 | 214 | 164 | 232 | 191 |
| | 55-74 | 147 | 107 | 122 | 89 | 82 | 56 |
| | | % | % | % | % | % | % |
| **Difficulties getting on with people** | | | | | | | |
| | 16-34 | 31 | 32 | 29 | 23 | 29 | 25 |
| | 35-54 | 26 | 28 | 23 | 21 | 21 | 25 |
| | 55-74 | 16 | 14 | 14 | 20 | 22 | 21 |
| *Bases (weighted)* | | | | | | | |
| | 16-34 | 25420 | 943 | 320 | 158 | 442 | 412 |
| | 35-54 | 37353 | 1561 | 301 | 79 | 500 | 230 |
| | 55-74 | 23281 | 807 | 203 | 37 | 214 | 83 |
| *Bases (unweighted)* | | | | | | | |
| | 16-34 | 228 | 179 | 247 | 362 | 227 | 403 |
| | 35-54 | 371 | 360 | 270 | 190 | 295 | 236 |
| | 55-74 | 236 | 193 | 176 | 98 | 121 | 85 |

Table 4.6

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by marital status[a]**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| **Summary indicator of social functioning** | | | | | | |
| Married/cohabiting | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | 4.1 | 4.1 | 4.4 | 5.8 | 5.0 | 5.4 |
| | Standard error of the mean | 0.14 | 0.15 | 0.19 | 0.16 | 0.17 | 0.18 |
| Divorced/separated | | | | | | | |
| | Mean | 5.7 | 5.3 | 6.1 | b | b | b |
| | Standard error of the mean | 0.48 | 0.42 | 0.45 | b | b | b |
| Single and never married | | | | | | | |
| | Mean | 4.5 | 5.3 | 5.1 | 5.0 | 5.2 | 4.9 |
| | Standard error of the mean | 0.25 | 0.27 | 0.20 | 0.23 | 0.35 | 0.28 |
| *Bases (weighted)* | | | | | | | |
| *Married/cohabiting* | 47493 | 1814 | 299 | 180 | 706 | 442 | |
| *Divorced/separated* | 7409 | 318 | 88 | b | b | b | |
| *Single and never married* | 18001 | 707 | 340 | 62 | 211 | 149 | |
| *Bases (unweighted)* | | | | | | | |
| *Married/cohabiting* | 467 | 415 | 257 | 437 | 410 | 452 | |
| *Divorced/separated* | 65 | 77 | 80 | b | b | b | |
| *Single and never married* | 170 | 126 | 269 | 136 | 104 | 149 | |
| **Summary indicator of chronic strains** | | | | | | | |
| Married/cohabiting | | | | | | | |
| | Mean | 1.7 | 1.8 | 2.0 | 2.8 | 2.0 | 2.2 |
| | Standard error of the mean | 0.05 | 0.06 | 0.08 | 0.06 | 0.06 | 0.06 |
| Divorced/separated | | | | | | | |
| | Mean | 2.4 | 2.2 | 2.6 | b | b | b |
| | Standard error of the mean | 0.15 | 0.16 | 0.15 | b | b | b |
| Single and never married | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | 2.1 | 2.2 | 2.4 | 2.4 | 1.9 | 1.7 |
| | Standard error of the mean | 0.10 | 0.09 | 0.08 | 0.10 | 0.12 | 0.09 |
| *Bases (weighted)* | | | | | | | |
| *Married/cohabiting* | 39614 | 1497 | 230 | 164 | 606 | 377 | |
| *Divorced/separated* | 6916 | 297 | 85 | b | b | b | |
| *Single and never married* | 13354 | 570 | 296 | 50 | 152 | 114 | |
| *Bases (unweighted)* | | | | | | | |
| *Married/cohabiting* | 391 | 337 | 202 | 404 | 355 | 388 | |
| *Divorced/separated* | 60 | 71 | 80 | b | b | b | |
| *Single and never married* | 128 | 101 | 236 | 111 | 83 | 119 | |
| | % | % | % | % | % | % | |
| **Difficulties getting on with people** | | | | | | | |
| Married/cohabiting | 23 | 24 | 16 | 22 | 21 | 22 | |
| Divorced/separated | 19 | 17 | 16 | b | b | b | |
| Single and never married | 34 | 34 | 32 | 24 | 30 | 26 | |
| *Bases (weighted)* | | | | | | | |
| *Married/cohabiting* | 54627 | 2080 | 332 | 188 | 829 | 506 | |
| *Divorced/separated* | 8079 | 353 | 100 | b | b | b | |
| *Single and never married* | 19434 | 766 | 371 | 66 | 236 | 176 | |
| *Bases (unweighted)* | | | | | | | |
| *Married/cohabiting* | 541 | 479 | 285 | 458 | 479 | 511 | |
| *Divorced/separated* | 71 | 83 | 93 | b | b | b | |
| *Single and never married* | 183 | 138 | 294 | 144 | 120 | 175 | |

[a] The sample base for widowed informants is too small for results to be shown.
[b] The sample bases for these categories are too small for results to be shown.

Table 4.7

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by social class of Head of Household**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| **Summary indicator of social functioning** | | | | | | |
| Non manual | | | | | | |
| Mean | 4.3 | 4.7 | 5.0 | 5.6 | 4.8 | 5.0 |
| Standard error of the mean | 0.15 | 0.18 | 0.19 | 0.31 | 0.21 | 0.26 |
| Manual | | | | | | |
| Mean | 4.3 | 4.3 | 4.8 | 6.2 | 5.6 | 5.3 |
| Standard error of the mean | 0.18 | 0.19 | 0.20 | 0.23 | 0.24 | 0.25 |
| *Bases (weighted)* | | | | | | |
| *Non manual* | 44706 | 1509 | 373 | 49 | 477 | 214 |
| *Manual* | 29062 | 1360 | 319 | 102 | 399 | 232 |
| *Bases (unweighted)* | | | | | | |
| *Non manual* | 437 | 339 | 310 | 104 | 286 | 200 |
| *Manual* | 275 | 291 | 276 | 248 | 214 | 244 |
| **Summary indicator of chronic strains** | | | | | | |
| Non manual | | | | | | |
| Mean | 1.7 | 1.8 | 2.3 | 2.6 | 1.9 | 2.1 |
| Standard error of | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | error of the mean | 0.05 | 0.07 | 0.08 | 0.11 | 0.07 | 0.09 |
| Manual | | | | | | | |
| | Mean | 2.0 | 2.1 | 2.3 | 2.9 | 2.1 | 2.1 |
| | Standard error of the mean | 0.08 | 0.07 | 0.07 | 0.08 | 0.09 | 0.07 |
| *Bases (weighted)* | | | | | | | |
| *Non manual* | 36401 | 1248 | 305 | 43 | 395 | 169 | |
| *Manual* | 24269 | 1135 | 273 | 92 | 352 | 202 | |
| *Bases (unweighted)* | | | | | | | |
| *Non manual* | 355 | 275 | 257 | 93 | 246 | 165 | |
| *Manual* | 233 | 243 | 243 | 223 | 187 | 211 | |
| | % | % | % | % | % | % | |
| **Difficulties getting on with people** | | | | | | | |
| Non manual | 25 | 30 | 24 | 27 | 24 | 21 | |
| Manual | 24 | 21 | 20 | 21 | 25 | 22 | |
| *Bases (weighted)* | | | | | | | |
| *Non manual* | 51020 | 1698 | 413 | 53 | 558 | 242 | |
| *Manual* | 33068 | 1556 | 351 | 107 | 466 | 270 | |
| *Bases (unweighted)* | | | | | | | |
| *Non manual* | 502 | 381 | 349 | 112 | 337 | 225 | |
| *Manual* | 315 | 340 | 303 | 258 | 247 | 276 | |

Table 4.8

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by employment status**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| **Summary indicator of social functioning** | | | | | | |
| In employment | | | | | | |
| Mean | 4.1 | 4.4 | 4.5 | 5.5 | 4.8 | 4.1 |
| Standard error of the mean | 0.13 | 0.15 | 0.15 | 0.24 | 0.18 | 0.19 |
| Economically inactive | | | | | | |
| Mean | 5.7 | 5.4 | 6.3 | 5.6 | 5.8 | 6.2 |
| Standard error of the mean | 0.41 | 0.38 | 0.34 | 0.17 | 0.31 | 0.24 |
| *Bases (weighted)* | | | | | | |
| *In employment* | 50804 | 1983 | 407 | 73 | 619 | 254 |
| *Economically inactive* | 12041 | 467 | 159 | 149 | 248 | 287 |
| *Bases (unweighted)* | | | | | | |
| *In employment* | 498 | 432 | 345 | 164 | 359 | 245 |
| *Economically inactive* | 105 | 105 | 134 | 355 | 128 | 302 |
| **Summary indicator of chronic strains** | | | | | | |
| In employment | | | | | | |
| Mean | 1.7 | 1.9 | 2.1 | 2.7 | 1.9 | 1.9 |
| Standard error of the mean | 0.05 | 0.05 | 0.07 | 0.09 | 0.06 | 0.07 |
| Economically inactive | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | 2.2 | 2.5 | 2.5 | 2.8 | 2.1 | 2.3 |
| | Standard error of the mean | 0.13 | 0.13 | 0.12 | 0.07 | 0.12 | 0.07 |
| *Bases (weighted)* | | | | | | | |
| *In employment* | 40028 | 1657 | 327 | 65 | 516 | 212 | |
| *Economically inactive* | 10645 | 427 | 142 | 131 | 191 | 241 | |
| *Bases (unweighted)* | | | | | | | |
| *In employment* | 395 | 348 | 280 | 146 | 306 | 212 | |
| *Economically inactive* | 95 | 99 | 123 | 315 | 100 | 251 | |
| | % | % | % | % | % | % | |
| **Difficulties getting on with people** | | | | | | | |
| In employment | 26 | 28 | 23 | 21 | 25 | 19 | |
| Economically inactive | 26 | 27 | 27 | 21 | 22 | 27 | |
| *Bases (weighted)* | | | | | | | |
| *In employment* | 55692 | 2213 | 447 | 76 | 704 | 296 | |
| *Economically inactive* | 13528 | 508 | 173 | 155 | 286 | 327 | |
| *Bases (unweighted)* | | | | | | | |
| *In employment* | 548 | 483 | 380 | 172 | 407 | 284 | |
| *Economically inactive* | 120 | 116 | 146 | 372 | 145 | 339 | |

The sample base for the ILO unemployed and retired informants is too small for results to be shown.

Table 4.9

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by housing tenure**

| | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | Black | | | |
| | | White | Irish | Caribbean | Bangladeshi | Indian | Pakistani |
| **Summary indicator of social functioning** | | | | | | | |
| Own/mortgage | | | | | | | |
| | Mean | 3.9 | 4.1 | 4.5 | 5.4 | 5.1 | 5.5 |
| | Standard error of the mean | 0.12 | 0.14 | 0.17 | 0.25 | 0.17 | 0.18 |
| Rent/ part-rent, part-buy | | | | | | | |
| | Mean | 5.7 | 5.5 | 5.4 | 5.9 | 5.5 | 5.8 |
| | Standard error of the mean | 0.33 | 0.29 | 0.21 | 0.16 | 0.37 | 0.34 |
| *Bases (weighted)* | | | | | | | |
| *Own/mortgage* | 50776 | 1985 | 371 | 79 | 794 | 437 | |
| *Rent/ part-rent, part-buy* | 15587 | 729 | 351 | 162 | 137 | 160 | |
| *Bases (unweighted)* | | | | | | | |
| *Own/mortgage* | 520 | 452 | 319 | 165 | 451 | 463 | |
| *Rent/ part-rent, part-buy* | 124 | 146 | 285 | 415 | 70 | 144 | |
| **Summary indicator of chronic strains** | | | | | | | |
| Own/mortgage | | | | | | | |
| | Mean | 1.6 | 1.8 | 1.9 | 2.5 | 1.9 | 2.0 |
| | Standard error of the mean | 0.04 | 0.06 | 0.07 | 0.09 | 0.06 | 0.06 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Rent/ part-rent, part-buy | | | | | | |
| Mean | 2.6 | 2.4 | 2.6 | 2.9 | 2.2 | 2.3 |
| Standard error of the mean | 0.11 | 0.09 | 0.07 | 0.06 | 0.15 | 0.10 |
| *Bases (weighted)* | | | | | | |
| *Own/mortgage* | 40483 | 1559 | 281 | 66 | 637 | 364 |
| *Rent/ part-rent, part-buy* | 13997 | 695 | 318 | 150 | 131 | 141 |
| *Bases (unweighted)* | | | | | | |
| *Own/mortgage* | 418 | 347 | 244 | 134 | 379 | 389 |
| *Rent/ part-rent, part-buy* | 112 | 145 | 266 | 389 | 62 | 128 |
| | % | % | % | % | % | % |
| **Difficulties getting on with people** | | | | | | |
| Own/mortgage | 26 | 27 | 21 | 25 | 23 | 25 |
| Rent/ part-rent, part-buy | 19 | 23 | 26 | 21 | 28 | 23 |
| Bases (weighted) | | | | | | |
| Own/mortgage | 58668 | 2291 | 418 | 83 | 921 | 501 |
| Rent/ part-rent, part-buy | 17373 | 814 | 380 | 170 | 160 | 184 |
| Bases (unweighted) | | | | | | |
| Own/mortgage | 604 | 524 | 360 | 173 | 527 | 521 |
| Rent/ part-rent, part-buy | 139 | 165 | 309 | 435 | 78 | 167 |

The sample base for informants reporting 'other' tenure is too small for results to be shown.

Table 4.10

**Mean scores on the summary indicators of chronic strains and social functioning and those reporting any problems getting on with people, by CIS-R score**

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| **Summary indicator of social functioning** | | | | | | |
| CIS-R score between 0 and 11 | | | | | | |
| Mean | 3.5 | 3.7 | 4.2 | 5.1 | 4.3 | 4.5 |
| Standard error of the mean | 0.09 | 0.11 | 0.12 | 0.12 | 0.13 | 0.13 |
| CIS-R score 12 or more | | | | | | |
| Mean | 8.3 | 7.5 | 8.4 | 9.6 | 8.5 | 9.2 |
| Standard error of the mean | 0.35 | 0.34 | 0.32 | 0.45 | 0.38 | 0.39 |
| *Bases (weighted)* | | | | | | |
| *CIS-R score between 0 and 11* | 62982 | 2322 | 608 | 227 | 798 | 498 |
| *CIS-R score 12 or more* | 12563 | 591 | 137 | 34 | 195 | 131 |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score between 0 and 11* | 608 | 505 | 504 | 544 | 439 | 499 |
| *CIS-R score 12 or more* | 120 | 133 | 120 | 76 | 114 | 138 |
| **Summary indicator of chronic strains** | | | | | | |
| CIS-R score between 0 and 11 | | | | | | |
| Mean | 1.7 | 1.8 | 2.1 | 2.7 | 1.8 | 1.9 |
| Standard error of the mean | 0.04 | 0.05 | 0.05 | 0.06 | 0.05 | 0.05 |
| CIS-R score 12 or more | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mean | 2.5 | 2.5 | 2.8 | 3.0 | 2.5 | 2.7 |
| | Standard error of the mean | 0.13 | 0.12 | 0.12 | 0.12 | 0.12 | 0.11 |
| *Bases (weighted)* | | | | | | | |
| *CIS-R score between 0 and 11* | 50274 | 1866 | 505 | 197 | 628 | 403 | |
| *CIS-R score 12 or more* | 11851 | 557 | 118 | 34 | 200 | 128 | |
| *Bases (unweighted)* | | | | | | | |
| *CIS-R score between 0 and 11* | 488 | 404 | 425 | 480 | 355 | 410 | |
| *CIS-R score 12 or more* | 113 | 122 | 106 | 76 | 117 | 132 | |
| | % | % | % | % | % | % | |
| **Difficulties getting on with people** | | | | | | | |
| CIS-R score between 0 and 11 | 22 | 22 | 20 | 18 | 23 | 23 | |
| CIS-R score 12 or more | 39 | 43 | 37 | 50 | 30 | 29 | |
| *Bases (weighted)* | | | | | | | |
| *CIS-R score between 0 and 11* | 73260 | 2697 | 681 | 239 | 947 | 582 | |
| *CIS-R score 12 or more* | 12794 | 614 | 144 | 35 | 209 | 142 | |
| *Bases (unweighted)* | | | | | | | |
| *CIS-R score between 0 and 11* | 713 | 595 | 567 | 572 | 520 | 576 | |
| *CIS-R score 12 or more* | 122 | 137 | 126 | 78 | 123 | 148 | |

# 5 Physical health, caring and mental health

*Saffron Karlsen and Martin Blanchard*

## 5.1 Introduction

The relationship between physical health and mental health is not fully understood. It is well documented that physical ill-health and associated disability and handicap are strongly associated with onset and perpetuation of depression.[1] It is also known that depression is related to an increase in mortality, though the exact mechanisms remain obscure. Poor physical health and disability generate the need for carers, and adopting a caring role has been found to be associated with an increased risk of depression, especially among women caring for their partners.[2] Previous studies of the relationship between ethnicity and physical health have shown important differences between groups.[3] Quite how ethnicity affects the relationships between physical health, caring and, in turn, mental health is not clear. However, it does appear that taking a detailed approach to the assignment of individuals to ethnic groups, rather than making broad categorisations, may help in revealing differences between groups which could then lead on to relevant interventions.[3]

Research suggests that people from ethnic minority groups experience disproportionate levels of physical ill health compared with those from the ethnic majority. For example, the Fourth National Survey of Ethnic Minorities (FNS)[4] found that those from ethnic minority groups were consistently more likely than the White group to report fair, poor or very poor health, limiting long-standing illness and a registered disability.[3] Findings from the Health Survey for England 1999, which focused on the health experience of different ethnic groups, showed similar patterns.[5] The prevalence of limiting long-standing illness was higher for Pakistani, Bangladeshi and Irish men and for Black Caribbean, Indian, Bangladeshi and Pakistani women compared with the general population. Informants of both sexes and of Pakistani, Bangladeshi or Indian origin and Black Caribbean women reported poorer general health than the general population. Not surprisingly, the prevalence of bad or very bad self-reported health increased with age for the general population and all ethnic minority groups, but this increase was particularly steep for those of South Asian origin.

The few studies examining ethnic differences in levels of disability have suggested that people from ethnic minority groups have greater levels of disability than members of the ethnic majority population.[6,7,8,9] Andreason and Brownson[10] used cross sectional data to investigate the relationship between ethnicity and disability in White, African-American, Hispanic and Native American women in the US. The prevalence of disability and the need for personal care assistance was higher among ethnic minority women. And fewer White women reported that their disability prevented them from working, compared with women from an ethnic minority group. These differences remained after taking account of the effects of socioeconomic status. Findings from British-based data have suggested

that Pakistani and Bangladeshi informants are consistently more likely, and Black Caribbean and Indian informants slightly more likely, to report that certain activities are limited because of their health, compared with White informants.[3] It is possible that these increased levels of disability result from differences in age associated declines in physical capacity. On the other hand, it is possible that there is some societal aspect of the experience of being of an ethnic minority group which influences the development of disability.

The current study's investigation into ethnic differences in physical health and the caring experience is timely given the ageing of our population and the need to support increasing numbers of older people in the community. While most ethnic minority communities in the UK are young compared with the White British population, these populations are ageing, as people who arrived in the 1950s and 1960s reach retirement.[11,12] The proportion of older people from ethnic minority communities will increase dramatically in the next two decades, accompanied by associated increases in the prevalence of chronic, disabling health problems and the need for carers. Despite the relatively young age profile of the ethnic minority community in Britain, findings from the FNS suggested that South Asian people aged between 40 and 59 (with at least one parent living in Britain) were as likely to be caring for a parent as White people of the same age,[13] with around a quarter of each group providing care. Black Caribbean people were significantly less likely to provide care for a parent than White or South Asian groups.[12]

Post-migration settlement patterns, cultural differences in family formation and residency, and problems with access to housing have meant that multigenerational households are relatively more common among ethnic minority groups than among the White British population.[12] This may lead to presumptions that there is less need to provide access to formal social support and domiciliary care for ethnic minority groups, since members of the household are more likely to be available to provide informal care. This could be seen to be supported by findings from the FNS which suggested that, although there were no differences between groups in reported levels of caring for a parent, those from ethnic minority groups were more likely to live within the same household as the cared-for parent.[12] Nevertheless, surveys indicate that there is still a significant proportion of older ethnic minority people who live alone, or as a couple.[12,14]

Research suggests that carers experience poor health compared with the general population.[15] In addition to the health impact of physical injury or fatigue, two-thirds of carers in a recent study believed that the worry produced by the threat of poverty and social isolation had a detrimental effect on their health. Carers from ethnic minority groups have been found to be particularly vulnerable to social exclusion and financial difficulties.[16] However there is little research exploring the reasons for this, or how this may influence their health. Harwood et al[2] investigated the prevalence of depressive symptoms among White Hispanic and White non-Hispanic primary caregivers of family members with Alzheimer's disease. Depression was more common among White Hispanic (45%) than among White non-Hispanic (36%) caregivers and was associated with being a female spouse and increased severity of illness among those who were receiving care. Patterson et al[17] compared informal caregivers of patients with Alzheimer's disease in the US and China and demographically matched non-caregiving controls. They found that the two groups of caregivers were very similar, with both reporting more depressive and physical symptoms than non-caregivers. Connell and Gibson[18] reviewed studies examining the impact of ethnicity on the experience of providing care for those with dementia. Compared with White caregivers, non-White caregivers were: less likely to be a spouse and more likely to be an adult child, friend, or other family member; more likely to report lower levels of caregiver stress, burden, and depression; more likely to endorse strongly held beliefs about filial

support, and; more likely to use prayer, faith, or religion as coping mechanisms. There is therefore conflicting evidence as to whether or not carers from ethnic minority groups may experience more psychological problems than the majority ethnic population, and, perhaps other factors, such as the location of care provision or the relationship to the person receiving care, are more important in determining this.

## 5.2 Measures

To assess health quality, this study used the SF12 questionnaire,[19,20] and questions on the existence of any limiting long-standing illness, disability or infirmity, which were very similar to those used in the 1991 British census. The twelve questions forming the SF12 require the respondent to report on: their level of physical health in general (ranging from excellent to poor); the extent to which they have felt calm and peaceful, energetic, and downhearted and low during the past four weeks; and the extent to which their (physical and emotional) health status limits their ability to perform certain tasks or social activities. The SF12 questions are then combined to form a summary score of physical health, where a higher score indicates better health. Regression weights and a constant are added to transform the score to have a mean of 50 and a standard deviation of 10 in the general US population. An equivalent has not been produced for the UK. This standardisation and norm-based scoring means the results have a direct interpretation in relation to the distribution of scores in the general US population. More detailed information on the scoring, including the general US population statistics used in the standardisation and aggregation of the score and formulas for scale aggregation and transformation of score has been published elsewhere.[19]

The SF12 items will be presented individually as well as in the summary score in the following tables.

Informants were also asked if they were looked after by, or provided care to, another person other than a child, as a result of illness, disability or old age, and other than in a professional capacity. These questions were taken from the General Household Survey.[21]

## 5.3 Physical health and the receipt of informal care

Table 5.1 shows the proportion of informants reporting a variety of physical health problems and those receiving informal care, by ethnic group, divided into three age bands. Among the youngest age group self-reported rates of fair or poor general health were similar, with around a fifth of informants from most groups, and one in seven Indian informants, reporting ill health. Between the ages of 35 and 54, differences emerge, with White and Irish informants reporting lowest rates of fair or poor health, Black Caribbean and Indian informants reporting slightly higher rates and Pakistani and Bangladeshi informants reporting the highest rates of fair or poor health. Almost half of Bangladeshi informants in this age group reported their health to be fair or poor. In the oldest age group, this pattern becomes even more striking, with a third of White informants, two-fifths of Irish informants and half of Black Caribbean and Indian informants reporting fair or poor health, compared with three-quarters of Pakistani and Bangladeshi informants.

Patterns of reported long standing illness showed a different pattern from that suggested by the self-assessed general health findings, which may suggest that this question is being interpreted differently to that exploring self-assessed health. In contrast with self-assessed health, where Bangladeshi informants reported the highest rates of fair or poor health at both the middle and older ages, this group reported the lowest rates of long standing illness in the youngest and middle age groups and a similar proportion to White informants among those aged between 55 and 74. Almost half of Bangladeshi and White informants reported long standing illness in the oldest age group, compared with three-fifths of Irish, Black Caribbean and Indian informants and almost three-quarters of Pakistani informants.

However, these findings conflicted with the numbers of informants who, having reported some long standing illness, were then asked whether this illness limited them in their work. Among each age group, Bangladeshi informants were more likely to report that their illness limited their work, with 86% of the oldest group reporting work-limiting long standing illness. White, Irish and Black Caribbean informants were the least likely to report that their illness limited their work.

There was a sharp increase among older informants across ethnic groups in those who reported that they had accomplished less or been limited in their daily activities as a result of poor physical health (Table 5.1). A quarter of White informants, a third of Irish, Black Caribbean and Indian and two-fifths of Bangladeshi and Pakistani informants reported accomplishing less as a result of poor physical health among the oldest age group. A quarter of White informants, a third of Black Caribbean and Bangladeshi informants, two-fifths of Irish and Indian informants and over two-fifths of Pakistani informants reported being limited in the kind of work or regular daily activity they could do as a result of poor physical health in the 55 to 74 age group. These age-related changes were not shown among those reporting that they had accomplished less, or performed work or other activities less carefully, as a result of poor emotional health in the past four weeks.

When asked the degree to which pain had interfered with normal work, during the past four weeks, there were similarities across ethnic groups in the proportions reporting pain interference among the youngest and middle age groups, although Pakistani informants reported more pain than other groups. Among the oldest age group, White and Bangladeshi informants reported the lowest rates of pain interference, followed by Black Caribbeans, Indians and then Irish informants. Almost half of Pakistani informants in the oldest group reported pain interference.

On the whole, South Asian informants, particularly those of Bangladeshi and Pakistani origin, reported more physical and emotional health problems, using the SF12 measures shown in Table 5.1. This pattern corresponds with those reporting receipt of informal care. Among the oldest group, one in eight White and Irish informants and one in six Black Caribbean informants reported receiving informal care, compared with a fifth of Indian, a quarter of Bangladeshi and a third of Pakistani informants.

## 5.4 Limitation of physical activities

Table 5.2 shows responses to two questions from the SF12 exploring the extent to which ill-health limits activities, by ethnic group and age. The large majority of White, Irish and Black Caribbean informants reported that ill health did not limit either their ability to do moderate activities, or their ability to climb several flights of stairs, in each age group. Among the oldest age group, seven in ten White and Irish people and three-fifths of Black Caribbean people reported no problems with moderate activities, with a fifth of each group reporting 'a little' difficulty. Again, among the oldest age group, three-fifths of White and Irish informants and over half of Black Caribbean informants reported no problems with climbing stairs, with a fifth of White and Irish informants and a quarter of Black Caribbean informants reporting 'a little' difficulty. Indian informants reported similar rates of health limitation to Black Caribbean informants, although they reported more limitation of moderate activities and of climbing stairs in the two older age groups. Among the oldest age group, a quarter of Pakistani informants, and between two-fifths and half of the Bangladeshi informants sampled reported that their health caused their activities to be limited a lot.

## 5.5 Emotional well-being

Table 5.3 shows responses to a question asking the amount of time the respondent had felt calm and peaceful during the past four weeks, by ethnic group and age. In the youngest age group, Irish and Indian informants were the most, with Bangladeshi informants the least, likely to report not feeling

calm and peaceful at any time. Among the over 55 age group, Pakistani informants were the most likely to report not feeling calm and peaceful at any time, followed by White, Bangladeshi and Indian, and then Irish and Black Caribbean informants.

Table 5.4 shows the amount of time informants felt they had had a lot of energy during the past four weeks, by ethnicity and age. The proportion of informants who reported feeling they had had a lot of energy for some or all of the time declined with increasing age, particularly among the Pakistani and Bangladeshi informants. Among the oldest age group, a fifth of White, Irish, Indian and Black Caribbean and a quarter of Indian informants reported that at no time did they feel that they had had a lot of energy, compared with two-fifths of Bangladeshi and Pakistani informants.

Table 5.5 shows the time informants felt downhearted and low during the past four weeks, by ethnicity and age. There was some similarity in the results across the different ethnic groups, and in the first two age groups. In the oldest age group four-fifths of White informants, three-quarters of Irish informants and three-fifths of Black Caribbean, Bangladeshi, Indian and Pakistani informants felt downhearted and low none of the time.

## 5.6 Limitation of social activities

Table 5.6 shows the amount of time the informants felt their physical health or emotional problems had interfered with their social activities during the past four weeks, by ethnic group, divided into the three age bands. There was some consistency in proportions reporting that their health had not affected their social activities among the youngest group. While there was little change with increasing age in these rates among White and Black Caribbean informants, and a slight fall in the proportions reporting no problems among Irish, Indian or Pakistani informants; the proportion reporting no interference in their social activities among the Bangladeshi group fell by a fifth between the youngest and oldest group.

## 5.7 Physical health and sex

The remaining tables and figures in this section report ethnic and age differences in the summary physical health indicator derived from the SF12 described in the Measures section of this chapter. A higher score on the summary indicates better physical health. Figure 5.1 shows the mean scores on the summary physical health indicator from the SF12 by age and ethnic group. Ethnic differences in physical health were small, but became greater with increasing age. At the oldest ages, White and Irish groups had the best health, followed by Black Caribbean and Indian informants. People from Pakistani and Bangladeshi groups had the poorest health, using this indicator.

Figure 5.1

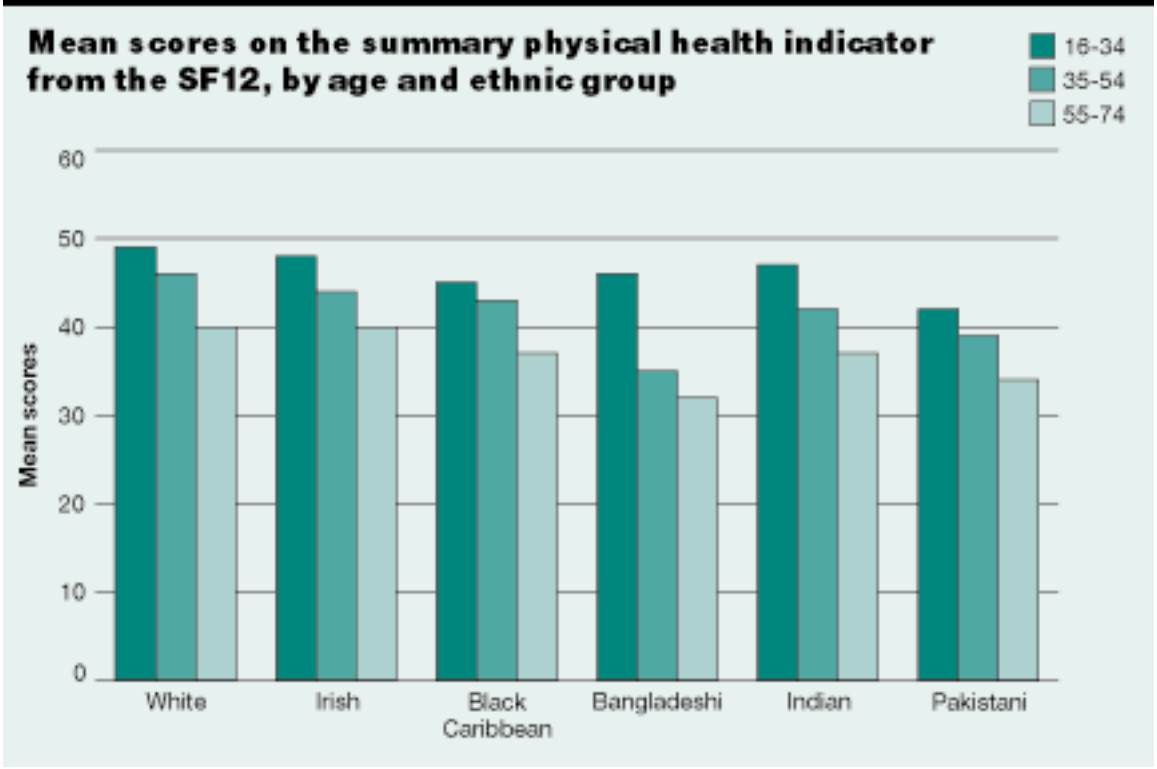



Table 5.7 shows the risk ratios and standard errors of the summary physical health indicator by ethnic group and gender, standardised for age. Each of the ethnic minority groups had poorer health, using this indicator, compared with White people of the same sex, with the exception of Irish men. This difference was significant for Bangladeshi and Pakistani men and women and for Indian men. Irish men had significantly better health than Black Caribbean and South Asian men and Black Caribbean men's health was significantly better than that of Pakistani and Bangladeshi men. Irish and Black Caribbean women both had significantly better health than Pakistani women.

## 5.8 Physical health and social position

Table 5.8 shows the risk ratios and standard errors of the summary physical health indicator by ethnic group and occupational social class of head of household, standardised for age. There was no statistically significant variation in health among non-manual informants between any of the ethnic groups, although there were small numbers of informants in the non-manual Bangladeshi group. Among informants from households with a manual worker as head, however, White and Irish informants had significantly better health than all the non-White ethnic minority groups. Bangladeshi informants from such households had significantly poorer health than Black Caribbean and Indian informants in this group.

Table 5.9 shows the risk ratios and standard errors of the summary physical health indicator by ethnic group and employment status, standardised for age. Among the employed, Indian informants had significantly poorer physical health compared with White people, and Irish informants had significantly better physical health than any of the other ethnic groups, although there was a small number of Bangladeshi informants in this group. Among the unemployed, all the non-White ethnic minority groups had significantly poorer health compared with White informants, but there were small numbers of informants in the White groups which makes these findings unreliable. Pakistani informants had significantly poorer health than Irish informants.

## 5.9 Physical and mental health

Table 5.10 shows the risk ratios and standard errors of the summary physical health indicator by ethnic group and CIS-R score, standardised for age. The CIS-R is a measure of common mental disorders and a score of 12 or more is often taken as evidence of the existence of some form of clinically significant condition (see chapter 3 for more discussion of this). Among those scoring 11 or under on the CIS-R, White informants had significantly better physical health compared with South Asian informants. Irish informants had significantly better physical health than all the non-White ethnic minority groups. Black Caribbean informants had significantly better physical health compared with Bangladeshi and Pakistani informants. And Indian informants had significantly better physical health than Bangladeshi informants.

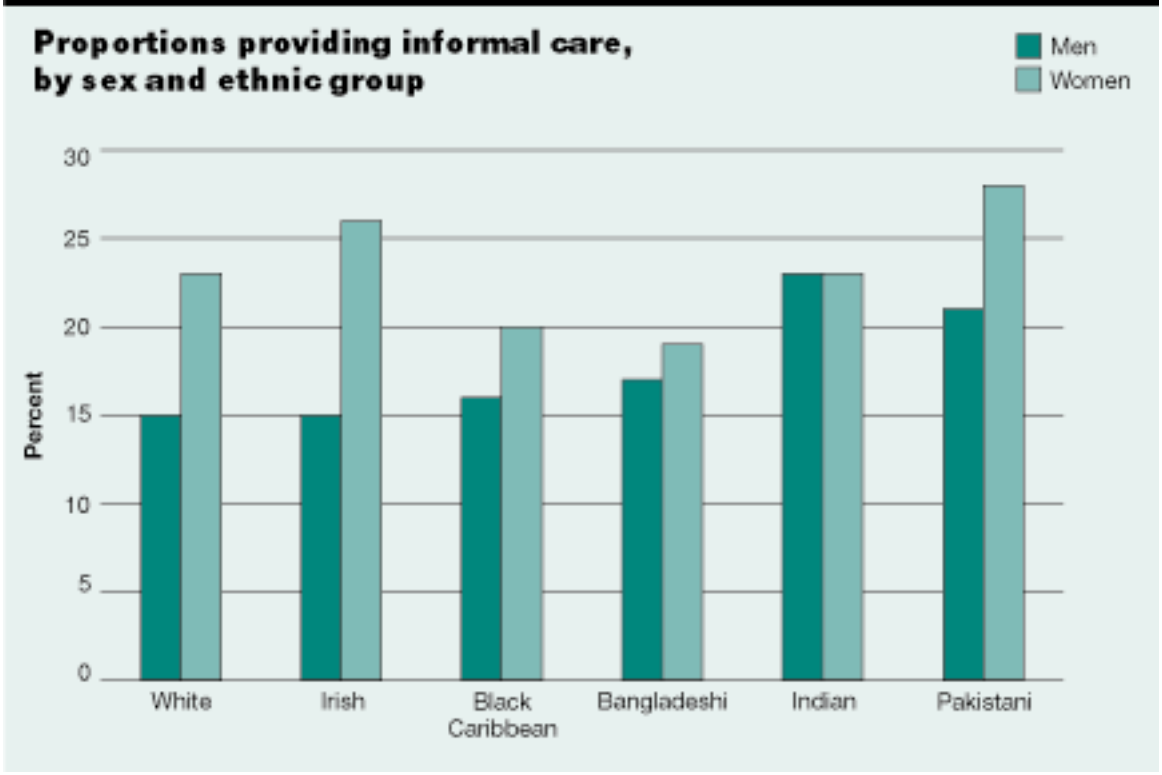
Among those scoring 12 or more on the CIS-R, White informants had statistically significantly better physical health than Bangladeshi and Pakistani informants. Pakistani informants had significantly poorer physical health compared with Irish, Black Caribbean and Indian informants.

## 5.10 Caring

Figure 5.2 and Tables 5.11 and 5.12 show ethnic differences in caring and its association with health. Figure 5.2 shows the proportions providing informal care to someone other than a child. And Table 5.11 shows these figures further divided by whether that care is provided within or outside the home. There are similar levels of informal care provided across the ethnic groups, with between 18 and 25% of informants providing care in each ethnic group. Women tend to provide more care both within and outside the home, regardless of ethnic group with the exception of Indian informants, among whom men provided as much informal care as women. South Asian groups provided more care in their own home, compared with other groups.

Table 5.12 shows the risk ratios and standard errors of the CIS-R score and the summary SF12 physical health indicators by ethnic group and carer status, standardised for age. Pakistani informants who were not involved in caring were significantly more likely to have a higher score on the CIS-R compared with White, Irish or Bangladeshi informants. There were no significant differences in CIS-R score among carers across ethnic group. However, there was some variation by ethnicity in scores on the summary physical health indicator for both carer and non-carer groups. Black Caribbean, Bangladeshi and Pakistani non-carers were significantly likely to have a lower score on the summary physical health indicator (and therefore poorer health) compared with White non-carers. Bangladeshi and Pakistani non-carers were also likely to have a lower score than Irish, Indian and Black Caribbean informants. South Asian carers were significantly likely to have a lower score on the summary physical health indicator compared with White carers. Pakistani and Bangladeshi carers were also more likely to have lower scores than Irish carers.

Figure 5.2




## 5.11 **Conclusions**

In conclusion, these findings would appear to support those of other studies exploring ethnic differences in physical health.[3,5] As would be expected there is a general increase in the reporting of fair or poor physical health with increasing age, but this is particularly the case among those from ethnic minority groups. There are similar age-related increases in reported limitation due to physical ill-health. On the whole, South Asian informants, particularly those of Pakistani and Bangladeshi origin, reported more physical and emotional health problems, compared with the other ethnic groups in the study. Findings for long-standing illness were not so clear-cut, however, as those reporting work-limiting long standing illness, while similar to patterns of self-assessed fair or poor health, ran contrary to findings for more general long standing illness. These findings would seem to support other studies suggesting an ethnic difference in the interpretation of the long standing illness (but not the work-limiting long standing illness) question.[23] These patterns of physical ill-health persisted after taking into account scores on the CIS-R.

In terms of social position, having separated the informants into 'manual' and 'non-manual' groups, defined in terms of the type of work performed by the head of household, it appears that the ethnic differences found in the summary physical health scores are concentrated within the 'manual' group. Therefore within this lower socioeconomic group, other factors associated with belonging to an ethnic minority group would seem to be influencing physical health detrimentally. So, some of the apparent ethnic difference in physical health found here would seem to be a consequence of social position, measured here using head of household's occupation. But, given the reported problems in measuring social position across different ethnic groups,[3] it is difficult to determine whether the remaining ethnic difference in physical health, among manual groups, is a genuine ethnic effect, or a consequence of poor measurement. More ethnically-sensitive measures of social position demanded elsewhere[3] could shed further light on these trends.

Ethnic differences in the rates of informal care receipt correspond to the ethnic differences in morbidity and disability reported earlier. Among the oldest group, one in eight White and Irish informants and one in six Black Caribbean informants reported receiving informal care, compared with a fifth of Indian, a quarter of Bangladeshi and a third of Pakistani informants. The numbers of people receiving informal care found in this study support the idea that the low level of care receipt among ethnic minority people reported in other studies is a consequence of variations in the age profile of different ethnic groups, rather than differences in the need for care.[3] The findings do not suggest that non-white ethnic minority groups provide less informal care compared with other groups.

In the literature, there are conflicting reports about levels of psychological distress and ill-health in carers from different ethnic groups.[2,15,17,18] In this study there is no difference in the risk ratios for score on the CIS-R among carers from different ethnic groups. This indicates similar levels of psychological morbidity. However, South Asian carers (and particularly those of Bangladeshi and Pakistani origin) do have poorer physical health compared with carers from White or Irish groups, as shown on the summary physical health indicator. Unfortunately we did not have sufficient numbers to explore any gender differences with respect to psychological and physical morbidity among carers. Thus we are unable to support or refute reports of greater psychological morbidity among female carers, and we are unable to explore any relationship with ethnicity, or social position.

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# 5 Physical health, caring and mental health

*Saffron Karlsen and Martin Blanchard*

## Tables

Table 5.1

### Proportion reporting physical health problems, performance limitation, and receipt of informal care, by age

| Age | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Health assessed as fair or poor** | | | | | | |
| 16-34 | 18 | 23 | 18 | 19 | 14 | 21 |
| 35-54 | 17 | 22 | 27 | 47 | 34 | 40 |
| 55-74 | 32 | 40 | 52 | 78 | 47 | 72 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Total | 21 | 26 | 30 | 35 | 29 | 33 |
| **Long-standing illness** | | | | | | |
| 16-34 | 23 | 26 | 20 | 12 | 14 | 19 |
| 35-54 | 36 | 39 | 34 | 33 | 35 | 39 |
| 55-74 | 49 | 58 | 58 | 51 | 61 | 72 |
| Total | 35 | 40 | 34 | 23 | 32 | 31 |
| **Accomplished less as a result of poor physical health** | | | | | | |
| 16-34 | 12 | 13 | 17 | 12 | 14 | 17 |
| 35-54 | 17 | 20 | 26 | 27 | 24 | 28 |
| 55-74 | 27 | 34 | 33 | 43 | 36 | 43 |
| Total | 18 | 22 | 24 | 20 | 22 | 23 |
| **Limited in work or other daily activities as a result of poor physical health** | | | | | | |
| 16-34 | 10 | 12 | 11 | 9 | 10 | 16 |
| 35-54 | 16 | 19 | 23 | 21 | 24 | 29 |
| 55-74 | 27 | 39 | 32 | 35 | 38 | 46 |
| Total | 17 | 22 | 21 | 16 | 21 | 24 |
| **Accomplished less as a result of emotional problems** | | | | | | |
| 16-34 | 20 | 21 | 22 | 14 | 20 | 24 |
| 35-54 | 21 | 24 | 30 | 30 | 24 | 32 |
| 55-74 | 15 | 25 | 22 | 25 | 25 | 33 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Total | 19 | 24 | 25 | 20 | 23 | 28 |
| **Performed work or any other activities less carefully as a result of emotional problems** | | | | | | | |
| | 16-34 | 17 | 19 | 17 | 11 | 16 | 17 |
| | 35-54 | 14 | 17 | 19 | 16 | 17 | 24 |
| | 55-74 | 10 | 19 | 15 | 16 | 17 | 20 |
| | Total | 14 | 18 | 17 | 13 | 17 | 19 |
| **Pain interfered with normal work** | | | | | | | |
| | 16-34 | 11 | 10 | 12 | 9 | 9 | 16 |
| | 35-54 | 18 | 19 | 21 | 23 | 17 | 27 |
| | 55-74 | 20 | 31 | 28 | 25 | 29 | 48 |
| | Total | 16 | 19 | 19 | 15 | 16 | 23 |
| **Receiving informal care** | | | | | | | |
| | 16-34 | 1 | 2 | 5 | 7 | 2 | 4 |
| | 35-54 | 4 | 6 | 6 | 11 | 8 | 11 |
| | 55-74 | 12 | 13 | 16 | 24 | 22 | 32 |
| | Total | 5 | 7 | 8 | 10 | 8 | 10 |
| *Bases (weighted)* | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *412* |
| | *35-54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| | *55-74* | *23522* | *808* | *203* | *37* | *214* | *83* |
| | *Total* | *86295* | *3313* | *824* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *16-34* | *228* | *179* | *247* | *362* | *227* | *403* |
| *35-54* | *371* | *360* | *270* | *190* | *295* | *236* |
| *55-74* | *238* | *194* | *176* | *98* | *121* | *85* |
| *Total* | *837* | *733* | *693* | *650* | *643* | *724* |
| **Long-standing illness that limits work** | | | | | | |
| 16-34 | 55 | 54 | [64] | [75] | [66] | 72 |
| 35-54 | 57 | 63 | 59 | 89 | 64 | 73 |
| 55-74 | 62 | 60 | 67 | [86] | 71 | 86 |
| Total | 58 | 60 | 64 | 84 | 67 | 76 |
| *Bases (weighted)* | | | | | | |
| *16-34* | *5769* | *246* | *63* | *19* | *62* | *76* |
| *35-54* | *13312* | *616* | *103* | *26* | *176* | *89* |
| *55-74* | *11478* | *471* | *118* | *19* | *131* | *60* |
| *Total* | *30560* | *1333* | *284* | *64* | *369* | *225* |
| *Bases (unweighted)* | | | | | | |
| *16-34* | *50* | *51* | *[49]* | *[46]* | *[35]* | *83* |
| *35-54* | *131* | *144* | *92* | *56* | *102* | *95* |
| *55-74* | *114* | *109* | *104* | *[47]* | *75* | *61* |
| *Total* | *295* | *304* | *245* | *149* | *212* | *239* |

Table 5.2

## Extent to which ill health limits the ability to perform activities, by age

| Age | | Ethnic group | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Moderate activities** | | | | | | | |
| 16-34 | | | | | | | |
| | A lot | 2 | 2 | 4 | 6 | 1 | 5 |
| | A little | 2 | 4 | 4 | 8 | 6 | 11 |
| | Not at all | 96 | 94 | 92 | 87 | 93 | 83 |
| 35-54 | | | | | | | |
| | A lot | 3 | 6 | 6 | 15 | 8 | 11 |
| | A little | 10 | 10 | 10 | 21 | 16 | 23 |
| | Not at all | 87 | 84 | 84 | 63 | 76 | 66 |
| 55-74 | | | | | | | |
| | A lot | 11 | 14 | 17 | 39 | 22 | 27 |
| | A little | 19 | 18 | 21 | 35 | 32 | 40 |
| | Not at all | 70 | 68 | 61 | 25 | 46 | 33 |
| All ages | | | | | | | |
| | A lot | 5 | 7 | 8 | 13 | 8 | 10 |
| | A little | 10 | 10 | 10 | 15 | 15 | 18 |
| | Not at | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Not at all | 85 | 83 | 82 | 72 | 77 | 72 |
| **Climbing several flights of stairs** | | | | | | | | |
| 16-34 | | | | | | | | |
| | | A lot | 3 | 1 | 5 | 5 | 2 | 5 |
| | | A little | 7 | 12 | 7 | 10 | 9 | 8 |
| | | Not at all | 90 | 88 | 88 | 85 | 90 | 87 |
| 35-54 | | | | | | | | |
| | | A lot | 4 | 6 | 7 | 17 | 10 | 9 |
| | | A little | 11 | 13 | 15 | 29 | 16 | 25 |
| | | Not at all | 85 | 81 | 78 | 54 | 74 | 65 |
| 55-74 | | | | | | | | |
| | | A lot | 18 | 17 | 22 | 48 | 27 | 26 |
| | | A little | 22 | 22 | 25 | 37 | 33 | 43 |
| | | Not at all | 60 | 60 | 53 | 15 | 40 | 31 |
| All ages | | | | | | | | |
| | | A lot | 8 | 7 | 10 | 14 | 10 | 9 |
| | | A little | 13 | 15 | 14 | 19 | 16 | 18 |
| | | Not at all | 80 | 78 | 76 | 67 | 74 | 74 |
| *Bases (weighted)* | | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *412* | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *35-54* | *37353* | *1561* | *301* | *79* | *497* | *230* |
| *55-74* | *23281* | *807* | *203* | *37* | *214* | *83* |
| *Total* | *86054* | *3312* | *824* | *274* | *1153* | *724* |
| *Bases (unweighted)* | | | | | | |
| *16-34* | *228* | *179* | *247* | *362* | *227* | *403* |
| *35-54* | *371* | *360* | *270* | *190* | *294* | *236* |
| *55-74* | *236* | *193* | *176* | *98* | *121* | *85* |
| *Total* | *835* | *732* | *693* | *650* | *642* | *724* |

Table 5.3

## Extent to which felt calm and peaceful, by age

| **Extent to which felt calm and peaceful** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| 16-34 | | | | | | | |
| | All of the time | 40 | 39 | 50 | 55 | 50 | 52 |
| | Some of the time | 46 | 43 | 38 | 36 | 32 | 34 |
| | None of the time | 15 | 18 | 12 | 9 | 18 | 14 |
| 35-54 | | | | | | | |
| | All of the time | 33 | 39 | 48 | 45 | 46 | 52 |
| | Some of the time | 50 | 43 | 38 | 42 | 39 | 32 |
| | None of | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | None of the time | 18 | 18 | 14 | 13 | 15 | 15 |
| 55-74 | | | | | | | | |
| | | All of the time | 55 | 59 | 57 | 34 | 55 | 46 |
| | | Some of the time | 32 | 33 | 38 | 54 | 35 | 39 |
| | | None of the time | 12 | 7 | 6 | 11 | 10 | 14 |
| All ages | | | | | | | | |
| | | All of the time | 41 | 44 | 51 | 49 | 49 | 51 |
| | | Some of the time | 44 | 41 | 38 | 40 | 35 | 34 |
| | | None of the time | 15 | 16 | 11 | 11 | 15 | 15 |
| *Bases (weighted)* | | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *409* | |
| | *35-54* | *37353* | *1561* | *301* | *79* | *500* | *230* | |
| | *55-74* | *23367* | *808* | *203* | *37* | *214* | *83* | |
| | *Total* | *86140* | *3313* | *824* | *273* | *1156* | *722* | |
| *Bases (unweighted)* | | | | | | | | |
| | *16-34* | *228* | *179* | *247* | *362* | *227* | *402* | |
| | *35-54* | *371* | *360* | *270* | *190* | *295* | *236* | |
| | *55-74* | *237* | *194* | *176* | *97* | *121* | *85* | |
| | *Total* | *836* | *733* | *693* | *649* | *643* | *723* | |

Table 5.4

## Amount of time had a lot of energy, by age

| Amount of time had a lot of energy | Ethnic group | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
|---|---|---|---|---|---|---|---|
| | | % | % | % | % | % | % |
| 16-34 | | | | | | | |
| | All of the time | 38 | 35 | 48 | 46 | 51 | 50 |
| | Some of the time | 53 | 50 | 40 | 41 | 39 | 38 |
| | None of the time | 10 | 15 | 12 | 12 | 10 | 12 |
| 35-54 | | | | | | | |
| | All of the time | 27 | 33 | 32 | 29 | 40 | 43 |
| | Some of the time | 55 | 48 | 46 | 39 | 41 | 33 |
| | None of the time | 18 | 19 | 22 | 32 | 18 | 24 |
| 55-74 | | | | | | | |
| | All of the time | 35 | 30 | 40 | 20 | 35 | 18 |
| | Some of the time | 43 | 48 | 38 | 39 | 39 | 41 |
| | None of the time | 22 | 22 | 22 | 41 | 26 | 41 |
| All ages | | | | | | | |
| | All of the time | 32 | 33 | 40 | 38 | 43 | 44 |
| | Some of the time | 51 | 48 | 42 | 40 | 40 | 37 |
| | None of | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | None of the time | 16 | 19 | 18 | 22 | 17 | 19 |
| *Bases (weighted)* | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *412* |
| | *35-54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| | *55-74* | *23367* | *808* | *203* | *37* | *214* | *83* |
| | *Total* | *86140* | *3313* | *824* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | | |
| | *16-34* | *228* | *179* | *247* | *362* | *227* | *403* |
| | *35-54* | *371* | *360* | *270* | *190* | *295* | *236* |
| | *55-74* | *237* | *194* | *176* | *98* | *121* | *85* |
| | *Total* | *836* | *733* | *693* | *650* | *643* | *724* |

Table 5.5

## Amount of time felt downhearted and low, by age

| **Amount of time felt downhearted and low** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| 16-34 | | | | | | | |
| | All of the time | 7 | 2 | 5 | 8 | 7 | 10 |
| | Some of the time | 32 | 38 | 25 | 18 | 26 | 31 |
| | None of the time | 61 | 59 | 69 | 74 | 67 | 59 |
| 35-54 | | | | | | | |
| | All of | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | All of the time | 6 | 5 | 11 | 13 | 7 | 15 |
| | | Some of the time | 28 | 25 | 25 | 21 | 38 | 26 |
| | | None of the time | 67 | 69 | 64 | 67 | 55 | 59 |
| 55-74 | | | | | | | | |
| | | All of the time | 4 | 7 | 8 | 7 | 11 | 12 |
| | | Some of the time | 16 | 19 | 29 | 34 | 28 | 28 |
| | | None of the time | 80 | 74 | 63 | 59 | 61 | 60 |
| Total | | | | | | | | |
| | | All of the time | 6 | 5 | 8 | 9 | 8 | 12 |
| | | Some of the time | 26 | 27 | 26 | 21 | 31 | 29 |
| | | None of the time | 68 | 68 | 66 | 70 | 61 | 59 |
| *Bases (weighted)* | | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *412* | |
| | *35-54* | *37353* | *1561* | *301* | *79* | *500* | *230* | |
| | *55-74* | *23367* | *808* | *203* | *37* | *214* | *83* | |
| | *Total* | *86140* | *3313* | *824* | *274* | *1156* | *724* | |
| *Bases (unweighted)* | | | | | | | | |
| | *16-34* | *228* | *179* | *247* | *362* | *227* | *403* | |
| | *35-54* | *371* | *360* | *270* | *190* | *295* | *236* | |
| | *55-74* | *237* | *194* | *176* | *98* | *121* | *85* | |
| | *Total* | *836* | *733* | *693* | *650* | *643* | *724* | |

Table 5.6

## Amount of time that physical health or emotional problems interfered with social activities, by age

| Amount of time that physical health or emotional problems interfered with social activities | Ethnic group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | | |
| | % | % | % | % | % | % | | |
| 16-34 | | | | | | | | |
| | All of the time | 5 | 6 | 7 | 6 | 8 | 9 |
| | Some of the time | 14 | 13 | 14 | 8 | 16 | 18 |
| | None of the time | 80 | 82 | 79 | 86 | 76 | 73 |
| 35-54 | | | | | | | | |
| | All of the time | 7 | 5 | 8 | 4 | 8 | 13 |
| | Some of the time | 15 | 14 | 21 | 19 | 16 | 20 |
| | None of the time | 78 | 82 | 70 | 77 | 77 | 67 |
| 55-74 | | | | | | | | |
| | All of the time | 7 | 11 | 9 | 10 | 14 | 15 |
| | Some of the time | 10 | 15 | 15 | 23 | 17 | 22 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | None of the time | 82 | 74 | 76 | 67 | 69 | 63 |
| All ages | | | | | | | |
| | All of the time | 7 | 6 | 8 | 6 | 9 | 11 |
| | Some of the time | 14 | 14 | 17 | 13 | 16 | 19 |
| | None of the time | 80 | 80 | 75 | 81 | 75 | 70 |
| *Bases (weighted)* | | | | | | | |
| | *16-34* | *25420* | *943* | *320* | *158* | *442* | *412* |
| | *35-54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| | *55-74* | *23367* | *808* | *203* | *37* | *214* | *83* |
| | *Total* | *86140* | *3313* | *824* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | | |
| | *16-34* | *228* | *179* | *247* | *362* | *227* | *403* |
| | *35-54* | *371* | *360* | *270* | *190* | *295* | *236* |
| | *55-74* | *237* | *194* | *176* | *98* | *121* | *85* |
| | *Total* | *836* | *733* | *693* | *650* | *643* | *724* |

Table 5.7

## Age-standardised risk ratios for scores on the summary physical health indicator from the SF12, by sex

| Standardised risk ratios | Ethnic group | | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| Men | | | | | | | |
| | Risk ratio | 1 | 1.03 | 0.95 | 0.85 | 0.94 | 0.87 |
| | Standard error of the ratio | 1 | 0.02 | 0.03 | 0.03 | 0.03 | 0.02 |
| Women | | | | | | | |
| | Risk ratio | 1 | 0.93 | 0.93 | 0.86 | 0.96 | 0.80 |
| | Standard error of the ratio | 1 | 0.04 | 0.05 | 0.05 | 0.06 | 0.04 |
| *Bases (weighted)* | | | | | | | |
| | *Men* | *13127* | *689* | *103* | *35* | *190* | *110* |
| | *Women* | *17432* | *644* | *181* | *27* | *179* | *114* |
| *Bases (unweighted)* | | | | | | | |
| | *Men* | *129* | *149* | *88* | *78* | *114* | *118* |
| | *Women* | *166* | *155* | *157* | *71* | *98* | *121* |

Table 5.8

## Age-standardised risk ratios for scores on the summary physical health indicator from the SF12, by social class of Head of Household

| **Standardised risk ratios** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| Non manual | | | | | | | |
| | Risk ratio | 1.00 | 1.03 | 0.98 | a | 1.00 | 0.97 |
| | *Standard error of the ratio* | *1.00* | *0.04* | *0.04* | *a* | *0.04* | *0.04* |
| Manual | | | | | | | |
| | Risk ratio | 1.00 | 0.99 | 0.90 | 0.78 | 0.90 | 0.84 |
| | Standard error of the ratio | 1.00 | 0.03 | 0.03 | 0.04 | 0.04 | 0.03 |
| Bases (weighted) | | | | | | | |
| Non manual | 17434 | 652 | 128 | 8 | 153 | 66 | |
| Manual | 12524 | 653 | 138 | 32 | 167 | 88 | |
| Bases (unweighted) | | | | | | | |
| Non manual | 172 | 148 | 112 | a | 96 | 65 | |
| Manual | 117 | 152 | 122 | 77 | 94 | 99 | |

[a] The sample base for these categories is too small for the results to be shown.

Table 5.9

**Age-standardised risk ratios for scores on the summary physical health indicator from the SF12, by employment status**

| **Standardised risk ratios** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| Employed | | | | | | | |
| | Risk ratio | 1.00 | 1.04 | 0.97 | a | 0.95 | 0.96 |
| | *Standard error of the ratio* | *1.00* | *0.02* | *0.03* | *a* | *0.02* | *0.03* |
| Economically inactive | | | | | | | |
| | Risk ratio | [1.00] | 1.07 | 0.95 | 0.98 | 0.97 | 0.94 |
| | *Standard error of the ratio* | *[1.00]* | *0.12* | *0.11* | *0.11* | *0.12* | *0.10* |
| *Bases (weighted)* | | | | | | | |
| *Employed* | *16406* | *746* | *116* | *10* | *167* | *66* | |
| *Economically inactive* | *4838* | *245* | *78* | *39* | *121* | *116* | |
| *Bases (unweighted)* | | | | | | | |
| *Employed* | *160* | *170* | *103* | *a* | *101* | *68* | |
| *Economically inactive* | *[46]* | *60* | *65* | *91* | *63* | *127* | |

The sample base for ILO unemployed and retired informants is too small for results to be shown.

[a] The sample base for these categories is too small for the results to be shown.

Table 5.10

# Age-standardised risk ratios for scores on the summary physical health indicator from the SF12, by CIS-R score

| Age-standardised risk ratios for scores on the summary physical health indicator | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| CIS-R score between 0 and 11 | | | | | | |
| Risk ratio | 1.00 | 1.03 | 0.95 | 0.85 | 0.94 | 0.87 |
| *Standard error of the ratio* | *1.00* | *0.02* | *0.03* | *0.03* | *0.03* | *0.02* |
| *CIS-R score 12 or more* | | | | | | |
| Risk ratio | 1.00 | 0.93 | 0.93 | 0.86 | 0.96 | 0.80 |
| *Standard error of the ratio* | *1.00* | *0.04* | *0.05* | *0.05* | *0.06* | *0.04* |
| *Bases (weighted)* | | | | | | |
| *CIS-R score between 0 and 11* | *23239* | *940* | *197* | *44* | *261* | *163* |
| *CIS-R score 12 or more* | *7321* | *393* | *87* | *20* | *108* | *62* |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score between 0 and 11* | *224* | *211* | *171* | *99* | *148* | *169* |
| *CIS-R score 12 or more* | *71* | *93* | *74* | *50* | *64* | *70* |

Table 5.11

## Proportion providing informal care to someone other than a child, by sex

| Proportion providing informal care | Ethnic group | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Men** | | | | | | | |
| | Yes, in this household | 3 | 5 | 6 | 11 | 12 | 13 |
| | Yes, in another household | 12 | 11 | 10 | 6 | 10 | 9 |
| | No | 85 | 85 | 84 | 83 | 77 | 79 |
| **Women** | | | | | | | |
| | Yes, in this household | 6 | 7 | 7 | 12 | 13 | 16 |
| | Yes, in another household | 16 | 19 | 13 | 7 | 10 | 11 |
| | No | 77 | 74 | 79 | 81 | 77 | 73 |
| **Total** | | | | | | | |
| | Yes, in this household | 5 | 6 | 7 | 12 | 12 | 15 |
| | Yes, in another household | 14 | 15 | 12 | 6 | 10 | 10 |
| | No | 81 | 79 | 81 | 82 | 77 | 76 |

*Bases (weighted)*

| | | | | | | |
|---|---|---|---|---|---|---|
| *Men* | *36744* | *1456* | *330* | *134* | *565* | *344* |
| *Women* | *49129* | *1840* | *484* | *137* | *588* | *375* |
| *Total* | *85873* | *3296* | *814* | *271* | *1153* | *718* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *364* | *328* | *276* | *310* | *314* | *335* |
| *Women* | *468* | *400* | *409* | *335* | *326* | *383* |
| *Total* | *832* | *728* | *685* | *645* | *640* | *718* |

Table 5.12

## Age-standardised risk ratios for scores on the CIS-R and the summary physical health indicator, by caring status

| **Age-standardised risk ratios** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| **CIS-R score** | | | | | | | |
| Non-carers | | | | | | | |
| Risk ratio | 1.00 | | 1.00 | 1.11 | 1.00 | 1.09 | 1.27 |
| *Standard error of the ratio* | *1.00* | | *0.06* | *0.07* | *0.08* | *0.08* | *0.09* |
| Carers | | | | | | | |
| Risk ratio | 1.00 | | 1.01 | 0.92 | 0.79 | 0.88 | 1.13 |
| *Standard error of the ratio* | *1.00* | | *0.12* | *0.11* | *0.11* | *0.10* | *0.13* |
| *Bases (weighted)* | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Non-carers* | *52071* | *2118* | *470* | *122* | *599* | *354* | |
| *Carers* | *13284* | *571* | *122* | *33* | *199* | *117* | |
| *Bases (unweighted)* | | | | | | | |
| *Non-carers* | *507* | *456* | *396* | *286* | *343* | *377* | |
| *Carers* | *127* | *129* | *102* | *71* | *116* | *111* | |
| **Summary physical health indicator** | | | | | | | |
| Non-carers | | | | | | | |
| | Risk ratio | 1.00 | 1.00 | 0.94 | 0.85 | 0.96 | 0.85 |
| | *Standard error of the ratio* | *1.00* | *0.03* | *0.03* | *0.03* | *0.03* | *0.03* |
| Carers | | | | | | | |
| | Risk ratio | 1.00 | 1.02 | [0.90] | [0.87] | 0.88 | 0.86 |
| | *Standard error of the ratio* | *1.00* | *0.04* | *[0.07]* | *[0.05]* | *0.06* | *0.04* |
| *Bases (weighted)* | | | | | | | |
| *Non-carers* | *22393* | *1002* | *223* | *47* | *266* | *163* | |
| *Carers* | *7841* | *321* | *55* | *16* | *101* | *59* | |
| *Bases (unweighted)* | | | | | | | |
| *Non-carers* | *215* | *227* | *194* | *109* | *151* | *183* | |
| *Carers* | *77* | *74* | *47* | *39* | *59* | *53* | |

# 6 Use of services

*Keith Lloyd and Elizabeth Fuller*

## 6.1 Introduction

Diagnosis and treatment of mental health problems largely occurs within primary care services, with fewer than one in ten patients being referred to specialist psychiatric care. This is the model recommended by the Department of Health's National Service Framework.[1,2]

Ethnic groups differ in their patterns of usage and the nature of their interactions with the primary care and specialist psychiatric services.[3] These differences exist in the rates of GP consultation, both in general and specifically for psychological problems,[4] as well as in relation to whether psychological problems are recognised, how they are diagnosed and what treatment individuals are offered.[5,6,7,8,9,10,11] Odell et al[7] argued that the needs of Black patients are different from those of non-Black patients and this may often go unrecognised. In general patients from ethnic minorities are more likely than White patients to be critical of their experience of primary care.[12]

Similarly, different groups have varying experiences of specialist psychiatric services.[13] Black patients are more likely than non-Black patients to be in contact with the police or prison services before admission and to be admitted to hospital under a section of the Mental Health Act. Overall there is evidence of more coercive treatment for people of African Caribbean origin.[14,15] Ethnic minorities are less likely to receive psychotherapy.[16]

Considerable attention has been given to why this should be so. How services are used and experienced by individuals from different groups is a product of their own beliefs, needs and expectations, but also of the attitudes and perceptions of service providers. These different perspectives may in turn influence research data, according to whether they are collected from doctors or patients.[4,17,18]

Two large community surveys have attempted to overcome the methodological limitations of smaller studies. The 1999 Health Survey of England[4] estimated annual rates of GP consultations and hospital visits among different ethnic groups. The predecessor of the present survey reported a clear relationship between psychiatric morbidity and increased GP consultation for all ethnic groups.[18,19]

## 6.2 Measures

The study asked informants when they had last seen a doctor on their own account, and subsequent questions referred to the six months preceding interview. Consequently these data do not provide estimates of absolute numbers of visits or of the relative use of different types of doctor or services over time, but rather provide a snapshot of service use.

Questions were abstracted from the Short Explanatory Model Interview.[20] Explanatory models (EMs) denote the 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process'.[21] They contribute to the research of informants' own perspectives of illness and elicit local cultural perspectives of the sickness episode. These include beliefs concerning the aetiology of the illness, its course, the timing of symptoms, the meaning of sickness, its diagnosis and the methods of treatment, and roles and expectations of the individuals involved in the process.

Epidemiological and health service research aims at understanding not only the distribution and determinants of disease but also illness-related behaviours, use of services and patient satisfaction. EMs are likely to play an important role in the last three objectives. In order to be employed in fieldwork such measures should be brief, standardised and reliable. The Short Explanatory Model Interview (SEMI) meets these criteria, and items from it were included in the pilot stage of this research. Constraints of time and length led to these being further reduced in number for the final interview.

## 6.3 **Recent doctor consultations**

### 6.3.1 **Sex and age**

Ethnic groups differed in their consultation rate, and women in every group were more likely than men to have spoken to a doctor within the last six months. Bangladeshi individuals were the most likely to have seen or spoken to a doctor within that time (77% of men, 85% of women), and White individuals were the least likely to have done so (56% of men, 71% of women). When age differences between ethnic groups were corrected, South Asian men, and Bangladeshi and Pakistani women were more likely than other groups to have spoken to a doctor within the last six months. (Table 6.1)

As Table 6.2 shows, age was related to the likelihood of having seen a doctor within the last six months. Consultation levels were particularly high among both men and women in the oldest South Asian and Black Caribbean groups  as high as 98% of Bangladeshi men, and 97% of Bangladeshi and Pakistani women aged 55 and over, compared to 70% of White people in the same age group.

Among South Asian and Black Caribbean men and South Asian women, the likelihood of having visited a doctor within the last six months increased with age. For White and Irish men and Irish and Black Caribbean women, this increase was only apparent for those aged over 55. Among White women it was those in the youngest age group who were most likely to have visited a doctor, with a dip in middle age.

In all groups, differences between the sexes were limited to younger age groups: this may be related to childbearing and contraception (not within the scope of this analysis). To some extent this might also explain the age pattern within groups, a clear increase for men in all ethnic groups, with a more complex pattern for women in the White, Irish and Black Caribbean groups. (Table 6.2)

### 6.3.2 **Migration status**

Table 6.3 shows the differences between those who were born in the UK or arrived when aged 11 or younger (non-migrant) and those who migrated when aged 12 or over (migrant). The table is restricted to those aged under 55 to minimise age differences between the migrant and non-migrant groups, and excludes White informants.

For the Asian groups, migrant status was associated with an increased consultation rate, 9% to 14% higher than that of non-migrants. This was not the case for the Irish and Black Caribbean groups. (Table 6.3)

### 6.3.3 **Socio-economic status**

Two socio-economic indicators were associated with the level of consultation among some groups, but not in a consistent way.

Table 6.4 shows the differences between manual and non-manual classes (based on the occupation of the head of household). Significant differences existed within the Irish and Black Caribbean groups, with those from manual classes more likely to have visited the doctor in the last six months (73% in the Irish group and 75% in the Black Caribbean group, compared to 63% and 62% respectively in non-manual classes). This difference was not apparent for White or South Asian individuals. (Table 6.4)

Two types of employment status are compared in Table 6.5. This shows the rate of consultation for those in employment and those who were economically inactive (but not retired). There were too few retired people or those meeting the ILO criteria for unemployment to analyse, and these categories are not shown.

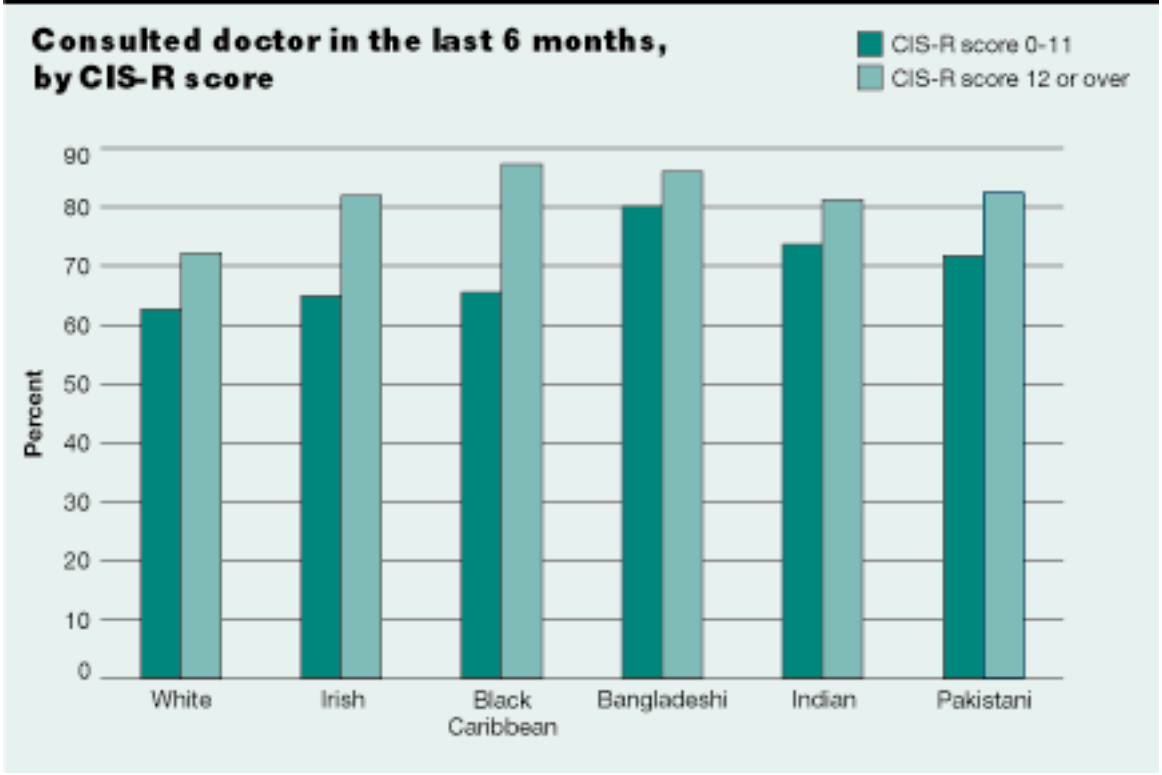
Individuals in all minority groups were more likely to have visited a doctor within the last six months if they were economically inactive. The greatest disparity was in the Irish group, where 83% of the economically inactive had seen a doctor, compared to 62% of those in employment. Among Irish, Indian and Pakistani informants, this difference was seen in both men and women; for the Black Caribbean and Bangladeshi groups it was limited to women (data for men and women not shown separately). (Table 6.5)

### 6.3.4 **CIS-R score**

A CIS-R score of 12 or more indicates the likely presence of one of the common mental disorders (see Chapter 2). In all minority groups, at least four in five of those with a CIS-R score of 12 or more had seen a doctor in the last six months.

Among the Irish, Black Caribbean and Pakistani groups a CIS-R score of 12 or more was associated with an increased likelihood of having seen a doctor. There was no such difference for Bangladeshi individuals overall. The proportion of Bangladeshi men and women with a CIS-R score of 12 or more was relatively low, and yielded bases too small for confident analysis. That acknowledged, it seems that Bangladeshi men  though not Bangladeshi women  are more likely to visit a doctor if they have a high CIS-R score.
(Table 6.6, Figure 6.1)

Figure 6.1




## 6.4 **Type of doctor seen**

Table 6.7 shows the percentage of each group who had seen GPs and other types of doctor in the last six months. The proportion of each group consulting a GP ranged from 58% of the White group to 75% of the Bangladeshi group. A minority in all groups saw other types of doctor (mainly hospital doctors), from 12% of Bangladeshi informants to 24% of White informants. Overall, Asian men and women differed from other ethnic groups, in that they were more likely to have seen a GP and less likely to have seen a hospital doctor (Black Caribbean men also had a comparatively low rate of hospital consultations).
(Table 6.7)

Individuals scoring 12 or more on the CIS-R scale were not only more likely to have seen a doctor in the last six months, but also were much more likely to have seen a doctor other than their GP. (See Table 6.8, where all visits other than to a GP have been combined into a single category.)

Irish, Black Caribbean, Indian and Pakistani individuals with a higher score were also more likely than other groups to have seen their GP during this time. (Table 6.8)

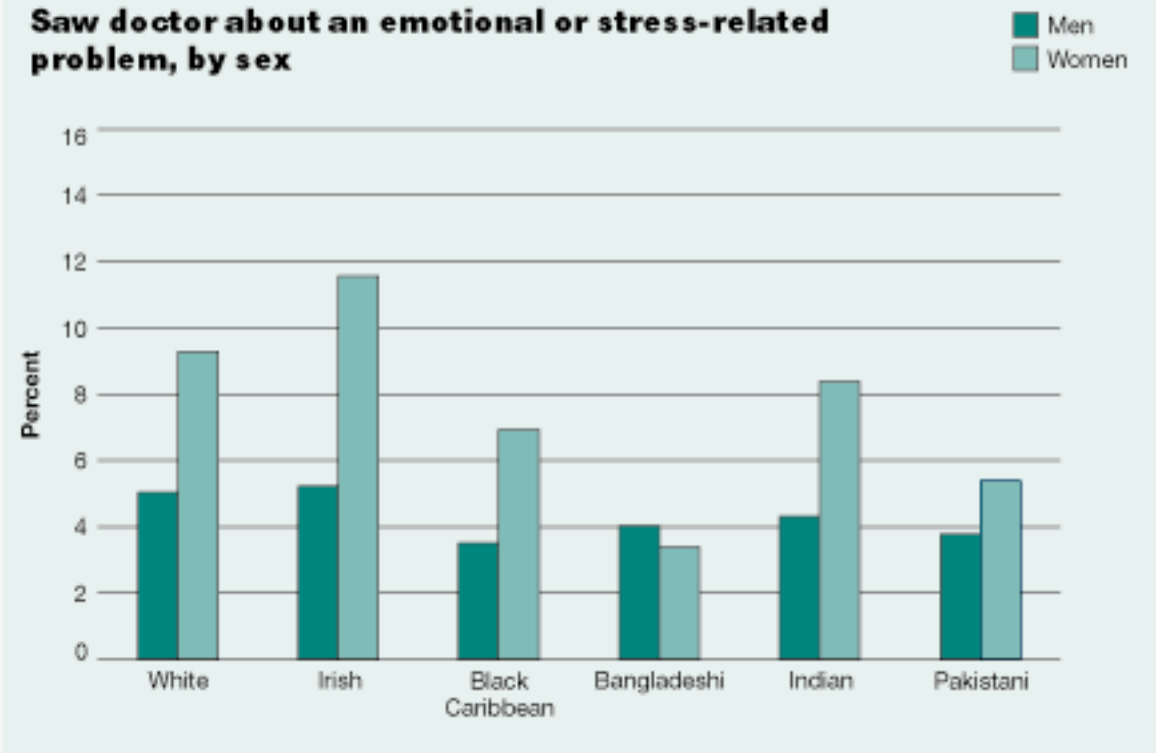
## 6.5 **Reasons for seeing a doctor**

Informants were asked to choose from a list of reasons for their most recent consultation: a physical problem, a stress-related or emotional problem or another reason. In contrast to the HSE 1999 and the FNS,[4,18] there was no explicit mention of symptoms such as anxiety, nervousness or depression. Almost all of those who chose 'other' gave a practical reason, such as the renewal of a prescription.

As Table 6.9 shows, physical problems greatly outnumbered stress-related and emotional ones in each group. Bangladeshi women were the most likely to have visited the doctor because of a physical

problem (82%), White men the least likely (49%). Bangladeshi women had the lowest rate of consultations (3%) for a stress-related or emotional reason; the highest level of consultations for that reason was among Irish women (12%).
(Table 6.9, Figure 6.2)

Figure 6.2

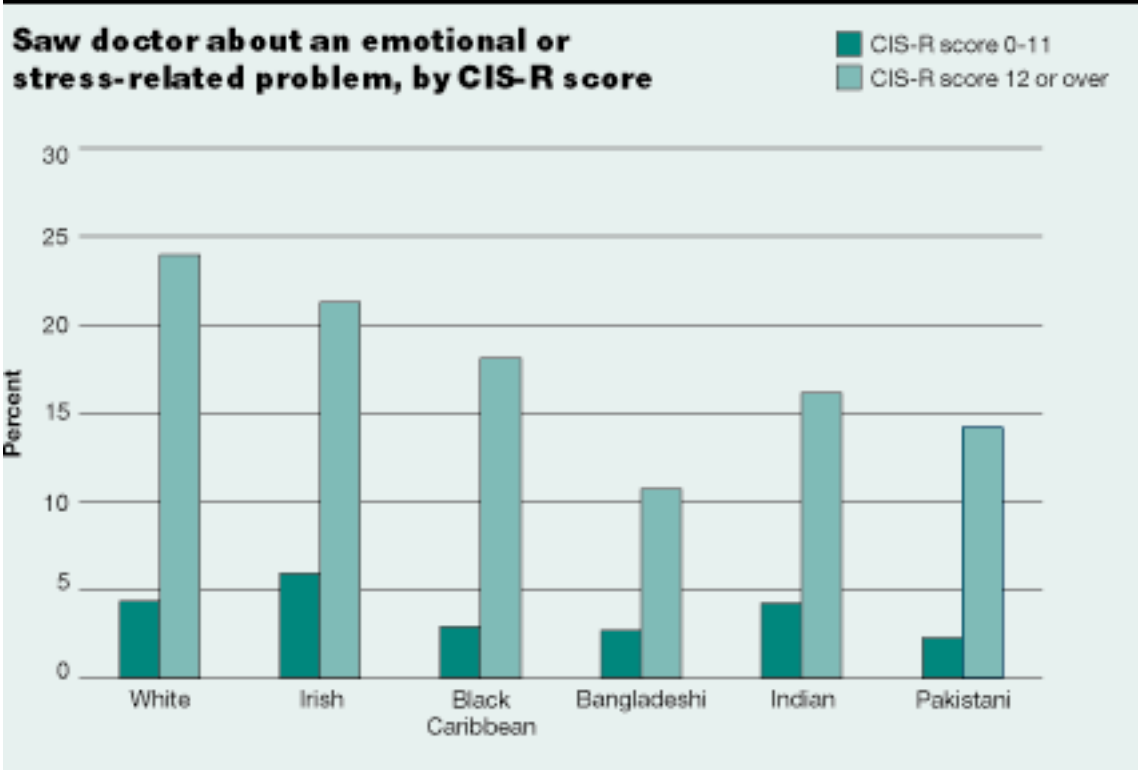



When age differences were corrected, Bangladeshi and Pakistani women were less likely to visit a doctor for a stress-related or emotional reason than were White women: this was especially true for Bangladeshi women. Other minority groups showed no real differences.
(Table 6.10)

Though individuals with a CIS-R score of 12 or above were more likely to visit a doctor than those with a score of 0 to 11, this was not fully reflected in the reasons they gave for their most recent visit. Compared to those with a score of 11 or below, individuals with a CIS-R score of 12 or more in all groups were much more likely to have visited a doctor for a stress-related or emotional reason (from 11% of Bangladeshi informants to 24% of White informants in the higher scoring category). But this was still a minority. In other words, even where individuals may have had a common mental disorder, they were still most likely to consult a doctor about a physical problem (from 71% of the White group to 92% of the Bangladeshi group; data not shown).

Table 6.11 also shows the differences between groups after standardisation for age. Among those with a higher CIS-R score, Bangladeshi and Black Caribbean informants were significantly less likely than White informants to have seen a doctor for stress-related or emotional reasons. (Table 6.11, Figure 6.3)

Figure 6.3




## 6.6 Other health problems

There is no evidence that significant numbers of individuals in any ethnic group saw themselves as having health problems for which they didn't seek help. Informants were asked if they had experienced a health problem in the last six months about which they had not seen a doctor, and, if they had, to state what type of problem it was. As Table 6.12 shows, while a minority in each group reported having such a problem but not consulting a doctor, these problems were few, and likely to be physical rather than stress-related or emotional in nature. (Table 6.12)

Having a stress-related or emotional problem, but not consulting a doctor about it, was strongly associated with a CIS-R score of 12 or more. Fewer than 1% in any group with a CIS-R score of 11 or less reported this. In all groups the proportion of those with score of 12 or more who said they had experienced a stress-related or emotional problem which they had not discussed with a doctor was greater, ranging from 3% of the Bangladeshi group to 11% of the Irish group. (Table 6.13)

## 6.7 Use of other health services

Two questions focused on a range of other health services, including clinics, nursing and other support services. Table 6.14 shows the overall uptake of any of the fourteen services asked about, as well as two services specifically related to psychological well-being, a community psychiatric nurse and a counsellor or psychologist (see the note to Table 6.14 for a full list).

The higher levels of service use by women reflects both differences in their use of specific services and the inclusion in the list of services largely or mainly targeted at women: well-woman clinics, breast and cervical screening, and services directed at mothers of babies and children.

Service uptake within the last six months was highest among Irish women (34%), lowest among Bangladeshi men (8%).

The use of the community psychiatric nurse was very low among all groups (up to 2%). White, Irish and Black Caribbean women made most use of counsellors or psychologists, though, again, uptake was generally at very low levels (4% or below). (Table 6.14)

Table 6.15 shows the uptake of these services among those scoring 12 or more on the CIS-R scale. Black Caribbean individuals were the most likely to have seen a community psychiatric nurse (6%), while use of a counsellor or psychologist was highest among the White, Irish and Black Caribbean groups (9% to 11%). (Table 6.15)

## 6.8 Conclusions

Higher consultation levels were associated with female gender, increasing age, Asian ethnicity, being economically inactive (though not retired), and a CIS-R score of 12 or more (indicating the presence of a common mental disorder). Other factors were important for specific groups. For the Asian group, but not the Irish and Black Caribbean groups, those who had migrated to the UK after the age of 11 had higher consultation rates. Informants in manual rather than non-manual social classes (based on head of household) also had higher consultation rates, particularly Irish and Black Caribbean individuals.

The present survey confirmed ethnic differences in patterns of self-reported primary care consultation found in other studies. Bangladeshi men and women were most likely to report having consulted a general practitioner in the last six months. Bangladeshi informants were also least likely to report an emotional or stress-related problem and least likely to make use of health services other than a GP. Access to counsellors or psychologists was highest amongst the White, Irish and Black Caribbean groups. Age-related variations in rates of consultation require further exploration, as do the relationships between gender, ethnicity and socio-economic status.

White informants were significantly more likely (and Black Caribbean, Bangladeshi, Indian and Pakistani informants significantly less likely) than other groups to report having attended the GP for a stress-related or emotional problem in the last six months. Less than a quarter of those who were cases on the CIS-R scale reported having seen a doctor for a stress-related or emotional problem in the last six months.

The associations between common mental disorders and service use are well documented. In the present study, common mental disorders, as assessed by the CIS-R, were associated with increased likelihood of having seen a doctor for people within the Irish, Black Caribbean and Pakistani groups, and among Bangladeshi men. However relatively few Bangladeshi men or women registered a CIS-R score of 12 or more, so the bases for these latter two groups were too small for confident inference.

There were significant ethnic differences in self-diagnosis which require clarification, for example, the high level of physical problems reported by the Bangladeshi group. This may reflect actual levels of morbidity or differing explanatory models, or it may be an artefact of the questionnaire design. A minority only of people who were cases on the CIS-R scale considered themselves to have consulted for an emotional or stress-related problem, and an even smaller group reported such a problem for which they had not sought medical help. This raises important questions about understanding of stress, access to services and the perceived value of consulting for emotional problems across ethnic groups.

Further analyses are necessary to clarify access to and use of services by different groups, for example why Bangladeshi women consult more frequently than other groups, and to examine cultural differences in illness-related perception and behaviour. Much has been written about developing culturally sensitive services and the development of core competencies for culturally aware psychiatrists. Further work is needed towards the development of services informed by users' views.

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# 6 Use of services

*Keith Lloyd and Elizabeth Fuller*

## Tables

Table 6.1

### Percent who spoke to a doctor, by sex

| When last spoke to a doctor | Ethnic group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | | |
| % | % | % | % | % | % | | | |
| Men | 56 | 63 | 62 | 77 | 73 | 68 | | |
| Women | 71 | 72 | 74 | 85 | 77 | 79 | | |
| **Age-standardised risk ratio for having visited doctor in last six months** | | | | | | | | |
| Male | | | | | | | | |
| | Risk ratio | 1 | 1.04 | 1.09 | 1.47 | 1.31 | 1.32 | |
| | *Standard error* | | | *.08* | *.08* | *.08* | *.08* | *.08* |
| Female | | | | | | | | |
| | Risk ratio | 1 | 1.04 | 1.04 | 1.23 | 1.08 | 1.17 | |
| | *Standard error* | | | *.04* | *.04* | *.04* | *.04* | *.04* |
| *Bases (weighted)* | | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |

Table 6.2

## Percent who saw a doctor in the last six months, by age and sex

| **Saw doctor in last six months** | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Men** | | | | | | | |
| | 16 to 34 | 50 | 54 | 43 | 66 | 61 | 60 |
| | 35 to 54 | 52 | 57 | 64 | 82 | 76 | 74 |
| | 55+ | 68 | 80 | 88 | 98 | 89 | [84] |
| **Women** | | | | | | | |
| | 16 to 34 | 81 | 72 | 72 | 79 | 71 | 71 |
| | 35 to 54 | 63 | 68 | 67 | 95 | 75 | 89 |
| | 55+ | 71 | 83 | 91 | [97] | 93 | [97] |
| **Total** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 16 to 34 | 67 | 65 | 59 | 73 | 66 | 66 |
| | 35 to 54 | 58 | 63 | 66 | 88 | 76 | 82 |
| | 55+ | 70 | 82 | 90 | 97 | 91 | 89 |
| *Bases (weighted)* | | | | | | | |
| *Men* | | | | | | | |
| | *16 to 34* | *10820* | *359* | *139* | *70* | *205* | *180* |
| | *35 to 54* | *16290* | *707* | *97* | *41* | *250* | *115* |
| | *55+* | *9963* | *393* | *98* | *24* | *110* | *51* |
| *Women* | | | | | | | |
| | *16 to 34* | *14599* | *584* | *182* | *89* | *237* | *232* |
| | *35 to 54* | *21063* | *855* | *204* | *37* | *249* | *115* |
| | *55+* | *13559* | *416* | *105* | *13* | *104* | *32* |
| *Total* | | | | | | | |
| | *16 to 34* | *25420* | *943* | *321* | *158* | *442* | *412* |
| | *35 to 54* | *37353* | *1561* | *301* | *79* | *500* | *230* |
| | *55+* | *23522* | *808* | *203* | *37* | *214* | *83* |
| *Bases (unweighted)* | | | | | | | |
| *Men* | | | | | | | |
| | *16 to 34* | *102* | *71* | *108* | *153* | *102* | *171* |
| | *35 to 54* | *166* | *164* | *86* | *96* | *148* | *117* |
| | *55+* | *100* | *94* | *86* | *63* | *65* | *49* |
| *Women* | | | | | | | |
| | *16 to 34* | *126* | *108* | *140* | *209* | *125* | *232* |
| | *35 to 54* | *205* | *196* | *184* | *94* | *147* | *119* |
| | *55+* | *138* | *100* | *90* | *35* | *56* | *36* |
| *Total* | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *16 to 34* | *228* | *179* | *248* | *362* | *227* | *403* |
| *35 to 54* | *371* | *360* | *270* | *190* | *295* | *236* |
| *55+* | *238* | *194* | *176* | *98* | *121* | *85* |

Table 6.3

## Percent who saw a doctor in the last six months, by migration status

| **Saw doctor in last six months** | **Ethnic group** | | | | |
|---|---|---|---|---|---|
| | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| *%* | *%* | *%* | *%* | *%* | |
| Migrated aged under 11 or born in UK | 65 | 63 | 71 | 67 | 66 |
| Migrated aged 11 or older | 59 | 61 | 85 | 76 | 80 |
| *Bases (weighted)* | | | | | |
| *Migrated aged under 11 or born in UK* | *2095* | *514* | *114* | *478* | *355* |
| *Migrated aged 11 or older* | *409* | *108* | *123* | *464* | *286* |
| *Bases (unweighted)* | | | | | |
| *Migrated aged under 11 or born in UK* | *440* | *424* | *248* | *270* | *356* |
| *Migrated aged 11 or older* | *99* | *94* | *304* | *252* | *283* |

Table 6.4

## Percent who saw a doctor in the last six months, by social class of Head of Household

| Saw doctor in last six months | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | |
| Non-manual | 63 | 63 | 62 | 78 | 74 | 70 |
| Manual | 65 | 73 | 75 | 82 | 76 | 74 |
| *Bases (weighted)* | | | | | | |
| *Non-manual* | *48156* | *1588* | *335* | *39* | *498* | *217* |
| *Manual* | *36755* | *1680* | *446* | *197* | *619* | *412* |
| *Bases (unweighted)* | | | | | | |
| *Non-manual* | *483* | *342* | *279* | *81* | *298* | *210* |
| *Manual* | *341* | *383* | *381* | *474* | *325* | *427* |

Table 6.5

## Percent who saw a doctor in the last six months, by employment status

| Saw doctor in last six months [a] | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |

| | | | | | | |
|---|---|---|---|---|---|---|
| | % | % | % | % | % | % |
| In employment | 61 | 62 | 63 | 73 | 71 | 65 |
| Economically inactive (not retired) | 66 | 83 | 74 | 83 | 80 | 79 |
| *Bases (weighted)* | | | | | | |
| *In employment* | *55692* | *2213* | *448* | *76* | *704* | *296* |
| *Economically inactive* | *13528* | *508* | *173* | *155* | *286* | *327* |
| *Bases (unweighted)* | | | | | | |
| *In employment* | *548* | *483* | *381* | *172* | *407* | *284* |
| *Economically inactive* | *120* | *116* | *146* | *372* | *145* | *339* |

[a]The sample bases for 'retired' and 'ILO unemployed' were too small for results to be shown.

Table 6.6

## Percent who saw a doctor in the last six months, by total CIS-R score

| **Saw a doctor in last six months** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| CIS-R score 0-11 | 63 | 65 | 66 | 80 | 74 | 72 |
| CIS-R score 12+ | 72 | 82 | 87 | 86 | 81 | 82 |
| *Bases (weighted)* | | | | | | |
| *CIS-R score 0-11* | *73414* | *2699* | *682* | *239* | *947* | *582* |
| *CIS-R score 12+* | *12880* | *614* | *144* | *35* | *209* | *142* |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score 0-11* | *714* | *596* | *568* | *572* | *520* | *576* |
| *CIS-R score 12+* | *123* | *137* | *126* | *78* | *123* | *148* |

Table 6.7

## Percent who have seen different types of doctor within the last six months, by sex

| Types of doctor seen in last six months[a] | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| GP | 50 | 58 | 57 | 70 | 67 | 63 |
| Hospital doctor in outpatients clinic | 18 | 23 | 14 | 9 | 15 | 14 |
| Hospital doctor as inpatient | 4 | 6 | 4 | 3 | 2 | 3 |
| Other | 2 | 2 | 2 | 1 | 2 | 2 |
| Did not see doctor in last six months | 44 | 37 | 38 | 23 | 27 | 32 |
| **Women** | | | | | | |
| GP | 65 | 65 | 66 | 80 | 73 | 74 |
| Hospital doctor in outpatients clinic | 23 | 18 | 23 | 11 | 13 | 13 |
| Hospital doctor as inpatient | 6 | 4 | 6 | 1 | 5 | 4 |
| Other | 2 | 1 | 3 | 2 | 1 | 2 |
| Did not see doctor in last six months | 29 | 28 | 25 | 15 | 23 | 21 |
| **Total** | | | | | | |
| GP | 58 | 62 | 62 | 75 | 70 | 69 |
| Hospital doctor in outpatients clinic | 20 | 20 | 19 | 10 | 14 | 13 |
| Hospital doctor as inpatient | 5 | 5 | 5 | 2 | 3 | 4 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Other | 2 | 1 | 2 | 1 | 1 | 2 |
| Did not see doctor in last six months | 36 | 32 | 29 | 18 | 25 | 24 |
| *Bases (weighted)* | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

[a]Multiple responses accepted.

Table 6.8

## Percent who saw a doctor in the last six months, by total CIS-R score

| **Types of doctor seen in last six months [a]** | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | *%* | *%* | *%* | *%* | *%* | *%* |
| CIS-R score 0-11 | | | | | | | |
| GP | 57 | 59 | 59 | 76 | 69 | 67 | |
| Other type of doctor | 22 | 20 | 21 | 9 | 16 | 14 | |
| CIS-R score 12+ | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| GP | 66 | 76 | 76 | 67 | 77 | 79 |
| Other type of doctor | 34 | 32 | 35 | 34 | 24 | 27 |
| *Bases (weighted)* | | | | | | |
| *CIS-R score 0-11* | *73414* | *2699* | *682* | *239* | *947* | *582* |
| *CIS-R score 12+* | *12880* | *614* | *144* | *35* | *209* | *142* |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score 0-11* | *714* | *596* | *568* | *572* | *520* | *576* |
| *CIS-R score 12+* | *123* | *137* | *126* | *78* | *123* | *148* |

[a] Multiple responses accepted.

Table 6.9

## Reasons why last saw doctor, by sex

| **Reason last saw doctor** [a] | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| Physical problem | 49 | 55 | 57 | 71 | 65 | 62 |
| Stress-related or emotional problem | 5 | 5 | 4 | 4 | 4 | 4 |
| Other reasons (eg repeat prescription) | 3 | 4 | 3 | 3 | 4 | 3 |
| Did not see doctor in last six months | 44 | 37 | 38 | 23 | 27 | 32 |
| **Women** | | | | | | |
| Physical problem | 58 | 59 | 64 | 82 | 64 | 71 |
| Stress-related or emotional | 9 | 12 | 7 | 3 | 8 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| problem | 9 | 12 | 7 | 3 | 8 | 3 |
| Other reasons (eg repeat prescription) | 6 | 7 | 5 | 2 | 5 | 3 |
| Did not see doctor in last six months | 29 | 28 | 25 | 15 | 23 | 21 |
| **Total** | | | | | | |
| Physical problem | 54 | 58 | 61 | 77 | 65 | 67 |
| Stress-related or emotional problem | 7 | 9 | 6 | 4 | 6 | 5 |
| Other reasons (eg repeat prescription) | 5 | 5 | 4 | 2 | 5 | 3 |
| Did not see doctor in last six months | 36 | 32 | 29 | 18 | 25 | 24 |
| *Bases (weighted)* | | | | | | |
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

[a] Multiple responses accepted.

Table 6.10

## Percent who last saw doctor because of a stress-related or emotional problem, by sex

| **Last saw doctor because of an emotional or stress-related problem** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *%* | *%* | *%* | *%* | *%* | *%* | | | |
| Men | 5 | 5 | 4 | 4 | 4 | 4 | | |
| Women | 9 | 12 | 7 | 3 | 8 | 5 | | |
| **Age-standardised risk ratio for having visited doctor for a stress-related or emotional problem in last six months** | | | | | | | | |
| Male | | | | | | | | |
| | Risk ratio | 1 | 1.09 | .76 | .58 | 1.01 | 1.10 | |
| | *Standard error* | | | *.42* | *.32* | *.23* | *.35* | *.39* |
| Female | | | | | | | | |
| | Risk ratio | 1 | 1.06 | .71 | .29 | .97 | .60 | |
| | *S*tandard error | | | .24 | .17 | .10 | .23 | .16 |
| Bases (weighted) | | | | | | | | |
| CIS-R score 0-11 | 73414 | 2699 | 682 | 239 | 947 | 582 | | |
| CIS-R score 12+ | 12880 | 614 | 144 | 35 | 209 | 142 | | |
| Bases (unweighted) | | | | | | | | |
| CIS-R score 0-11 | 714 | 596 | 568 | 572 | 520 | 576 | | |
| CIS-R score 12+ | 123 | 137 | 126 | 78 | 123 | 148 | | |

Table 6.11

## Percent who last saw doctor because of a stress-related or emotional problem, by total CIS-R score

| **Last saw doctor because of an emotional or stress-related problem** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **CIS-R score 0-11** | | | | | | |
| Stress-related or emotional problem | 4 | 6 | 3 | 3 | 4 | 2 |
| **CIS-R score 12+** | | | | | | |
| Stress-related or emotional problem | 24 | 21 | 18 | 11 | 16 | 14 |
| **Age-standardised risk ratio for having visited doctor for a stress-related or emotional problem in last six months** | | | | | | |
| CIS-R score 0-11 | | | | | | |
| Risk ratio | 1 | 1.16 | .74 | .41 | 1.09 | .66 |
| Standard error | | .33 | .23 | .14 | .30 | .21 |
| CIS-R score 12+ | | | | | | |
| Risk ratio | 1 | .80 | .58 | .47 | .72 | .67 |
| Standard error | | .20 | .14 | .16 | .18 | .17 |
| *Bases (weighted)* | | | | | | |
| *CIS-R score 0-11* | *73414* | *2699* | *682* | *239* | *947* | *582* |
| *CIS-R score 12+* | *12880* | *614* | *144* | *35* | *209* | *142* |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score 0-11* | *714* | *596* | *568* | *572* | *520* | *576* |
| *CIS-R score 12+* | *123* | *137* | *126* | *78* | *123* | *148* |

Table 6.12

## Type of health problem experienced in the last six months which individual did not see doctor about, by sex

| Type of health problem experienced, but doctor not seen | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| Physical problem | 16 | 17 | 17 | 11 | 13 | 12 |
| Stress-related or emotional problem | 2 | 3 | 2 | 1 | 1 | 1 |
| *Base (weighted)* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Base (unweighted)* | *837* | *733* | *694* | *650* | *643* | *724* |

Table 6.13

## Percent who had a stress-related or emotional problem in last six months, but did not see doctor about it, by total CIS-R score

| Experienced stress-related, or emotional problem, but doctor not seen | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| CIS-R score 0-11 | 1 | 1 | 1 | 0 | 1 | 1 |
| CIS-R score 12+ | 6 | 11 | 8 | 3 | 4 | 4 |

*Bases (weighted)*

| | | | | | | |
|---|---|---|---|---|---|---|
| *CIS-R score 0-11* | *73414* | *2699* | *682* | *239* | *947* | *582* |
| *CIS-R score 12+* | *12880* | *614* | *144* | *35* | *209* | *142* |
| *Bases (unweighted)* | | | | | | |
| *CIS-R score 0-11* | *714* | *596* | *568* | *572* | *520* | *576* |
| *CIS-R score 12+* | *123* | *137* | *126* | *78* | *123* | *148* |

Table 6.14

## Health-related services used in last six months, by sex

| **Health services used in last six months**[a] | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Men** | | | | | | |
| Any service | 20 | 23 | 14 | 8 | 17 | 12 |
| Community psychiatric nurse | 1 | 1 | 0 | 1 | 1 | - |
| Counsellor/psychologist | 2 | 1 | 1 | 0 | 1 | 1 |
| **Women** | | | | | | |
| Any service | 30 | 34 | 29 | 13 | 26 | 21 |
| Community psychiatric nurse | 1 | 1 | 2 | 1 | 1 | 1 |
| Counsellor/psychologist | 3 | 3 | 4 | 1 | 2 | 2 |
| **Total** | | | | | | |
| Any service | 25 | 28 | 23 | 11 | 21 | 17 |
| Community psychiatric nurse | 1 | 1 | 1 | 1 | 1 | 0 |
| Counsellor/psychologist | 3 | 3 | 3 | 1 | 1 | 2 |
| *Bases (weighted)* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Men* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| *Women* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Total* | *86295* | *3313* | *825* | *274* | *1156* | *724* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *368* | *329* | *280* | *312* | *315* | *337* |
| *Women* | *469* | *404* | *414* | *338* | *328* | *387* |
| *Total* | *837* | *733* | *694* | *650* | *643* | *724* |

[a] Services asked about: Child health/baby clinic, Well woman clinic, Travel vaccination clinic, Practice based nurse, District nurse, Midwife, Health visitor, Community psychiatric nurse, Physiotherapist, Chiropodist, Dietician, Counsellor/psychologist, Cervical screening, Breast screening. Multiple responses accepted.

Table 6.15

## % saw community psychiatric nurse or a counsellor or psychologist in the last six months (based on CIS-R score of 12 or more)

Base:CIS-R score = 12+

| **Saw community psychiatric nurse or counsellor/psychologist in last six months[a]** | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **CIS-R score 12+** | | | | | | |
| Community psychiatric nurse | 4 | 4 | 6 | 3 | 2 | 1 |
| Counsellor/psychologist | 11 | 9 | 11 | 2 | 5 | 4 |
| *Bases (weighted)* | *12880* | *614* | *144* | *35* | *209* | *142* |
| *Bases (unweighted)* | *123* | *137* | *126* | *78* | *123* | *148* |

[a] Multiple responses accepted.

# 7 Social support and networks

*Stephen Stansfeld and Kerry Sproston*

## 7.1 Introduction

There are many studies that demonstrate that being integrated into social networks and receiving high levels of social support are important for mental health and well-being.[1] The number of social contacts, both close and not so close, is related to higher levels of well-being. Within relationships, different types of support from different sources may benefit health. These types of support include emotional, practical and informational support.[2] On the other hand, close relationships may be stressful as well as stress-relieving, and high levels of negative interaction within relationships increase the risk of mental ill health.

Two pathways for the influence of social support on health have been postulated, 'direct' effects and 'buffering' effects. The direct pathway implies that high levels of social support and social contact act to improve levels of well-being, or enhance self appraisal and self esteem, positively influencing mental health.[3] The buffering hypothesis implies that social support only influences health in the context of exposure to acute or chronic stressors.[4] In this situation, persons exposed to stressors are helped, either in reappraising the threat implicated in the stressor, or in coping with the consequences of the stressor through emotional, informational or material support.

As lack of social support has been aetiologically linked to common mental disorder, it is possible that differing patterns of support might contribute to the explanation of differences between ethnic groups in rates of mental disorder. For example, it has been suggested that the fact that South Asian people in the UK show relatively low rates of common mental disorder, in spite of the high levels of social disadvantage faced by ethnic minority groups, is a consequence of the extended social support networks characteristic of Asian culture, which may be protective of mental health.[5,6] Others have criticised the stereotyped basis of this theory.[7] Close social relationships are not always beneficial to health, as there may be scope for conflict as well as support. Analyses of immigrant mortality statistics show that mortality rates from suicide are higher among young women of South Asian origin, and that this is particularly the case for young women (aged 15 to 24) where the rate is two to three times the national average.[8] Further analyses have suggested that the high rates are restricted to those born in India and East Africa.[9] It is possible that intense close relationships in these families coupled with intergenerational cultural conflicts might increase suicidal risk in these young women.[10]

This study allows an examination of levels of support across different ethnic groups and the opportunity to investigate whether this contributes to differences in psychiatric morbidity.

## 7.2 Measures

Social support has been measured in this study using the Close Persons Questionnaire, developed in

the Whitehall II Study of British Civil Servants.[11] This study employed a briefer version of the original questionnaire, measuring confiding/emotional support (seven items), practical support (four items) and the negative aspects of close relationships (four items). This version of the Close Persons Questionnaire asks about support received over the previous twelve months from two sources of support nominated by the informant  the two people they feel are closest to them. The measures reported here are taken only from responses concerning the closest person. The constituent items of each of the sub-scales are included in the Appendix A of this report. Two example questions are shown below:

Thinking about the person you are closest to, please tell us how you would rate the practical and emotional support they have provided for you in the last 12 months.

How much in the last 12 months did this person give you information, suggestions and guidance that you found helpful? Please take your answer from this card:

Not at all

A little

Quite a lot

A great deal.

How much in the last 12 months could you rely on this person (was this person there when you needed him/her)? Please take your answer from this card:

Not at all

A little

Quite a lot

A great deal.

Social Networks were measured by questions developed from the Alameda County Study.[12] These include the number of face to face contacts with friends and relatives during the last month, and the frequency of contact with friends and relatives, either face to face or by telephone and letter, in the last month. The questions are included in the Appendix A of this report. Results are presented in this chapter as mean numbers of relatives and friends seen in the last month.

## 7.3 **Social support**

### 7.3.1 **Sex and age**

Low levels of confiding/emotional support and practical support were most evident in the Black Caribbean group. At the other end of the spectrum, Bangladeshi men and women were by far the least likely to report low levels of practical support, and were, along with the Pakistani group, the least likely to report low levels of confiding/emotional support. However, the Bangladeshi group was also by far the most likely to report high levels of negative aspects of close relationships, with Indian, Pakistani and Black Caribbean people reporting moderate levels, and the White and Irish groups the lowest. (Table 7.1)

For all ethnic groups, low levels of confiding/emotional support from the closest person were more evident among men than women. There was very little difference between the sexes on the measure of

practical support, and the pattern for negative aspects of close relationships was relatively complicated. Among the White, Irish and Pakistani groups, women were more likely than men to report negative aspects, while there was no sex difference among the remaining ethnic groups. (Table 7.1)

There was no systematic pattern of association between social support and age across the different ethnic groups. Among White, Irish and Black Caribbean informants, the lowest levels of confiding/emotional support were found in the oldest age group. Among the Indian group, this pattern was reversed, while in the remaining groups there was little association with age. In terms of negative aspects of close relationships, the oldest group of White, Irish, Black Caribbean and Pakistani people were the least likely to report this. There was no real age difference among the remaining two groups. (Table 7.2)

Since there were some differences associated with age, and since the age distribution of the ethnic groups varied, age-standardised analysis was carried out on the social support measures. Table 7.3 shows that differences between ethnic groups remained after age was taken into account. Black Caribbean men and women were significantly more likely than the White comparison group to report low levels of confiding/emotional support, and Black Caribbean men were also significantly more likely than White men to report high negative aspects of close relationships. This pattern was not replicated in the practical support measure, where the only significant results were that Bangladeshi men and women, along with Irish women, reported better levels of practical support than their White counterparts. On the other hand, Bangladeshi men and women were more likely than the white group to report negative aspects, and this was also true of the other two South Asian groups.

### 7.3.2 **Marital status**

Social support was, as might be expected, related to marital status (Table 7.4). For all ethnic groups, lower levels of confiding/emotional and practical support were found among single compared with married and cohabiting informants. For the White group, the lowest support on both measures was found among divorced and separated people. There was not a systematic pattern across ethnic groups. For example, the lowest level of support among Irish informants was reported, on both measures, by single people. Among Black Caribbean people, the lowest confiding/emotional support was found among the single group, while the lowest levels of practical support was evident among the divorced and separated group. The number of divorced people among the South Asian sample was too small for reliable estimates to be made. There was relatively little difference between the three marital status groups on the measure of negative aspects of close relationships, with single people, perhaps surprisingly, reporting high negative aspects, and in the case of White and Irish people, higher than that of the other two marital status groups. (Table 7.4)

### 7.3.3 **Age at migration**

Black Caribbean, Bangladeshi and Pakistani informants who were born in the UK or migrated at the age of 10 or younger, were more likely to report low levels of confiding/emotional support. The pattern associated with levels of practical support was more complicated. Irish informants who had moved to England aged 11 or older were more likely to report low levels of practical support, while the reverse was true for all the other ethnic minority groups. Irish informants who had moved to England aged 11 or over were also more likely to report high levels of negative aspects of close relationships, while, among the Pakistani group, this pattern was reversed. (Table 7.5)

### 7.3.4 **Degree of urbanisation**

The pattern of association with the degree of urbanisation of the informant's residence, as judged by the interviewer, differed between ethnic groups. Among the White, Irish and Black Caribbean groups, lower levels of both social support measures were found among those living in urban areas, although

the differences were not always large. For Indian informants, this pattern was reversed, with lower social support more evident among those living in suburban or rural areas. Among the Pakistani group, there was no clear pattern of association between the factors. (Table 7.6). Negative aspects of the closest relationship were more evident among those living in suburban/rural compared with urban areas for all except the Bangladeshi group, where the association was reversed.

### 7.3.5 **Social class**

Among the White and Irish groups, lower levels of confiding/emotional support and practical support were found among informants from a manual social class background. Among Bangladeshi informants, the pattern was the opposite, with those from a non-manual background more likely to report low levels of support on both measures. There was no difference between the two social class groups among Black Caribbean people, and there was no clear pattern of association among the remaining groups. As for the measure of negative aspects of the closest relationship, there were few clear differences between the two social class groups, with the exception of Bangladeshi informants, where the manual group was more likely to report negative aspects. (Table 7.7)

### 7.3.6 **Tenure**

The pattern of association with tenure was more complicated than that of social class. On the measure of confiding/emotional support, low levels were more common among informants who were renting their home for the Irish and Black Caribbean groups and this pattern was reversed for the Indian and Bangladeshi groups. Among the White, Irish and Indian groups, lower levels of practical support were found among renters, while among the Bangladeshi group, this pattern was reversed. The pattern of association with negative aspects of the closest relationship also varied across ethnic groups, and was notably high among those of Bangladeshi origin who were renting their home. (Table 7.8)

### 7.3.7 **Employment status**

There was fairly little difference in levels of confiding/emotional and practical support between the three employment status categories. Among the White, Irish and Black Caribbean groups, retired informants reported the lowest levels of emotional support, while there were few marked differences on the practical support measure. On the negative aspects of close relationships measure, the economically inactive tended to have the most problems. (Table 7.9)

### 7.3.8 **Common mental disorder**

Common Mental Disorder was dichotomised into low scorers, less than twelve on the CIS-R and high scorers, scoring twelve or more on the CIS-R. The distribution of types of social support by CIS-R score are reported in Table 7.10. Low confiding/emotional support differed fairly little and not in a consistent direction between low scorers and high scorers on the CIS-R. Among Irish and Black Caribbean groups, there tended to be lower levels of confiding/emotional support in low scorers on the CIS-R, while only Bangladeshi people showed significantly lower levels of confiding/emotional support among high CIS-R scorers. The same pattern among the Bangladeshi group was shown for low practical support, which was considerably more common in high scorers on the CIS-R. It is possible that the results for these two social support measures are more clear-cut in the Bangladeshi group because they are more homogenous than other groups with regard to marital status. The most notable finding was that there were higher negative aspects of close relationships in high CIS-R scorers for all groups except Bangladeshi people
(Table 7.10, Figures 7.1, 7.2, 7.3)

Figure 7.1

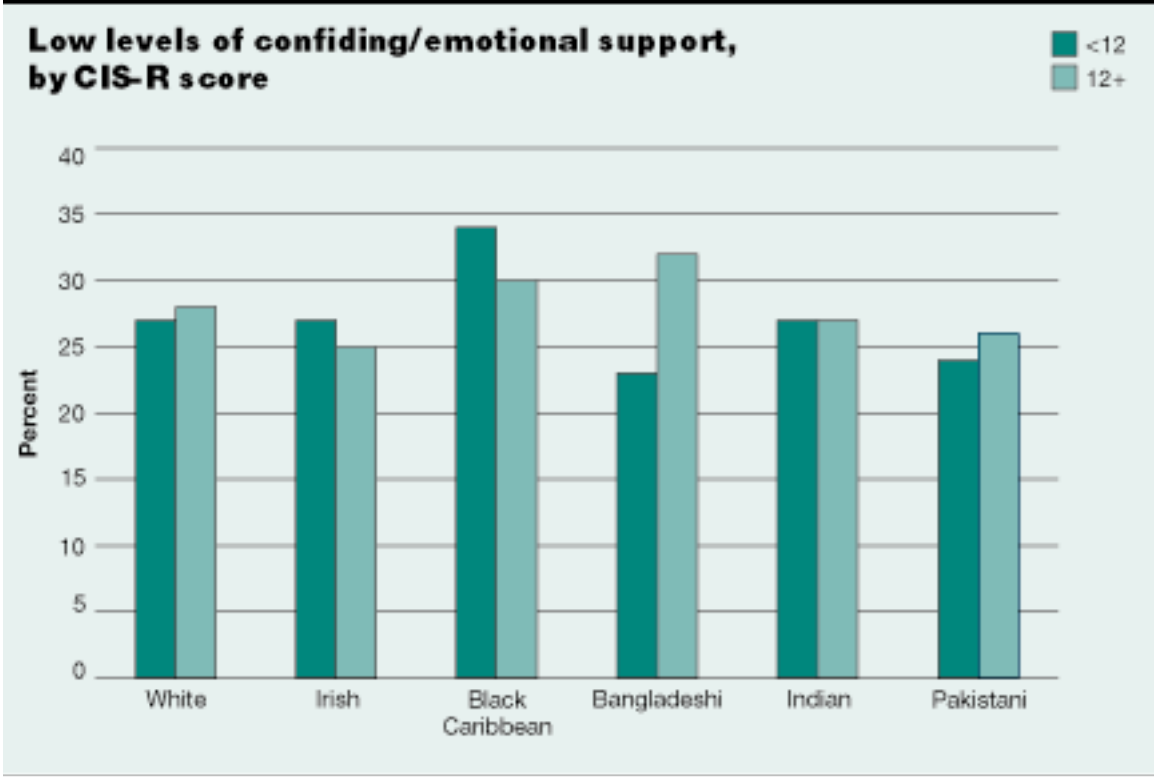



Figure 7.2

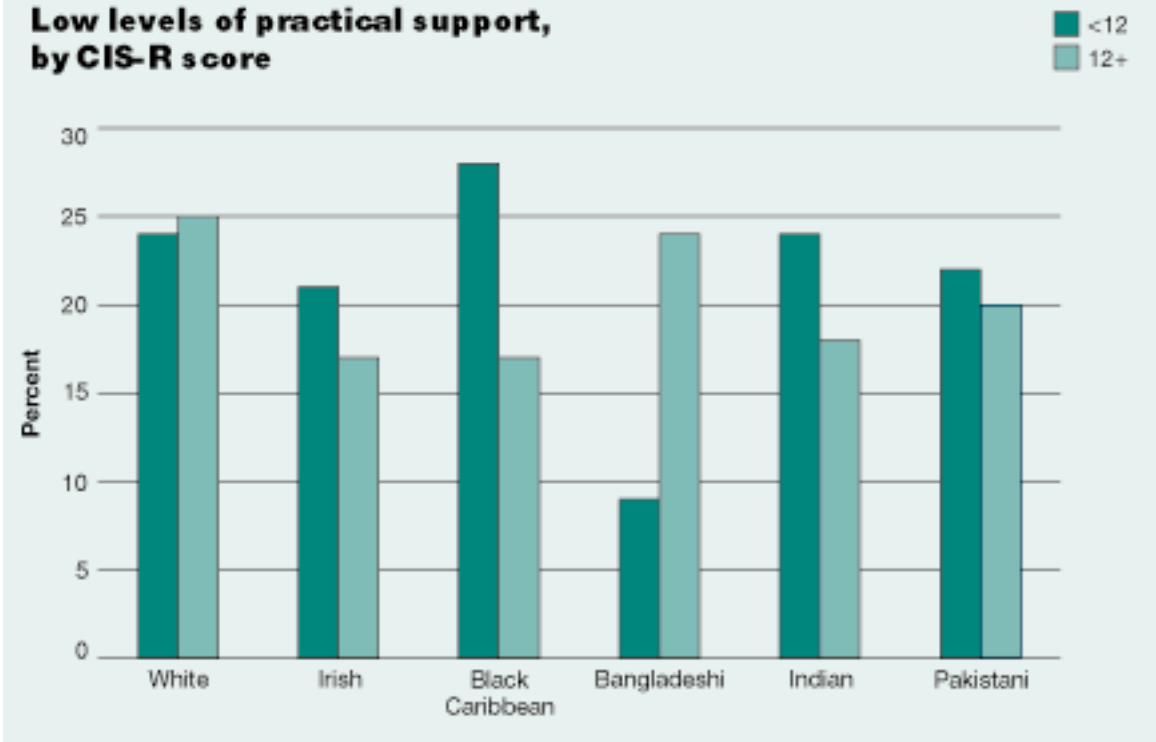
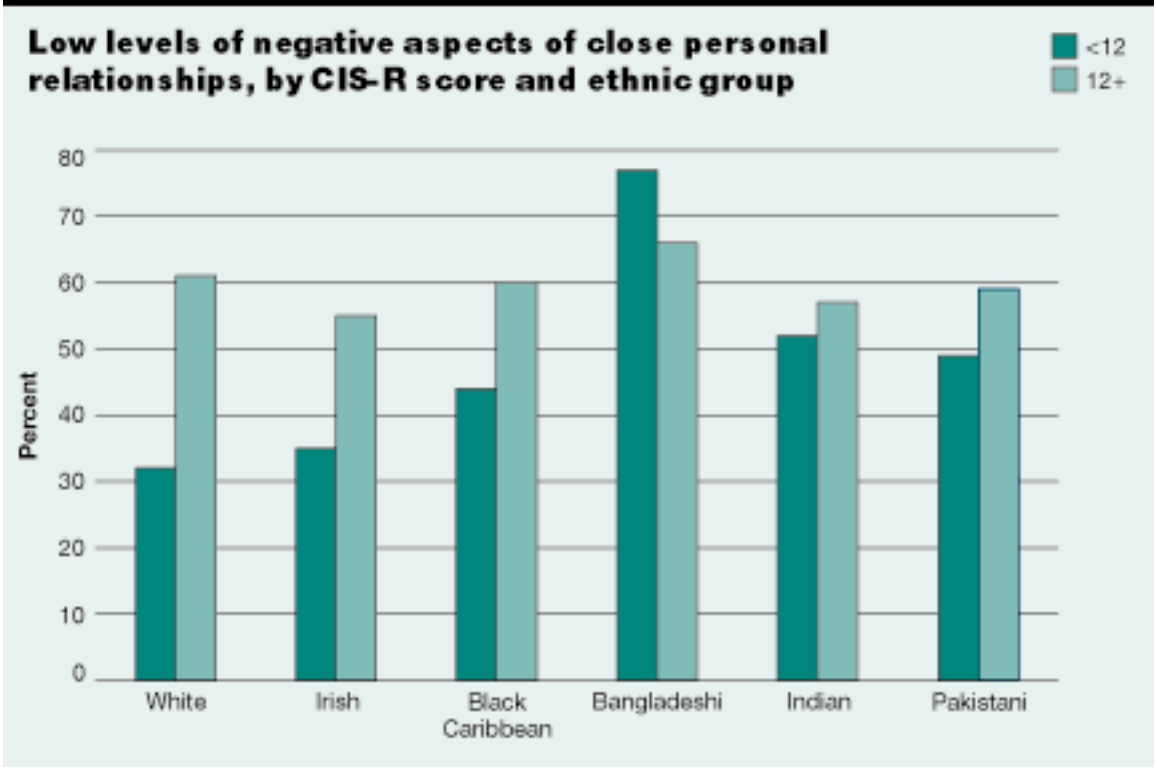


Figure 7.3




## 7.4 Social networks

### 7.4.1 Age and sex

Social networks were measured as numbers of friends and relatives outside the household seen by the informant during the previous month. Mean numbers of friends and relatives seen have been computed for each ethnic group. Informants in all ethnic groups saw a higher number of friends than relatives, and this finding was most marked among the White, Irish and Black Caribbean groups. White informants saw the highest number of friends, but the lowest number of relatives, while Bangladeshi informants saw the fewest friends and the Pakistani group saw the highest number of relatives. (Table 7.11)

Among women, the White, Irish and Black Caribbean groups saw more friends per month than the South Asian groups, among men there was less difference between ethnic groups, although Bangladeshi men saw the fewest friends. There was a tendency for women to see less friends per month than men, and this was particularly striking among the South Asian groups, especially those of Indian and Pakistani origin. (Table 7.11). There did appear to be a slight pattern of substitution, in that the South Asian groups, who tended to see the least friends, saw the most relatives.

There was no consistent association across ethnic groups between contact with friends and the informant's age. In most cases, the youngest informants tended to see the most friends, with the exception of the Black Caribbean and Bangladeshi groups. Among the oldest age group, Black Caribbean people saw the most friends, and Indian people saw the least. The oldest Indian group also saw a small number of relatives, but not as few as the White group. (Table 7.11)

In order to account for differences in the age distribution across ethnic groups, age-standardised relative risk ratios were calculated for the average number of relatives and friends seen in the last month. In terms of the number of friends seen, South Asian men and women, and Black Caribbean

women, saw significantly fewer than the White group. This pattern was reversed for the relatives measure, where the South Asian groups, and Black Caribbean women, saw more relatives per month than the White group. (Table 7.12)

### 7.4.2 **Marital Status**

Mean numbers of friends and relatives seen per month by marital status are reported in Table 7.13. In general, single informants tended to see more friends than the other two groups, with the exception of Black Caribbean informants. There was less difference between the three marital status groups in terms of the number of relatives seen per month. The number of divorced/separated informants in the South Asian groups was too small to allow reliable estimates. (Table 7.13)

### 7.4.3 **Age at migration**

There was a tendency for informants who were born in the UK, or who migrated at a young age, to have a greater number of friends and relatives who they saw regularly, as might be expected. This difference was most marked among the Pakistani and Indian groups. However, this pattern of association was not consistent across the board. Among the Black Caribbean group, it was those who had migrated aged 11 or over who saw the highest average number of friends. (Table 7.14)

### 7.4.4 **Degree of urbanisation**

Informants living in suburban or rural areas generally saw more friends and relatives per month than those living in an urban area. The only exception to this rule was among Indian informants, where those living in urban areas tended to see a slightly larger average number of relatives. (Table 7.15)

### 7.4.5 **Social Class**

Among White, Irish and Indian groups, more friends were seen per month in non-manual compared with manual groups. This is in keeping with findings in the Whitehall II study of British Civil Servants.[13] However, for Black Caribbean, Bangladeshi and Pakistani groups, higher mean numbers of friends were seen amongst manual compared with non-manual groups. Again, in keeping with the Whitehall II study White, Black Caribbean, and Pakistani groups, saw more relatives, on average, per month, in manual groups, than non-manual groups. Indian people were the exception to this. (Table 7.16)

### 7.4.6 **Employment status**

There was no systematic pattern of association between the number of friends seen and employment status. Irish, Indian and Pakistani retired people saw the least friends, while White and Irish employed people and Bangladeshi retired people saw the most. There was little difference between the three groups in the number of relatives seen, except among Bangladeshi people, where retired people saw the highest mean number of relatives
(Table 7.17)

### 7.4.7 **Common mental disorder**

Mean numbers of friends and relatives seen showed associations with CIS-R score, but this varied between ethnic groups. Among White, Irish, Black Caribbean and Pakistani groups, those with high CIS-R scores, indicating that they had a common mental disorder, saw fewer friends and relatives per month. In contrast, high scorers on the CIS-R among Bangladeshi and Indian groups, saw more friends and relatives than low scorers. (Table 7.18)

## 7.5 **Conclusions**

The distribution of types of social support by sociodemographic factors largely fits expected trends. As might be expected, married and cohabiting people received higher levels of emotional and practical support than single people, but, in all non-White groups, they also received higher levels of negative aspects of close relationships. There were some associations between social support and the other demographic analysis variables, but there was no systematic pattern across ethnic groups. In terms of social networks, it was evident that, overall, informants had more contact with friends than relatives.

Unlike other studies of social support and mental health using this questionnaire,[14] social support, particularly confiding/emotional and practical support, did not seem to be strongly related to common mental disorder in this sample. There was, however, a consistent finding, with the exception of the Bangladeshi group, that negative aspects of close relationships were more prevalent among those with common mental disorder. Of course, in these cross-sectional analyses, it is not possible to establish whether negative aspects of close relationships are an aetiological factor in common mental disorder, or are a consequence of the disorder.

Looking at differences between the ethnic groups in the sample, it is striking that Black Caribbean people received less confiding/emotional and practical support than others, despite the fact that their levels of contact with relatives and friends were relatively high. Also notable was the finding that Bangladeshi informants received high levels of emotional and practical support from their closest person, but also very high levels of negative aspects. The higher levels of confiding/emotional and practical support, together with the lower levels of Common Mental Disorder, Depressive Episodes, Anxiety Disorders and Mixed Anxiety and Depressive Disorder in Bangladeshi women reported in Chapter 2 suggest a protective effect of support on mental health in this group. It is notable that the high negative aspects of close relationships associated with psychological distress in other samples is not associated with high CIS-R scores among Bangladeshi people. Close intimate relationships may have both advantages and disadvantages for mental health. This finding is reminiscent of Brown's studies of Hebridean women, where intimate family networks were linked to low levels of depression.[15] On the other hand Hebridean women had high levels of anxiety, which was not the case among Bangladeshi women in the EMPIRIC study.

Close intimate relationships, with high levels of expectation, and a traditional format, resistant to change, are likely to be especially problematic for young people, who may have to reconcile family demands with indigenous British culture. Analysis of the hospital records of attempted suicide in young South Asian women has focussed on this notion of culture-conflict, where young women are apparently in disagreement with their parents' or husband's traditional or religious expectations.[16,17,18] In relationships with high levels of support and concurrently high levels of negative interaction, in which it is likely that there are high expectations of certain behaviours in return for the emotional and practical support given to young women, the risk of self-harm may be increased.

Overall, there was little association between psychiatric morbidity and the social support measures, except among the Bangladeshi group, where high CIS-R scorers were more likely to report lower confiding and practical support. High levels of support were the norm among the Bangladeshi group, and may contribute to their low prevalence of common mental disorder. The fact that low levels of support were associated with high CIS-R scores, among Bangladeshis, suggests that low support might be more of a factor in the development of mental illness among this group, compared with other groups. Lower number of friends and relatives, according to the social network measures, were seen amongst those with common mental disorder in the White, Irish, Black Caribbean and Pakistani groups. It is also interesting to note the relatively small friendship networks of Indian and Pakistani women in comparison with men. Some studies have suggested that smaller social networks precede the onset of common mental disorder, and it is possible that the smaller networks contribute to the higher

rates of Common Mental Disorder, Depressive Episodes, Anxiety Disorders and Mixed Anxiety and Depressive Disorder found in Pakistani women.[1] Other studies suggest that smaller networks are a consequence of existing common mental disorder and that people tend to become more socially isolated. It is interesting that the opposite pattern is seen among the Bangladeshi and Indian groups in this study. Could it be that the expression of common mental disorder in these groups leads to a greater mobilisation of friends and relatives?

The Close Persons Questionnaire has not been specifically validated in ethnic minority groups, having been originally developed within a largely white Civil Service population. Thus, it is possible that this questionnaire does not capture the diversity of social relations in different cultural groups. This may especially be the case since the results in this report include types of support from only the closest person, and cultural groups where extensive high quality support comes from a large social network may not be fully covered (although the reported contact with friends and relatives does give an impression of these wider networks).

Overall, these results suggest there is diversity of social relations across ethnic groups, but also some consistency. The diversity needs to be interpreted in the light of the cultural, socioeconomic and historical context of each ethnic group. For example, the results reported here seem to suggest that the Black Caribbean group may have low levels of support from their closest person, despite having a large social network of friends. Further investigation is needed to understand whether this group receives extra support from their wider social network. Similarly, Bangladeshi people seem to receive high levels of simultaneous support and conflict from their closest person, a finding that is likely to be relevant to mental health among this group. The association between these findings and the mental health of these groups warrants further investigation.

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# 7 Social support and networks

*Stephen Stansfeld and Kerry Sproston*

## Tables

Table 7.1

### Social support, by sex

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| Men | 30 | 33 | 42 | 28 | 27 | 29 |
| Women | 25 | 22 | 28 | 20 | 26 | 20 |
| All | 27 | 27 | 33 | 24 | 27 | 24 |
| **Low levels of practical support** | | | | | | |
| Men | 23 | 22 | 25 | 11 | 21 | 23 |
| Women | 25 | 19 | 28 | 11 | 25 | 20 |
| All | 24 | 20 | 27 | 11 | 23 | 21 |
| **High negative aspects of close relationships** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Men | 31 | 35 | 48 | 74 | 52 | 44 |
| Women | 41 | 42 | 46 | 77 | 53 | 58 |
| All | 37 | 39 | 47 | 75 | 53 | 51 |
| *Bases (weighted)* | | | | | | |
| *Men* | *36735* | *1430* | *325* | *133* | *549* | *337* |
| *Women* | *48965* | *1846* | *481* | *136* | *580* | *370* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *365* | *322* | *271* | *306* | *309* | *328* |
| *Women* | *467* | *402* | *407* | *334* | *322* | *380* |

Table 7.2

## Social support, by age

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| 16-34 | 21 | 30 | 35 | 25 | 28 | 25 |
| 35-54 | 27 | 19 | 28 | 22 | 28 | 22 |
| 55-74 | 35 | 37 | 40 | 26 | 21 | 26 |
| **Low levels of practical support** | | | | | | |
| 16-34 | 22 | 17 | 25 | 10 | 27 | 23 |
| 35-54 | 24 | 22 | 28 | 11 | 21 | 19 |
| 55-74 | 26 | 22 | 27 | 11 | 20 | 19 |
| **High negative aspects of close relationships** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 16-34 | 38 | 40 | 51 | 74 | 54 | 54 |
| | 35-54 | 41 | 44 | 45 | 78 | 52 | 50 |
| | 55-74 | 29 | 29 | 41 | 74 | 53 | 41 |
| *Bases (weighted)* | | | | | | | |
| | *16-34* | *25270* | *943* | *319* | *156* | *433* | *404* |
| | *35-54* | *37000* | *1533* | *294* | *78* | *487* | *222* |
| | *55-74* | *23430* | *800* | *193* | *36* | *209* | *81* |
| *Bases (unweighted)* | | | | | | | |
| | *16-34* | *227* | *179* | *246* | *357* | *224* | *397* |
| | *35-54* | *368* | *353* | *265* | *187* | *289* | *229* |
| | *55-74* | *237* | *192* | *167* | *96* | *118* | *82* |

Table 7.3

## Social support: risk ratios standardised by age

| | | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|---|
| | | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | | % | % | % | % | % | % |
| **Age standardised risk ratio for low confiding support** | | | | | | | |
| Male | | | | | | | |
| | Risk ratio | 1 | 1.25 | 1.39 | 0.9 | 0.88 | 0.91 |
| | Standard error | 1 | 0.14 | 0.15 | 0.12 | 0.11 | 0.11 |
| Female | | | | | | | |
| | Risk ratio | 1 | 1.02 | 1.22 | 0.9 | 1.1 | 0.95 |
| | Standard | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Standard error | 1 | 0.13 | 0.14 | 0.13 | 0.14 | 0.13 |
| **Age standardised risk ratio for low practical support** | | | | | | | |
| Male | | | | | | | |
| | Risk ratio | 1 | 0.98 | 1.16 | 0.5 | 0.91 | 1.02 |
| | Standard error | 1 | 0.16 | 0.17 | 0.11 | 0.14 | 0.15 |
| Female | | | | | | | |
| | Risk ratio | 1 | 0.76 | 1.11 | 0.42 | 1.02 | 0.75 |
| | Standard error | 1 | 0.11 | 0.13 | 0.08 | 0.13 | 0.11 |
| **Age standardised risk ratio for high negative aspects of close relationship** | | | | | | | |
| Male | | | | | | | |
| | Risk ratio | 1 | 1.12 | 1.53 | 2.37 | 1.69 | 1.34 |
| | Standard error | 1 | 0.13 | 0.16 | 0.21 | 0.16 | 0.14 |
| Female | | | | | | | |
| | Risk ratio | 1 | 1.02 | 1.09 | 1.85 | 1.28 | 1.35 |
| | Standard error | 1 | 0.09 | 0.09 | 0.13 | 0.1 | 0.11 |
| *Bases (weighted)* | | | | | | | |
| | *Male* | *37072* | *1459* | *335* | *135* | *565* | *345* |
| | *Female* | *49222* | *1854* | *491* | *139* | *591* | *379* |
| *Bases (unweighted)* | | | | | | | |
| | *Male* | *368* | *329* | *280* | *312* | *315* | *337* |
| | *Female* | *469* | *404* | *414* | *338* | *328* | *387* |

Table 7.4

## Social support, by marital status

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| Married / cohabiting | 22 | 19 | 28 | 19 | 23 | 22 |
| Divorced / separated | 44 | 33 | 33 | [47] | [30] | [36] |
| Single and never been married | 32 | 43 | 38 | 35 | 37 | 28 |
| **Low levels of practical support** | | | | | | |
| Married / cohabiting | 15 | 13 | 19 | 9 | 18 | 19 |
| Divorced / separated | 53 | 28 | 38 | [35] | [40] | [24] |
| Single and never been married | 34 | 34 | 31 | 13 | 37 | 29 |
| **High levels of negative aspects of close relationships** | | | | | | |
| Married / cohabiting | 37 | 37 | 50 | 77 | 56 | 51 |
| Divorced / separated | 32 | 39 | 40 | [56] | [46] | [52] |
| Single and never been married | 43 | 47 | 47 | 73 | 46 | 51 |
| *Bases (weighted)* | | | | | | |
| *Married / Cohabiting* | *54868* | *2064* | *326* | *185* | *815* | *498* |
| *Divorced / Separated* | *7983* | *349* | *95* | *7* | *52* | *21* |
| *Single and never been married* | *18934* | *755* | *365* | *66* | *228* | *172* |
| *Bases (unweighted)* | | | | | | |
| *Married / Cohabiting* | *543* | *476* | *279* | *451* | *472* | *503* |
| *Divorced / Separated* | *70* | *82* | *90* | *15* | *28* | *15* |
| *Single and never been married* | *179* | *135* | *289* | *143* | *117* | *171* |

The sample base for widowed informants is too small for results to be shown.

Table 7.5

## Social support, by migration status (informants aged 16 to 54 only)

| | Ethnic group | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Low levels of confiding/ emotional support** | | | | | | | |
| Migrated aged < 11 or born in UK | 24 | 24 | 33 | 27 | 28 | 26 | |
| Migrated aged 11 or older | | | 21 | 25 | 21 | 28 | 21 |
| **Low levels of practical support** | | | | | | | |
| Migrated aged < 11 or born in UK | 23 | 19 | 27 | 13 | 27 | 25 | |
| Migrated aged 11 or older | | | 28 | 22 | 8 | 21 | 18 |
| **High levels of negative aspects of close relationships** | | | | | | | |
| Migrated aged < 11 or born in UK | 17 | 11 | 18 | 5 | 15 | 17 | |
| Migrated aged 11 or older | | | 16 | 16 | 4 | 16 | 11 |
| *Bases (weighted)* | | | | | | | |
| *Migrated aged < 11 or born in UK* | *62270* | *2081* | *507* | *112* | *469* | *350* | |
| *Migrated aged 11 or older* | | | *395* | *106* | *122* | *451* | *276* |
| *Bases (unweighted)* | | | | | | | |
| *Migrated aged < 11 or born in UK* | *595* | *436* | *419* | *244* | *267* | *351* | |
| *Migrated aged 11 or older* | | | *96* | *92* | *300* | *246* | *275* |

Table 7.6

## Social support, by degree of urbanisation

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Low levels of confiding/ emotional support** | | | | | | | |
| Urban | 33 | 29 | 38 | 23 | 23 | 25 |
| Suburban/rural | 26 | 27 | 30 | 22 | 29 | 23 |
| **Low levels of practical support** | | | | | | | |
| Urban | 32 | 28 | 29 | 9 | 15 | 18 |
| Suburban/rural | 23 | 19 | 24 | 15 | 26 | 23 |
| **High negative aspects of close relationships** | | | | | | | |
| Urban | 35 | 33 | 45 | 80 | 54 | 51 |
| Suburban/rural | 38 | 40 | 48 | 56 | 53 | 51 |
| *Bases (weighted)* | | | | | | | |
| *Urban* | *16110* | *424* | *394* | *221* | *322* | *263* |
| *Suburban/rural* | *60445* | *2685* | *387* | *34* | *759* | *415* |
| *Bases (unweighted)* | | | | | | | |
| *Urban* | *136* | *139* | *316* | *530* | *160* | *275* |
| *Suburban/rural* | *610* | *548* | *339* | *74* | *444* | *405* |

Table 7.7

## Social support, by social class of Head of Household

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| Non Manual | 25 | 23 | 32 | 27 | 24 | 18 |
| Manual | 30 | 30 | 33 | 23 | 29 | 23 |
| **Low levels of practical support** | | | | | | |
| Non-manual | 22 | 19 | 26 | 17 | 24 | 21 |
| Manual | 27 | 22 | 26 | 9 | 23 | 19 |
| **High levels of negative aspects of close relationships** | | | | | | |
| Non-manual | 37 | 37 | 45 | 65 | 54 | 55 |
| Manual | 36 | 40 | 48 | 77 | 51 | 48 |
| *Bases (weighted)* | | | | | | |
| *Non manual* | *47806* | *1571* | *328* | *37* | *486* | *213* |
| *Manual* | *36510* | *1665* | *435* | *196* | *604* | *402* |
| *Bases (unweighted)* | | | | | | |
| *Non manual* | *480* | *338* | *274* | *78* | *292* | *205* |
| *Manual* | *339* | *379* | *371* | *470* | *319* | *418* |

Table 7.8

## Social support, by tenure

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| Owns/buying | 28 | 26 | 30 | 32 | 28 | 24 |
| Rent/part rent and part buy | 28 | 32 | 38 | 20 | 17 | 25 |
| **Low levels of practical support** | | | | | | |
| Owns/buying | 23 | 18 | 25 | 19 | 22 | 22 |
| Rent/part rent and part buy | 30 | 27 | 28 | 6 | 29 | 21 |
| **High levels of negative aspects of close relationships** | | | | | | |
| Owns/buying | 35 | 39 | 49 | 62 | 54 | 50 |
| Rent/part rent and part buy | 44 | 43 | 44 | 84 | 54 | 56 |
| *Bases (weighted)* | | | | | | |
| *Owns/buying* | *58722* | *2269* | *412* | *83* | *902* | *488* |
| *Rent/part rent and part buy* | *16965* | *805* | *368* | *166* | *151* | *179* |
| *Bases (unweighted)* | | | | | | |
| *Owns/buying* | *604* | *519* | *354* | *171* | *518* | *509* |
| *Rent/part rent and part buy* | *136* | *163* | *300* | *427* | *75* | *163* |

Table 7.9

## Social support, by employment status

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of emotional/ confiding support** | | | | | | |
| In employment | 26 | 24 | 29 | 22 | 25 | 23 |
| Retired | 36 | 35 | 42 | 27 | 24 | 20 |
| Other economically inactive | 26 | 31 | 29 | 24 | 30 | 27 |
| **Low levels of practical support** | | | | | | |
| In employment | 22 | 20 | 25 | 15 | 21 | 24 |
| Retired | 31 | 20 | 26 | 11 | 28 | 12 |
| Other economically inactive | 27 | 23 | 27 | 8 | 24 | 20 |
| **High levels of negative aspects of close relationships** | | | | | | |
| In employment | 37 | 40 | 47 | 77 | 50 | 48 |
| Retired | 27 | 28 | 39 | 58 | 58 | 41 |
| Other economically inactive | 40 | 40 | 51 | 75 | 57 | 55 |
| *Bases (weighted)* | | | | | | |
| *In employment* | *55450* | *2195* | *443* | *76* | *690* | *292* |
| *Retired* | *13774* | *427* | *106* | *14* | *88* | *40* |
| *Other economically inactive* | *13282* | *500* | *171* | *153* | *277* | *319* |
| *Bases (unweighted)* | | | | | | |
| *In employment* | *546* | *479* | *377* | *169* | *401* | *281* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Retired* | *138* | *100* | *95* | *35* | *53* | *38* |
| *Other economically inactive* | *118* | *114* | *144* | *368* | *141* | *333* |

The sample base for ILO unemployed informants is too small for results to be shown.

Table 7.10

## Social support, by CIS-R score

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Low levels of confiding/ emotional support** | | | | | | |
| <12 | 27 | 27 | 34 | 23 | 27 | 24 |
| 12 + | 28 | 25 | 30 | 32 | 27 | 26 |
| **Low levels of practical support** | | | | | | |
| <12 | 24 | 21 | 28 | 9 | 24 | 22 |
| 12 + | 25 | 17 | 17 | 24 | 18 | 20 |
| **High levels of negative aspects of close relationships** | | | | | | |
| <12 | 32 | 35 | 44 | 77 | 52 | 49 |
| 12 + | 61 | 55 | 60 | 66 | 57 | 59 |
| *Bases (weighted)* | | | | | | |
| *<12* | *73021* | *2679* | *665* | *236* | *925* | *567* |
| *12 +* | *12679* | *597* | *142* | *34* | *205* | *139* |
| *Bases (unweighted)* | | | | | | |
| *<12* | *711* | *592* | *554* | *565* | *510* | *562* |
| *12 +* | *121* | *133* | *125* | *75* | *120* | *146* |

Table 7.11

## Mean numbers of friends and relatives seen per month, by sex and age

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Friends** | | | | | | | |
| Men | 9.8 | 9.2 | 9.3 | 7.1 | 8.1 | 9.5 |
| Women | 9.0 | 8.6 | 7.8 | 5.1 | 4.6 | 5.0 |
| All | 9.3 | 8.9 | 8.4 | 6.1 | 6.3 | 7.2 |
| **Relatives** | | | | | | | |
| Men | 3.5 | 3.8 | 3.8 | 5.3 | 4.6 | 6.9 |
| Women | 4.1 | 4.3 | 4.6 | 5.6 | 5.8 | 6.0 |
| All | 3.8 | 4.1 | 4.3 | 5.4 | 5.2 | 6.4 |
| **Friends** | | | | | | | |
| 16-34 | 12.4 | 11.6 | 8.1 | 5.7 | 8.6 | 9.0 |
| 35-54 | 8.3 | 7.8 | 8.3 | 5.8 | 5.5 | 4.3 |
| 55-74 | 7.5 | 7.7 | 9.0 | 8.3 | 3.2 | 5.6 |
| **Relatives** | | | | | | | |
| 16-34 | 4.5 | 4.8 | 4.1 | 5.0 | 6.3 | 7.1 |
| 35-54 | 3.4 | 3.7 | 4.1 | 5.4 | 4.9 | 6.0 |
| 55-74 | 3.5 | 4.0 | 4.7 | 7.5 | 3.9 | 4.1 |
| *Bases (weighted)* | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Men* | *37072* | *1459* | *334* | *134* | *565* | *342* |
| *Women* | *49203* | *1854* | *489* | *139* | *591* | *376* |
| *Bases (unweighted)* | | | | | | |
| *Men* | *365* | *323* | *279* | *318* | *316* | *342* |
| *Women* | *470* | *410* | *411* | *329* | *331* | *376* |
| *Bases (unweighted)* | | | | | | |
| *16-34* | *260* | *209* | *269* | *375* | *248* | *409* |
| *35-54* | *354* | *345* | *250* | *185* | *280* | *228* |
| *55-74* | *221* | *179* | *170* | *87* | *120* | *81* |
| *Bases (weighted)* | | | | | | |
| *16-34* | *25420* | *943* | *321* | *158* | *442* | *409* |
| *35-54* | *37234* | *1561* | *300* | *78* | *500* | *229* |
| *55-74* | *23522* | *808* | *203* | *37* | *214* | *81* |

Table 7.12

## Number of friends and relatives seen per month: ratios of means standardised by age

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Age standardised ratio of means for number of relatives** | | | | | | |
| Male | | | | | | |
| Ratio of means | 1 | 1.08 | 1.10 | 1.62 | 1.33 | 1.92 |
| Standard error | 1 | 0.12 | 0.11 | 0.16 | 0.15 | 0.21 |
| Female | | | | | | |
| Ratio of | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Ratio of means | 1 | 1.06 | 1.05 | 1.4 | 1.28 | 1.33 |
| | Standard error | 1 | 0.1 | 0.1 | 0.15 | 0.14 | 0.12 |
| **Age standardised ratio of means for number of friends** | | | | | | | |
| Male | | | | | | | |
| | Ratio of means | 1 | 0.9 | 0.95 | 0.78 | 0.78 | 0.84 |
| | Standard error | 1 | 0.12 | 0.13 | 0.1 | 0.1 | 0.11 |
| Female | | | | | | | |
| | Ratio of means | 1 | 0.93 | 0.81 | 0.52 | 0.5 | 0.46 |
| | Standard error | 1 | 0.11 | 0.1 | 0.06 | 0.06 | 0.07 |
| *Bases (weighted)* | | | | | | | |
| *Male* | *37072* | *1459* | *334* | *134* | *565* | *342* | |
| *Female* | *49203* | *1854* | *489* | *139* | *591* | *376* | |
| *Bases (unweighted):* | | | | | | | |
| *Male* | *365* | *323* | *279* | *318* | *316* | *342* | |
| *Female* | *470* | *410* | *411* | *329* | *331* | *376* | |

Table 7.13

## Social support, by employment status

| | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |

| | % | % | % | % | % | % |
|---|---|---|---|---|---|---|
| **Friends** | | | | | | |
| Married/cohabiting | 8.0 | 7.5 | 9.1 | 6.0 | 4.9 | 5.5 |
| Divorced/separated | 8.0 | 10.2 | 7.8 | [4.0] | [6.2] | [2.2] |
| Single | 13.4 | 12.4 | 8.1 | 6.8 | 11.4 | 12.6 |
| **Relatives** | | | | | | |
| Married/cohabiting | 3.9 | 4.3 | 5.1 | 6.1 | 5.3 | 6.5 |
| Divorced/separated | 4.0 | 3.7 | 3.3 | [4.1] | [2.4] | [3.1] |
| Single | 3.6 | 3.7 | 3.7 | 3.9 | 5.5 | 6.7 |
| *Bases (unweighted)* | | | | | | |
| *Married/cohabiting* | *518* | *461* | *277* | *443* | *464* | *502* |
| *Divorced/separated* | *74* | *78* | *84* | *18* | *32* | *26* |
| *Single* | *205* | *170* | *310* | *157* | *132* | *175* |
| *Bases (weighted)* | | | | | | |
| *Married/cohabiting* | *54868* | *2081* | *331* | *187* | *829* | *502* |
| *Divorced/separated* | *7959* | *353* | *100* | *8* | *58* | *26* |
| *Single* | *19433* | *766* | *371* | *66* | *236* | *175* |

The sample base for widowed informants is too small for results to be shown.

Table 7.14

## Mean number of friends and relatives seen, by migration status (informants aged 16 to 54 only)

| | **Ethnic group** |
|---|---|
| | Black |

| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | | |
|---|---|---|---|---|---|---|---|---|
| | % | % | % | % | % | % | | |
| **Friends** | | | | | | | | |
| Migrated aged < 11 or born in UK | 10.0 | | 9.8 | 7.9 | 6.2 | 9.0 | 9.6 | |
| Migrated aged 11 or older | | | | 6.2 | 9.6 | 5.3 | 4.8 | 4.5 |
| **Relatives** | | | | | | | | |
| Migrated aged < 11 or born in UK | 3.9 | | 4.6 | 4.1 | 4.8 | 6.5 | 7.2 | |
| Migrated aged 11 or older | | | | 1.4 | 4.3 | 5.4 | 4.6 | 6.0 |
| *Bases (unweighted)* | | | | | | | | |
| *Migrated aged < 11 or born in UK* | *614* | | *464* | *428* | *270* | *268* | *353* | |
| *Migrated aged 11 or older* | | | | *91* | *90* | *290* | *260* | *284* |
| *Bases (weighted)* | | | | | | | | |
| *Migrated aged < 11 or born in UK* | *62653* | | *2095* | *513* | *114* | *478* | *353* | |
| *Migrated aged 11 or older* | | | | *409* | *108* | *122* | *464* | *285* |

Table 7.15

## Mean number of friends and relatives seen, by degree of urbanisation

| | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Friends** | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Urban | 7.8 | 5.6 | 7.0 | 5.9 | 4.3 | 6.1 |
| | Suburban/rural | 9.6 | 9.4 | 9.5 | 7.5 | 6.8 | 7.8 |
| **Relatives** | | | | | | | |
| | Urban | 3.1 | 3.2 | 3.4 | 5.1 | 5.7 | 5.1 |
| | Suburban/rural | 3.8 | 4.1 | 4.8 | 6.5 | 5.1 | 7.1 |
| *Bases (unweighted)* | | | | | | | |
| | *Urban* | *156* | *96* | *341* | *531* | *186* | *270* |
| | *Suburban/rural* | *155* | *96* | *335* | *532* | *186* | *270* |
| *Bases (weighted)* | | | | | | | |
| | *Urban* | *16261* | *436* | *405* | *224* | *331* | *270* |
| | *Suburban/rural* | *60770* | *2709* | *393* | *34* | *776* | *420* |

Table 7.16

## Mean number of friends and relatives seen, by social class of head of household

| | **Ethnic group** | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Friends** | | | | | | | |
| | Non-manual | 9.8 | 10.2 | 7.9 | 5.8 | 8.6 | 6.9 |
| | Manual | 8.4 | 7.7 | 9.0 | 6.5 | 4.7 | 7.7 |
| **Relatives** | | | | | | | |
| | Non-manual | 3.7 | 4.0 | 3.5 | 5.4 | 5.8 | 5.8 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Manual | 4.0 | 4.1 | 4.9 | 5.5 | 5.0 | 7.2 |
| *Bases (unweighted)* | | | | | | |
| *Non-manual* | *463* | *351* | *279* | *91* | *279* | *215* |
| *Manual* | *359* | *372* | *374* | *467* | *347* | *408* |
| *Bases (weighted)* | | | | | | |
| *Non-manual* | *48156* | *1588* | *335* | *38* | *498* | *215* |
| *Manual* | *36636* | *1680* | *445* | *196* | *619* | *409* |

Table 7.17

## Mean number of friends and relatives seen, by employment status

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Friends** | | | | | | |
| In employment | 9.9 | 9.5 | 8.9 | 6.6 | 6.4 | 7.5 |
| Retired | 7.7 | 5.2 | 9.0 | 9.7 | 3.7 | 5.6 |
| Other economically inactive | 8.5 | 9.3 | 7.6 | 5.8 | 6.3 | 6.8 |
| **Relatives** | | | | | | |
| In employment | 3.9 | 4.1 | 4.2 | 5.4 | 5.4 | 7.3 |
| Retired | 3.5 | 3.5 | 4.5 | 8.1 | 3.4 | 4.2 |
| Other economically inactive | 3.8 | 4.7 | 5.0 | 5.5 | 4.9 | 6.3 |
| *Bases (unweighted)* | | | | | | |
| *In employment* | *535* | *489* | *371* | *180* | *391* | *296* |

| | | | | | | |
|---|---|---|---|---|---|---|
| *Retired* | *130* | *96* | *95* | *32* | *49* | *42* |
| *Other economically inactive* | *130* | *112* | *143* | *369* | *160* | *326* |
| *Bases (weighted)* | | | | | | |
| *Employed* | *55573* | *2213* | *447* | *75* | *704* | *294* |
| *Retired* | *13774* | *434* | *115* | *14* | *88* | *41* |
| *Economically inactive* | *13528* | *508* | *173* | *155* | *286* | *323* |

The sample base for ILO unemployed informants is too small for results to be shown.

Table 7.18

## Mean number of friends and relatives seen, by CIS-R score

| | **Ethnic group** | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani |
| | % | % | % | % | % | % |
| **Friends** | | | | | | |
| < 12 | 9.5 | 9.0 | 8.7 | 6.0 | 6.2 | 7.7 |
| 12 + | 8.5 | 8.2 | 6.9 | 6.3 | 6.7 | 5.0 |
| **Relatives** | | | | | | |
| < 12 | 3.9 | 4.2 | 4.4 | 5.3 | 5.1 | 6.4 |
| 12 + | 3.2 | 3.7 | 3.8 | 6.4 | 5.8 | 6.3 |
| *Bases (unweighted)* | | | | | | |
| *< 12* | *702* | *597* | *569* | *565* | *531* | *577* |
| *12 +* | *132* | *136* | *120* | *82* | *117* | *142* |
| *Bases (weighted)* | | | | | | |
| *< 12* | *73295* | *2699* | *679* | *238* | *947* | *577* |
| *12 +* | *12880* | *614* | *144* | *35* | *209* | *142* |

Table 7.19

## Mean number of friends and relatives seen, by CIS-R score

| | Ethnic group | | | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
| | % | % | % | % | % | % | |
| **Friends** | | | | | | | |
| | < 12 | 9.5 | 9.0 | 8.7 | 6.0 | 6.2 | 7.7 |
| | 12 + | 8.5 | 8.2 | 6.9 | 6.3 | 6.7 | 5.0 |
| **Relatives** | | | | | | | |
| | < 12 | 3.9 | 4.2 | 4.4 | 5.3 | 5.1 | 6.4 |
| | 12 + | 3.2 | 3.7 | 3.8 | 6.4 | 5.8 | 6.3 |
| *Bases (unweighted)* | | | | | | | |
| | *< 12* | *702* | *597* | *569* | *565* | *531* | *577* |
| | *12 +* | *132* | *136* | *120* | *82* | *117* | *142* |
| *Bases (weighted)* | | | | | | | |
| | *< 12* | *73295* | *2699* | *679* | *238* | *947* | *577* |
| | *12 +* | *12880* | *614* | *144* | *35* | *209* | *142* |

Table 7.20

## Mean number of friends and relatives seen, by CIS-R score

| | Ethnic group |
|---|---|
| | Black |

| | White | Irish | Black Caribbean | Bangladeshi | Indian | Pakistani | |
|---|---|---|---|---|---|---|---|
| | *%* | *%* | *%* | *%* | *%* | *%* | |
| **Friends** | | | | | | | |
| | < 12 | 9.5 | 9.0 | 8.7 | 6.0 | 6.2 | 7.7 |
| | 12 + | 8.5 | 8.2 | 6.9 | 6.3 | 6.7 | 5.0 |
| **Relatives** | | | | | | | |
| | < 12 | 3.9 | 4.2 | 4.4 | 5.3 | 5.1 | 6.4 |
| | 12 + | 3.2 | 3.7 | 3.8 | 6.4 | 5.8 | 6.3 |
| *Bases (unweighted)* | | | | | | | |
| | *< 12* | *702* | *597* | *569* | *565* | *531* | *577* |
| | *12 +* | *132* | *136* | *120* | *82* | *117* | *142* |
| *Bases (weighted)* | | | | | | | |
| | *< 12* | *73295* | *2699* | *679* | *238* | *947* | *577* |
| | *12 +* | *12880* | *614* | *144* | *35* | *209* | *142* |

# 8 Context, cause and meaning: qualitative insights

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## 8.1 Introduction

The quantitative epidemiological method adopted for much of this study has been successful in measuring broad patterns of health and illness, and in isolating specific problems or specific groups where patterns of ill health are concentrated. Such an approach forms the basis of most investigations of inequalities in health, including ethnic inequalities in mental health. However, some have taken a critical view of the epidemiological method, particularly within the mental health field, suggesting that this approach ignores social context and the experiences of people as lived rather than as constructed by diagnostic categories.[1,2,3,4] Central to this critical view has been the claim that the idioms used to express mental distress, the ways in which people describe their feelings and their understanding of the category 'mental health', vary across different cultural groupings, and that this needs to be addressed by both research and practice. Kleinman describes how the use of inappropriate disease categories to assess illness experience can lead to 'category fallacies', when the application of a particular disease category that was developed in one cultural group is applied to another group and fails to identify many people to whom it can apply, because it lacks coherence in the second culture.[3] The concern here, therefore, is that the idioms of mental distress used by researchers and practitioners are different from those used by the researched or treated group.

Used in addition to quantitative methods, qualitative methodologies can be particularly useful for addressing such a concern, by further developing our understanding of the factors and experiences underlying the quantitative patterning of mental health. In addition, they are able to explore more subtle variations, where the particular language used to describe emotions and experiences, or where the context of the situation, can provide further insights that may be missed by the 'itemised' approach of quantitative material. In this report we have used quantitative methodologies to describe how the basic patterns of mental health and other related factors vary across different ethnic groups. In this chapter, we will contextualise these trends using information imparted by respondents during follow-up in-depth qualitative interviews, as well as posing some questions about the measurement and diagnosis of mental illness across different ethnic groups.

This chapter reports on qualitative interviews with a sub-sample of respondents to this survey. It is concerned both with understanding the context of respondents' lives and how this shapes their experiences of mental distress; and with exploring how far the quantitative western assessments of mental illness used elsewhere in this report, in particular the CIS-R, adequately capture the experience of mental distress across different ethnic groups.

## 8.2 Culture-bound syndromes

Evidence from studies of treatment rates suggest that the prevalence of mental illness among populations that have been broadly described as South Asian appears, on balance, to be lower than that for the general population.[5,6,7] It has been suggested that these lower detected rates could reflect language and communication difficulties, or a general reluctance among some South Asian groups to consult with doctors over mental health problems, rather than a genuinely lower prevalence of mental illness. More fundamentally, it is possible that they may reflect a difference in the symptomatic experience of South Asian peoples with a mental illness compared with white people. It has been suggested, for example, that some groups may experience particular 'culture-bound' syndromes that is a cluster of symptoms that is restricted to a particular culture such as 'sinking heart' described by Punjabi people.[8] Or some may be more likely to somatise mental illness that is experience and describe psychological distress more in terms of physical symptoms,[9] which are less likely to be identified as mental illness in both epidemiological research and clinical practice. For example, it has been demonstrated that a standardised western assessment of psychological distress under-estimates problems among South Asian people living in Glasgow relative to their white peers when compared with self-reports of distress, or a measure that more directly assessed somatic symptoms.[10]And that this under-estimation may be specific to distress resulting from situations that were more commonly experienced by South Asian people, such as a low standard of living.[11] Of course, culture-bound syndromes need not be specific to, nor indeed uniform across, South Asian groups. The very category 'South Asian' has been viewed as inappropriate, too wide and misleading to be useful in health research.[12,13]

Kleinman, in what comes close to a relativist perspective on mental illness, has suggested that the problems with cross-cultural psychiatric research may be even more fundamental than this. Somatisation, for example, is typically seen as a result of different, culturally informed, ways of expressing biologically similar disorders. However, Kleinman suggests that the reliance on a biological definition of disease crucially undermines an understanding of how different the culturally shaped illness may be, including symptoms, help-seeking behaviour and course of illness.[3]

Given the reliance of psychiatric research on the identification of clusters of symptoms that reflect an underlying disease and the potentially different idioms for mental distress used in different cultures, as described above, Kleinman argues that cross-cultural psychiatric research can easily lead to the 'category fallacy', because the idioms of mental distress in the researched group are simply different from those used in the research tool.[3] So he points out the obvious fallacy in attempting to identify the prevalence of 'semen loss' or 'soul loss' in white western groups.[3] This may, of course, equally be the case for instruments designed to detect western expressions of mental illness when applied to other cultures. Indeed, Jadhav has been able to describe the historical and regional development of 'western depression', leading him to suggest that this apparently universal disorder is culturally and historically specific.[2]

There has been little empirical work in this area, so there is only limited evidence to support this position. In one example, Fenton and Sadiq-Sangster identified an expression of distress used by Pakistani origin women in Bristol that they described, using their respondents' words, as 'thinking too much in my heart'.[14] While they found that this correlated strongly with the expression of most of the standard western symptoms of depression, they were also able to show that some of these standard symptoms were not present (those relating to a loss of meaning in life and self-worth), suggesting that at least the form that the disease took was different. They also pointed out that 'thinking too much in my heart' was not only a symptom as such, but a core experience of the illness, raising the possibility that there were more fundamental differences between this illness and depression. Another study has suggested that cultural differences in the expression of mental distress meant that South Asian people

who consulted with their GPs about mental health problems often went undiagnosed.[15]

The Fourth National Survey, despite its quantitative nature, lends some support for such a perspective. Although South Asian people in that study were overall found to have low rates of mental disorder, this in fact only applied to those who had migrated to the UK in late childhood or adulthood (ie aged 11 or more on migration), 'second generation' South Asian people did not have lower rates of mental disorder.[16] Two possible explanations were considered for this finding in the study. First, that this was a consequence of language differences, with those less fluent in English being less likely to have symptoms adequately identified, despite the use of translation and the ethnically matched interviewers. Age on migration is, of course, strongly related to English language ability for South Asian people, and similar findings to those just described were found if fluency in English was used instead of age on migration in the analysis.[16] The second possible explanation is that the difference between 'migrant' and 'non-migrant' South Asian people was a consequence of variation in cultural distance from western idioms of mental distress, that is those who were migrants were more culturally distant and therefore less likely to describe their mental distress in a way that would be detected by the research instruments used in the study. To explore the relative contribution of these two possibilities, both fluency in English and age on migration were considered together in a regression analysis. In the resulting model the crucial factor appeared to be that related to cultural distance (ie age on migration), rather than familiarity with language or quality of translation (ie fluency in English), lending support to Kleinman's hypothesis.[16]

## 8.3 **The qualitative approach**

Qualitative research is of particular value for an exploratory study such as this. The interactive probing and questioning methods used allow flexibility in the structure and content of interviews, which facilitates exploration of individual circumstances and experiences in a way that is responsive to the accounts of individual respondents. This is essential for the detailed investigative approach that the study required. However, it is important to note that qualitative research samples are not designed to be statistically representative of the researched population, and this means that statements about incidence or prevalence cannot be sustained. Similarly it is not possible to determine statistically discriminatory variables from qualitative data. Where relationships are described between, for example, circumstances and needs, the purpose in doing so is to present explanations identified explicitly or implicitly by respondents and hypotheses for further research.

### 8.3.1 **Sample design and selection**

The sample for the qualitative follow-up study was purposively selected from those who participated in the quantitative survey and who gave their consent to be re-contacted about future research. The sample was not designed to be statistically representative. Unlike quantitative samples, those used for qualitative studies are chosen to cover the full range of sub-groups within the given population, in order to identify and explain variations in the nature of experiences and views between them. The sample was, therefore, purposively selected on the basis of a range of key characteristics identified as relevant to the given population. Given the intention to explore cultural differences in the experience of mental illness, the key variables included in the sample design were: ethnic group, migration history, main language spoken, gender and age. In addition, respondents were purposively selected on the basis of their experience of mental distress, as determined by the CIS-R score, collected as part of the quantitative survey. The study focused on two types of respondents: those with a CIS-R score of 12 or over and those with a CIS-R score of lower than 12, but who had indicated through the answers given to other modules in the survey that they may have experienced some form of mental distress. The inclusion of the second group was intended to ensure that the sample did not only reflect those

whose distress had been identified to allow a more complete exploration of the applicability of psychiatry's model of mental distress.

Letters of invitation were sent to all potential respondents (using the language in which the person had been interviewed in at the survey) allowing those who did not wish to participate the opportunity to withdraw. Following this, a screening interview took place in the appropriate language to establish eligibility for the qualitative study according to the quotas for purposive selection. Selected individuals were then invited to take part and arrangements were made for an interview. Respondents were asked to indicate any preferences concerning the ethnic origin or gender of the interviewer and the language in which the interview would be conducted.

One hundred and sixteen people participated in the qualitative study across each of the six ethnic groups covered in the survey. Table 8.1 shows the composition of the sample in terms of the key sampling variables. The sample is evenly distributed across the six ethnic groups covered in the survey. Slightly more women than men were interviewed, particularly among Black Caribbean and South Asian groups. Achieving a diversity of migration experiences was difficult in some groups since the range of migration characteristics was limited within ethnic groups. For instance, Bangladeshi respondents were more likely to have moved to the UK after the age of 11, while Indian respondents were more likely to have been born in England or to have moved here prior to commencing secondary education.

### 8.3.2 **Conduct of the interviews**

All interviews were in-depth, exploratory and interactive in form, based on a topic guide that was developed by the research team in conjunction with the Department of Health. This listed the key themes to be covered during the interview, and the subtopics within each to be explored. Interviews were carried out in respondents' own homes and they were paid £15 in appreciation of their time and help in taking part, as is usual with this type of research. Thirty-four of the interviews were conducted in languages other than English, all with people from one of the South Asian groups (see Table 8.1), but most commonly Bangladeshi people, for whom interviews were predominantly conducted in Bengali or Sylheti. All interviews were tape-recorded and transcribed verbatim. Those interviews carried out in languages other than English were translated and transcribed by the interviewer to minimise the loss of context.

The interviews began by exploring with respondents current events in their life  such as housing, health, employment, family, relationship and household circumstances  and attempted to assess whether the respondent was currently experiencing any form of mental distress. Where respondents identified episodes of distress, the interview went on to explore the respondent's views about the origin of that distress, including: the meanings attached to the situation (by themselves and other people); their practical, emotional and physical ramifications; and the ways in which respondents tried to cope with their experience. Differences in the occurrence and nature of distress meant that the length of the interviews varied quite widely, ranging from as little as thirty minutes to over two hours. Pilot fieldwork took place in August 2000, to test the topic guide and recruitment strategy. The main fieldwork took place between October 2000 and March 2001. Fieldwork took place in a variety of areas in England including London and the Southeast, East Anglia, East and West Midlands, Yorkshire and Lancashire.

Inevitably, given the nature of the discussions, some respondents became upset during the course of the interview. In several cases, respondents remarked that they had revealed traumatic experiences about which they had never spoken to anyone before. Interviewers used specific strategies during such interviews. They were aware of the potential sensitivity of the interviews and in all cases aimed to be non-judgmental and empathetic. Also, in the event of a respondent becoming upset, they were given

the opportunity by the interviewer not to continue with either the discussion of the traumatic event or with the remainder of the interview. Furthermore, the topic guide was structured so that the focus of the discussion shifted towards the end of the interview from personal to more particular issues. With the aim of bringing the interview to a close, respondents were asked more forward-looking questions, particularly about what advice or suggestions they had for other people who had had similar experiences to them, or for agencies and organisations who provide services to people in difficult situations. Finally, where appropriate, interviewers left with respondents a leaflet containing contact details for support organisations such as Mind, Sane, The Samaritans and the Citizen's Advice Bureau. In addition, for each of the fieldwork areas, interviewers were equipped to provide details of local culturally specific support organisations or agencies that offered advice or support in a variety of community languages.

### 8.3.3 **Data analysis**

Data from the qualitative study were analysed using 'Framework', a content analysis method developed for use with qualitative research data.[17,18] This involves the systematic analysis of verbatim material within a thematic matrix. The key topics and issues emerging from the data were identified through familiarisation with the interview transcripts. A series of thematic charts were then drawn up and data from each transcript was summarised under each topic. The phrasing used by the respondent was retained in the summary and the page of the transcript noted on the chart so that it was possible to return to the full transcript to explore a point in more detail. These charts then formed the basis for detailed exploration of the data, examining the range of views and experiences of individuals, comparing and contrasting individuals and groups and seeking explanations for similarities and differences within the data.

## 8.4 **Findings**

Data from the qualitative interviews suggested a number of areas that would be instructive in terms of developing our understanding of the patterns described elsewhere in this report. In the following we discuss respondents' accounts of the causes of their problems and illness, sources of support that respondents draw on when dealing with their problems, the language that they use to express any mental distress and cultural differences in attitudes towards mental illness. We report on each of these with a view to both identifying general patterns, and the way in which they may suggest similarities or differences across ethnic groups that might not have been picked up by the quantitative survey.

### 8.4.1 **Perceptions of cause**

In this section we will discuss the concept of cause of illness. We will look at the principal headings under which the 'discourses of causality', as used by respondents, can be conceptually organised. Illustrations will be provided under each heading. At the end of this section there is a short summary of our observations and conclusions about the pattern of understandings of cause of illness among the respondents to this study.

Respondents generally used the idea of 'cause' or 'precipitating circumstances', making recurrent mention of 'how it all began', and in doing so detailed a range of circumstances, situations, or difficulties that they felt underpinned their experience of mental distress. While some of the difficulties mentioned below  in particular racism  were fairly specific to non-white groups, other problems were common to all ethnic groups represented in the study. The interviews also suggested, however, that each of these may have particular features in Pakistani, Bangladeshi and, occasionally, Indian groups.

***Family relationships***

Family relationships were described as a source of distress by all of the ethnic groups included in the study, particularly where they involved loss, separation and divorce, and interpersonal violence and abuse, and were given equal emphasis by men and women. This encompassed different types of relationships: between spouses or partners, within an immediate family (such as between parents and children, or between siblings), or with wider family.

***Marital problems, divorce and separation***

Marital problems and breakdowns, together with their consequences, were discussed as an important cause of emotional distress. The circumstances of the relationship breakdown, particularly those involving violence, betrayal, financial difficulty, or situations that resulted in lone parenthood, or difficult arrangements to get access to children, were particularly influential in terms of the trauma produced. For example, an Irish woman, aged 29, who had been in an "extremely abusive" relationship her partner had attacked both her and her young daughter described how this had led to a loss of confidence and self-esteem and left her feeling that she was "damaged as far as another relationship goes". She spoke of the subsequent difficulties she experienced with trust and commitment and how she worried that she may not be able to form another relationship and would "end up alone". While a 47-year-old Irish man described "a sense of failure" about his divorce: "I've been brought up that one only gets married once, married for life and that's it". Some respondents talked about divorce in terms of getting married "too young" and not being careful enough in their choice of partner.

In contrast to these experiences of relationship breakdowns, the tension arising from ongoing unsuitable marriages and difficult relationships with in-laws was a recurrent theme among some of the respondents in South Asian groups. Such relationships clearly produced enormous difficulties with no obvious escape. However, these problems were not experienced in a uniform way. While 'family' was seen by some to exert unwanted constraints and to make unreasonable demands on them, others appeared to think the demands were reasonable, but feared that they could not meet them. One Indian woman in her early forties, for example, spoke of how her mother-in-law had come to stay with her and her husband after her first child was born and had insisted on "having [her] own say", telling her "how to deal with them". And a 46-year-old Pakistani widow described how she had been treated by the father-in-law, who had said "people don't let you live, do they?". Family problems were not confined to South Asian groups, though, either in their severity or in the way they were seen as the 'cause' of distress.

Difficulties surrounding the arrangement of marriage were a recurrent theme in the accounts of both women and men in the Pakistani, Bangladeshi and, to a lesser extent, Indian, groups. Some of the younger women who had migrated from Pakistan, Bangladesh and India had particular problems related to becoming a bride and coming to a new country at the same time. One 49-year-old Indian woman who moved to the UK aged 27, after an arranged marriage, described the pressure she felt at getting married to someone and moving to a country she did not know, having to come to terms with a very different culture and his very orthodox family. So, while women migrating from South Asian countries as brides did not necessarily object to the principle of the arranged marriage, in some cases they did object to both having no contact with the husband-to-be at all prior to the marriage and finding that the husband in Britain had no concept of changing gender roles. In expectations of greater freedom for women such brides were often ahead of their British husbands. This perhaps reflects social change in the Indian sub-continent and the fact that 'traditionalist' communities in the UK may not be keeping pace with this change. The 49-year-old Indian woman described earlier discussed her frustration at being kept in a "traditional Asian position" and, allied to this, that she felt her husband did not consult her about anything, even about selling his business, speaking only to his "own" family she had "no voice". In contrast, a 28-year-old Pakistani woman described how, because she was born in the UK, her husband felt that she was "too modernised".

Many women in the South Asian groups complained about how their husbands treated them. The various problems included not being allowed to go out, to work, or to have friends, feeling a lack of support or feeling frustration about not being included in key decision-making. This treatment was seen to be typical of South Asian men, with one Pakistani man discussing how he acted in a way that "a lot of Pakistani men wouldn't", treating his wife like the head of the household and apologising when he upset her. Not all men saw such behaviour as negative. For example, in one interview, where the wife was present and commented on the responses given by her husband, she described her frustration that he would "rather tell outside people" about his problems. He replied that he wished to avoid giving her his "pressure".

As well as more general issues, problems associated with arranged marriages partly arose from how decisions were made in relation to the marriage in the event of marital difficulties. One 32-year-old Pakistani woman, who was born in the UK, described how she felt unable to act about her husband's suspected affair because "it's just really for my parents, I can't take a step". In addition, the pressures on some men to get married and to make a good match were seen by some to lead to bad choices and, ultimately, unstable relationships. One 37-year-old Pakistani man, who moved to the UK when he was 11, commented that his plans to go to university and to pursue a career in the RAF had been "ruined" because he had to get married and provide for his wife and family. He now works part-time in a take-away. A 30-year-old Bangladeshi man blamed his divorce on having had to make a quick decision about marrying someone he did not know:

> "it's like going into somewhere blindly and you can't see things clearly. I've been looking for a bride, I couldn't find the right bride, at the last moment I had to get married".

Another problematic issue that seemed to be particular to those in the South Asian groups, and that exacerbated problems with in-laws and other wider family members, involved living arrangements after marriage. South Asian people often lived with one set of parents and siblings, which, in some circumstances, caused considerable stress.

Despite these accounts, it should not be assumed either that arranged marriages are necessarily difficult or that, where they are difficult, the configuration is the same in all cases. For example, one 28-year-old Pakistani woman, who was born in the UK, described how after their arranged marriage she and her husband had initially had some problems, because they did not know or understand each other, but how they now have a very close and supportive marriage. It is important to appreciate that so-called arranged marriages are frequently successful, and the difficulties of cultural change are successfully managed.

***Other family difficulties***

The legacy of past family difficulties, or longstanding problematic relationships with family members was seen by some to be the cause of current distress. Such experiences were often located in childhood. For example, an Indian man in his thirties, who had been born in the UK, spoke of a "traumatised childhood" that "wasn't a relaxed family situation" and had "no real affection", partly because his mother was "clinically depressed all her life". He said that his childhood experiences, combined with other problems in his life made him feel "cursed". Another respondent, a 47-year-old Irish man who had been out of work for some time as a result of his mental ill health, described how his father had had a troubled upbringing, which had affected the whole family, and particularly him. While he felt that he now understood his father better, his major concern was that his illness would affect his family in the same way his father's did him when he was a child. And a Black Caribbean woman described how her lack of confidence stemmed from her father's physical and psychological abuse towards herself, her siblings and her mother.

More recent family problems were also a source of difficulty for respondents. Caring for family members were seen by some respondents to be a source of considerable strain and worry. For instance, a Bangladeshi woman in her forties, who cared for her sick husband and six children in a three-bedroom house, spoke of the distress brought about by her home situation:

> "My husband is sick, my daughters are sick, no job, so many children, small house to live so I only know how much day to day worry I have".

Respondents were also concerned about, and alert to, the impact their own problems could have on other family members. In this respect, respondents talked about not wanting to be a 'burden' on their families, especially where this might lead to difficulty for others. For example, the 32-year-old Pakistani woman described earlier was concerned that her father's health might deteriorate if she told him about her marital problems. And one young Black Caribbean man described how him being attacked by his ex-girlfriend's new partner led to his mother having a stroke. And, in turn, problems experienced by family members were a source of distress for some respondents. So, for the man just described, his mother's stroke was far worse for him, "it was like the biggest heartbreak", and more instrumental in the development of the distress he reported, than anything associated with his girlfriend or the attack. Feeling unable to give sufficient or effective support to family members in difficulty made people feel impotent or isolated. However, some respondents also found that being a source of emotional support for friends and family caused problems. One Irish 29-year-old woman described how her family are constantly ringing for advice, which makes her feel that she has no-one to turn to herself in times of crisis: "who do I ring sometimes, you know?".

***Bereavement***

Finally, bereavement had serious consequences for mental health across all of the groups included in the study. A 35-year-old Bangladeshi man, who had severe mental health problems, described feeling like his "world collapsed" when his mother died. In general, when it happened respondents described bereavement as an important precursor to depression. Again, however, the circumstances of the bereavement acted as an important mediator. For example, while these issues affected individuals in all populations, they appeared to be associated with particular difficulties for those where there were family tensions and difficulties over funerals, especially where they involved international travel, problems that may particularly affect people from ethnic minority groups.

***Employment issues***

Another set of causes of mental distress mentioned in the interviews was a variety of problems related to employment. For some the type of work that they did was related to a sense of underachievement. One Bangladeshi man in his late thirties, who had been living in the UK for ten years, described his work as a restaurant chef as boring and "below me". Similarly, an Indian man of similar age and migration history, who worked as an assistant accountant, described how he feels overlooked at work, that his job is not progressing, and how this produces feelings of "stagnation and boredom". In migrant communities, it is common for people to work 'below their qualifications'.

Another recurrent work-related difficulty was that of being overworked. This was sometimes the only source of distress for some people. However, where it was reported along with other difficulties, it was difficult to decipher whether work was the cause of distress, or whether the combination of many different sources of stress culminated in a feeling of 'being over-worked'. For instance, a white British 46-year-old woman talked about how she felt she had to reduce the number of jobs she was doing for the sake of her "future health", although then went on to describe how her work problems were exacerbated by other family, marital and health problems. People described the tensions of trying to

hold a job when they knew that working conditions or job security were at risk. For example a white British man in his early thirties commented on how the restructuring of the company for which he was an account manager had made him feel stressed and "vulnerable". Most of his longstanding colleagues had been made redundant and he felt that the new regime was "making my life difficult".

Bankruptcies also led to serious problems for some people. One 37-year-old Pakistani man, who moved to the UK at 11 years of age, had owned a shop for five years. He had great difficulties while running the shop, which led to long hours and a lot of stress and, ultimately, to the shop being repossessed. This made him feel shocked and embarrassed "very small when sitting among friends" and "you lose your self-confidence, afraid to meet people, lose your self-respect". Such feelings were often exacerbated by having to take on menial work to make ends meet. For instance, the man described above was forced to take on a part-time job in a local takeaway, a job that he described as "rubbish". Business bankruptcies were concentrated among the South Asian group and, as others have illustrated, may reflect less experience in business enterprise and/or that such businesses are less well funded, compared with others, particularly for Pakistani and Bangladeshi people, or that they may have been 'pushed' towards self-employment as a response to unemployment.[19] Bankruptcies are then a real risk, and very distressing.

There were also cases where problems at work, or health problems, made people unable to work. Losing (or 'downgrading') employment or being on long-term sickness leave had significant effects on self-esteem and personal identity. One 45-year-old Pakistani man, who had worked as a machinist for 15 years before becoming unemployed, described how he had enjoyed his work and how he now feels bored and that he is not longer "achieving in life". Another man, aged 30 and from Bangladesh, who had had to stop work after being involved in a car accident, described how this made him feel "hopeless". A 42-year-old white British man expressed concerns that colleagues at work thought that he was "trying to work his ticket", because the doctors were having problems diagnosing the condition that is keeping him off work.

***Racism***

Experiences of racism were central to the accounts of 'non-white' respondents and were also present for some Irish respondents. Such experiences were clearly painful and important in the deep impact they had on people's lives. People referred to racism in a range of contexts. One such context was bullying (of their children or themselves) at school, in which the person or child may become fearful of going to school. One 36-year-old Indian man, who was born in the UK, said:

> "White kids and Indian kids just didn't mix, it was just kind of like they just spent all playtime beating each other up ... I found that quite a shock ... I genuinely hated it".

People experiencing such racism sometimes developed physical symptoms that prevented them from going to school and became part of a pattern of severe personal stress either for the child, the parent, or both. The Indian man mentioned above described how he "would have asthma attacks, not want to go to school, it's one way of hiding, it got me lots of attention at home".

Reports of racism in the workplace were also common. An Indian woman in her late twenties, who had been born in the UK, described how she was forced to give up her job as a teacher as a result of the racially-motivated discrimination and bullying she experienced:

> "How can I forget I used to be crying, crying ... all the time ... worst day in such a state I couldn't even walk home ... my body was shaking, I couldn't even walk from the school office to my classroom".

Racism experienced in the workplace was not always overt or explicit and respondents sometimes

spoke of what one person called "hidden racism". Here respondents referred to situations where they felt that their work life or career was impeded by racial prejudice, but could not identify a particular incident to substantiate their fears. For example, a lack of promotion, or the loss of the job altogether was sometimes felt to be the result of racism: "sometimes when you phone up for jobs ... they say they're going to phone you back and you know they're not going to". An Indian man, who felt he was struggling to succeed in his career in the face of prejudice, said:

> "You can kind of explain it on individual terms ... you can rationalise it ... the thing about institutional racism [is] statistically after a while you can't explain these things just on individual explanations"

Respondents also described experiencing racism in public places, either through shouted abuse or physical violence, generally from people unknown to respondents. For example, one respondent spoke of a pattern of repeated physical attacks, which severely undermined his confidence and his willingness to go out in public places. And a 37-year-old Pakistani man talked about the racism he experienced while running his shop:

> "[It was] very downheartening, because you're there and you're working, minding your own business, and you're providing a service ... you're not appreciated and that's very sickening".

Another respondent felt that he had been labelled as a "troublemaker" because of the combination of his ethnicity and his occupation:

> "The kind of attitude people have as well is that you're young and you're Asian and that you're a taxi driver so you have got to be a troublemaker... you're pulled up and blamed for something as soon as because of your colour ... there are people who do not even consider you to be a human being if you're not white".

More generally people spoke of how vulnerable they felt in public as a member of a non-white ethnic group. A Black Caribbean man in his mid-forties remarked that: "it's quite messy going out there ... you end up getting killed, end up getting stabbed".

The effects of racism on respondents' mental and physical health were clearly profound. In addition, was recurrent mention of how "tiring" it was to deal with racism. Respondents described how dealing with racism required an enormous amount of energy, both in handling the situation itself and in coping with its 'internal' (or personal) consequences, and in sustaining and encouraging themselves to move on and get over it.

***Financial difficulties***

Financial worries were a common and strong theme in respondents' accounts, and these problems seemed to be very stressful, both on their own, and in the way that they often accompanied other negative life events. In some cases, financial problems were related to a lack of employment and trying to live on benefits. For example, one Irish man in his forties who cares for his disabled wife was particularly frustrated at what he felt was a lack of recognition from the Government:

> "I could do with more state benefit ... you're a fulltime carer, you're on call 24 hours, 24/7, you don't get appreciated for it".

Failing businesses also led to financial difficulties, as described earlier. People also sometimes struggled to find the money to pay for education. For example, a 26-year-old Black Caribbean man who was trying to put himself through university commented that he had "never been in so much debt in all my life".

In addition to other problems, relationship breakdowns also produced significant financial strain as people tried to set up a household on their own, or with their children, perhaps having been left in some financial debt. A Black Caribbean single mother in her mid-thirties described how she felt a "smack in the face every time", as she discovered how much debt her ex-partner had left her in. And a 39-year-old white British single mother spoke of her financial problems occurring as a result of her ex-partner being "dead irresponsible with money".

Financial difficulties also affected other aspects of life. This was particularly evident in the problems people had with their housing, especially in South Asian households where large, often multigenerational, households led to overcrowding. One Bangladeshi woman in her mid-forties talked about how her youngest daughters have to sleep with her and her husband due to lack of space, but she did not feel that their situation was unusual: "everyone over here having more or less same problem like me". Such problems were not exclusive to those in South Asian groups. White British respondents also described problems with housing, such as their housing being in a bad state of repair or just general overcrowding. For example, a single mother who shared her bedroom with her two sons commented on how "it would be quite nice just to have my space that I could relax in".

***Health concerns***

Another key area thought by respondents to lead to mental distress was concern about physical health, although the two were rarely neatly separated in the accounts provided by respondents (see the section on symptomatic expression). For example, a 37-year-old Indian man described how his back was painful when he was under stress and how he had problems with his digestion, which led him to worry that he had bowel cancer, although he also said that he believes this to be unlikely.

This connection between physical and mental ill health was especially evident where the respondent appeared to have been given an unsatisfactory (from his or her point of view) understanding of the condition by a doctor, including its causes and consequences. This, and where the respondent was not convinced by a medical diagnosis, may also explain the concern about their treatment expressed by some respondents, particularly, though not exclusively, those in South Asian groups. One 40-year-old Bangladeshi woman, who had moved to the UK when she was 17, said that she only takes the medication her doctor gave her for her gastric pain when the pain is very bad, because "I don't trust doctors' medicine too much". The connection between mental and physical health was also particularly apparent where medical personnel had difficulty diagnosing the problem, a situation that was not specific to particular ethnic, gender, or language groups. For example, one white British man in his early forties experienced a condition that had kept him away from work for a year, but he had yet to receive any diagnosis. He talked about how he desperately wants a diagnosis and a sense of closure, even if it means he has to accept he is "mad", "it's confusing, it's very very very frustrating ... basically it leads to a lot of stress".

Health problems also made the impact of other negative life circumstances greater for some respondents. For example, a 40-year-old Bangladeshi man described how his work stress had been worse since his health had been bad. He reported having diabetes and high blood pressure.

***General causes***

Although respondents did make direct connections between events occurring in their lives (and often complex chains of events) and their experiences of mental distress and illness, they also located the cause and nature of mental illness in individual personalities and the environment more generally.

In terms of individual vulnerability to mental illness, a Bangladeshi woman, who had a high CIS-R score herself, described how mental illness "can get hold of people in different ways, some people

have it in the brain, others have it in their soul ['jaan'], some people have their, go bad inside". Similarly a Black Caribbean woman, also with a high CIS-R score, said:

> "I feel sorry for people ... they go ... mentally disturbed ... because they can't cope with society in general and they can't handle the system ... If they don't take their medication they're like animals ... crazy ... mad ... so mentally disturbed and gone".

Indeed, some respondents talked about depressive personalities. For example, a Black Caribbean man commented that "a lot of people are just miserable people full stop ... they just like being miserable ... you ain't got nothing to be depressed about you just want to be depressed". Related to this, some people felt that mental health problems are not curable. The Bangladeshi woman described above also said that there is no cure for "illness in the head there is no medicine ... nothing will work for this. You cannot alter someone's mind". And a Black Caribbean man, who had a low CIS-R score, said: "Once it's in your head, you can't get rid of it".

Another set of explanations for mental illness related it to the build up of worries and stress. One white British man talked about how stress:

> "Takes you out of your normal personality and your normal day-to-day thinking ... [over a long period] stress can turn into something more than that ... It starts affecting the state of mind in everything you do and the way you act with people ... You'll come to a point where there's the line and do you cross it or don't you and you can't go that far beyond it ... you're a complete mess".

And a 26-year-old Black Caribbean man, with a high CIS-R score, commented: "The brain can only take so much before it starts to overload". An Irish man, with a high CIS-R score, described how external stress becomes internalised:

> "Depression comes from ... down the line ... you become inactive through the anxiety and ... you withdraw from ... social things ... and then you become demoralised ... the next thing you know you do become depressed and you're always fighting ... to avoid sinking into [it]".

More specifically, some respondents from non-white ethnic minority groups described how their ill health had been at least partially caused by the British climate and culture. The cold British climate not only caused ill health itself, but also made people feel lonely and trapped inside their homes, unable to meet people. One Black Caribbean woman in her late thirties, who had moved to the UK from Jamaica when she was 14, said:

> "This country is so damn lonely ... when you're in Jamaica you can go outside and sit down, it's hot, it's beautiful, you know, it's not cold ... [in Britain] you have to wait for summer to come before you can go outside and relax".

And some people felt that their problems were specifically related to the 'British' way of doing things, with a Pakistani man commenting: "in this culture there are a lot of bills".

In contrast, some ethnic minority respondents felt that there were specific ways in which their own community affected their experiences of mental ill health. People in South Asian groups talked about how there is little understanding or experience of mental health problems in their "community", while other health problems are very common and so produce less worry. One 30-year-old Bangladeshi man, with a high CIS-R score, described feeling "very lonely", because he felt that he was the only one in the Bengali community who had problems of this nature. Some respondents also discussed such influences on people from different cultures and how this might lead them to deal with mental ill health in different ways. For example, a Pakistani man, who had moved to the UK aged 11 and who had a high CIS-R score, discussed how other people in a similar situation to himself might: "[go] off

the rail, probably English will start drinking and drugs, but I didn't do that".

***Summary and conclusions***

In the preceding section we explored what people see as the causes of their mental distress, and the ways in which these experiences have impacted on their health and lives. We have identified several key areas which were repeatedly discussed by respondents. These areas were discussed across the ethnic and language groups, however there were also important differences between the different ethnic groups in some areas. Family and marital problems, for example, were experienced by people across the different ethnic groups, but there were also some particular problems associated with divorce and separation that were concentrated among white and Black Caribbean groups and being in arranged marriages that were concentrated among people in South Asian groups. Experience of racism was also concentrated among those in non-white ethnic groups. There was no ethnic or language specificity in the discussion of other problems, including those related to employment, financial difficulties and health.

Our exploration of respondents' discussions of the experiences affecting their lives also suggested that different life experiences differed in the way they affected mental health. Racism, for example, was described as producing feelings of fear and tiredness, while financial difficulties (particularly bankruptcy or unemployment) were associated with a loss of self-respect, while bereavement left people feeling distraught. It is also important to recognise that the circumstances of an experience will be crucial. Both marital and employment problems, for example, may lead to, or be associated with financial difficulties, and employment problems were related to health difficulties and experiences of racism. So, while the broad experiences discussed in the preceding sections will all produce mental distress, there will also be subtle differences in the way these different experiences will affect mental health, which means that people will talk about themselves, and their mental health, differently. This evidence suggests that while health practitioners may find that these broad issues underlie severe anxieties and depressions across the different ethnic groups, they will also vary in nature from case to case.

8.4.2 **Social support**

The following describes the social support received by respondents, both in terms of helping them cope with the 'causes' of their mental distress (as described above) and with the mental distress itself. It covers the sources, nature and impact of that support. And also covers discussion of where a lack of support was problematic for the respondent. As such, this section shows how social support is closely related to both cause and experience of mental distress.

***Support from family and friends***

Family and friends were an important source of support for all of the different groups included in the study. Respondents talked about their family and friends providing both emotional and financial support in times of difficulty, with their help often described as providing the crutch that prevented them experiencing more extreme distress. A British-born 35-year-old Black Caribbean woman talked about how it was her friends who stopped her committing suicide:

> "They were just like there for me ... they just sort of made sure I didn't sort of like close myself off totally so that suicide was never an option".

Where this support was lacking it seemed to add an additional dimension to the distress experienced. A white British woman in her late thirties spoke of her sense of having "no release" from her situation, because she had insufficient support. Lack of forthcoming support from family and friends also

produced feelings of anger.

Respondents had several concerns related to discussing their problems with their family, including the impact that their mental illness itself might have on them. One 47-year-old Irish man with a high CIS-R score, said the "bad thing about [depression] is people don't always pick up upon how it affects everybody else around you". Respondents talked about making their family worry and about being a "burden", that members of their family have their own lives to lead, and that there may be things they feel they cannot talk about to their family. There was also a desire not to discuss problems with their family when they themselves are seen as the cause of the difficulty.

Some respondents talked about differences in the roles that family and friends provided. So some talked about their family providing practical support and their friends providing emotional support. Others did not make such a distinction, for example a Bangladeshi woman described being able to talk to her family "like they are my friends". But, it was widely felt, across the different ethnic groups included in the study, that even where they do not provide different roles, you need the support of both family and friends: "it's your whole network of support, not just your family, you need your friends".

Issues of whom to trust and the consequences of betrayal of that trust also influenced the decision about whom to talk to about problems. Here some respondents appeared to place more trust in friends, others in their family. For example, in explaining her preference for talking to her sister a Black Caribbean women in her mid-thirties said: "My sister not my friend, I would rather my sister stab me in the back than my friend". Some women in the South Asian groups expressed concern about talking to anyone other than their husbands. In some cases this was related to issues of trust, and in others to a lack of opportunities to discuss things with others, as they had no close family in the UK. This was particularly an issue for those who had experienced problems with 'local' members of their family. For example, a Pakistani 37-year-old woman said: "all of the time it is my husband who I speak to...because I have nobody here". She also described how she felt "sad" and "lonely" and would like to move back to Pakistan to be near her family. Despite such distance, though, some respondents also discussed how supportive they found their relationships with relatives overseas.

There were also problems that occurred when people felt they knew of no one who had had a similar experience to theirs and with whom they could helpfully discuss their problems. Some people felt that talking about your problems at all could make them worse. A Bangladeshi born man in his mid-forties, with a low CIS-R score, said:

> "I think talking about it has no benefit ... even if I shared it I would have to think seriously what I would say ... because if I say that I am getting worse that I have a dangerous illness that would increase my stress, and that would make me weaker".

***Role of religious faith***

There were religious (and therefore ethnic) differences in the extent to which religion provided a source of support in times of difficulty. Interestingly, those not reporting any particular religious faith also discussed spiritual support in general, or support from some form of god. In many cases, Muslim, Sikh and Hindu respondents with severe difficulties in their lives mentioned religious faith and observance both as a source of support and as a possible way of 'making sense of' ill-fortune (along the lines of 'God gives and takes away'). Religious faith as a source of support was also often mentioned by Black Caribbean respondents, but these religious supports were seemingly absent among white (British and Irish) respondents.

Religious faith was enacted in different ways. Some respondents, particularly those from South Asian groups, talked about attending the mosque, church, or other religious centre, and their children taking

religious lessons. Others talked about religious faith as a more personal experience. One 42-year-old UK-born Black Caribbean woman, who reported having no specific religion, had attended a number of different 'churches', but had become disillusioned by their doctrines:

> "I'm more of an emotional person and that's how I want my relationship with God to be ... a one-to-one ... my views with religion don't really work because they want this big happy family, you know, which I think is, it's important, but not to the point that it's more important than your inner self and your relationship with God".

This variation in the role of religion may also explain the absence of religious support in the accounts of white respondents. They tended to use religion more to provide a moral code than as a sense of community and support. As one 48-year-old, British-born Irish man explained:

> "I can't say I have got a strong burning conviction ... I believe in good Christian principles and try to get over to your children ... in your behaviour, but I am not a convicted Christian out evangelising".

The strength of religious faith also appeared to be related to suicidal thoughts and actions. Those who were more religious were less likely to discuss having considered suicide, and this may explain the infrequent mention of suicide by people from South Asian groups compared with other ethnic groups. So, for example, of those respondents in South Asian groups who did discuss suicidal tendencies, none followed a strict religious doctrine, with the exception of one Indian Hindu woman who described how her religious belief stopped her attempting suicide. She said:

> "I wanted to like kill myself ... something I felt, something inside me wanted to survive, not me, something inside wanted to survive. That's when I believe God, he had a miracle ... I was that close to death and I walked away and I ... said I'm going to fight for you".

However, this pattern may instead be a consequence of how strength of religious belief influences willingness to acknowledge or discuss suicidal thoughts, rather than differences in actual experience between groups. For example, one Bangladeshi respondent said that the interview was the first time he had disclosed his suicidal thoughts. While this 35-year-old Bangladeshi Muslim man also appeared not to be particularly religious, for example he did not discuss religion as providing him with any form of support, unlike other South Asian people interviewed, he also said that he did take part in religious practice when he was "scared".

***Summary and conclusions***

The preceding section moves beyond the first section and its exploration of the way in which specific causes of mental distress may affect its discussion, to determine whether there may be differences in who members of different ethnic groups choose to discuss their mental health problems with. This has included exploration of the roles of social and religious support.

Although in some instances, people may not wish to discuss their problems with anyone, on the whole the support of family and friends was seen to be crucial, both for help with the causes and with the consequences of their mental health problems. Although there was no ethnic difference in the overall importance attached to social support, some comments made during the interviews suggest there may be ethnic, and gender, differences in the availability of such support. Some women in South Asian groups, for example, may be at a particular disadvantage. Earlier in the chapter we discussed how arranged marriages mean some women have left their own family in the country in which they were brought up, although forms of long-distance communication have improved this, and some women have supportive relationships with their husband's family, which may go some way to counteract this problem. There was also a suggestion, again discussed earlier, that some more 'traditional' partnerships

in the South Asian groups did not allow much scope for the woman to make friends of her own.

Religion was another area where there may be some ethnic difference in what was perceived to be the most appropriate context for discussing mental illness and distress. Non-white ethnic groups had a religious orientation that, among other things, involved 'making sense of ill fortune', such that problems were seen to be initiated by god and often seen as a test. Passing this test involved greater religiosity, focus and determination. This sense of religious support was seemingly absent from discussions with white (British or Irish) groups. In this way, there may be seen to be some differences in the way that people from different ethnic groups interpret mental ill-health and ways to combat it.

### 8.4.3 **Symptomatic expression idioms of mental distress**

As described in the introduction, a central concern of studies of ethnic differences in mental illness is whether the idioms used to express mental distress are culturally informed; and culturally informed to a sufficient extent to make western psychiatric models of illness culturally bound. In this section the symptoms, idioms, or metaphors, used by respondents to describe mental distress are outlined. Here, it is worth remembering that the purposive selection of the sample for the qualitative study means that comparisons can be drawn between those who had high and low scores on the CIS-R (those with low scores were sampled on the basis of having reported difficulties in their lives), across different ethnic groups and, for ethnic minority respondents, age on migration and whether or not the interview was conducted in English.

As we have already indicated, in the qualitative interviews respondents often acknowledged that they had difficulties that were mental, or psychological, or 'psychiatric' in origin. Respondents in all of the ethnic groups included in the study used English language terms, such as 'depression', 'stress', 'anxiety', being 'mentally ill', or 'mentally disturbed', to describe their mental health problems. And there did not appear to be any variation in the use of these terms by migration status. Those who were interviewed in languages other than English used equivalent terms, such as the Bengali terms "dorchita" (meaning feeling anxious) "oshanti" (having no peace) and "shorill shanti" (something being stressful). Other, more colloquial, phrases, like people going 'mad', or 'off their heads', were also used cross-culturally.

But respondents also described their feelings in both mental and physical ways; respondents discussed their physical and mental health as related. As one Indian woman put it: "if you stay happy then your health will stay happy too". So, as with discussions of the causes of mental distress, the descriptions of symptoms of mental distress showed that they were closely inter-related and difficult to untangle. However, for ease of comparison with psychiatric models, in the following symptomatic expression is split into two broad (but as just suggested not exclusive) categories: emotional or psychological and physical. Then some description is provided of the metaphors used by respondents to describe their mental distress.

#### *Emotional or psychological symptoms*

The general terms depression, stress and anxiety were used by respondents across the different ethnic groups, regardless of age on migration to the UK and whether or not the respondent had a high CIS-R score. Related phrases such as sadness, downhearted, heartbreak and worries were also a feature of respondents' descriptions of their feelings, regardless of ethnic group. Similarly, feelings of anger and frustration were strong features of respondents' discussions. Typical phrases used by respondents were "short-tempered", "aggressive", "tantrums", "snappiness" and "moodiness". A Black Caribbean man talking about how depressed people tend to "growl" at people.

A loss of confidence, lack of self esteem, a lack of courage, or feeling "useless" were also experiences described across many of the different ethnic groups. For example, an Indian woman, who had

experienced racially-motivated work place bullying described how it: "made me feel I was nothing...I didn't deserve to live in this world...had no brain, I shouldn't have been born", and an Irish 29-year-old woman described feeling "like a piece of dog-doo". Respondents typically talked about how a loss of confidence stopped them doing the things they wanted to. However, such descriptions were exceptional among Bangladeshi respondents and among other South Asian respondents who were not interviewed in English.

Hopelessness was an experience described by respondents in all of the different ethnic groups, but on the whole only by those who had high CIS-R scores. One 36-year-old Indian man with a high CIS-R score described "feeling cursed", and a 29-year-old Irish woman, also with a high CIS-R score, spoke of having "no hope for the future, no glimmer of light".

Being nervous, "on edge", "uneasy", fearful, or panic (either generally or in terms of attacks) was a strong theme in the descriptions of respondents with a high CIS-R score, but mainly by those in the white (Irish and British) groups. However, these experiences were not entirely absent from the discussions of symptoms by respondents in other groups. Related feelings of being "trapped", restricted, desperate, without control and the "world closing in on you", were fairly universal experiences across groups.

A desire to hide, or be alone, was also a prominent theme in respondents' discussions of their feelings. Across the ethnic groups respondents spoke of wanting to "hide", or run away: "lock yourself in a room, in the dark and don't talk to anybody"; or going "into a hole ... I lock myself away ... I won't talk to people". This type of discussion was more commonly and strongly used by respondents with high CIS-R scores. Connected to this discourse were descriptions of feelings of guilt and shame, with some related discussions of being "punished", "victimised", loss of trust, "everyone hunting me". Again these were described across most of the different ethnic groups, the exception being Bangladeshi people. Another set of related experiences, expressed exclusively by white respondents with high CIS-R scores, were feeling lost and sorry for yourself. As discussed earlier, suicidal thoughts were much less prominent in the discussions by respondents in South Asian groups compared with other groups, and this absence appeared to be related to religiosity.

Along with these descriptions of distressing emotional experiences, respondents also talked about the impact of their distress on their functioning. So across ethnic groups respondents described classical symptoms of:

- Problems with getting to sleep, disturbed sleep and waking (early) and being unable to get back to sleep
- Fatigue
- Loss of concentration and poor memory
- Loss of motivation (which seemed to be more typically discussed by non-migrant ethnic minority respondents, or white respondents)
- A change (usually loss) of appetite
- Weight change.

There were also some apparently ethnic-specific experiences. Irish respondents with high CIS-R scores described being manic, psychotic and self-destructive. White respondents with low CIS-R scores described feeling pressures as a consequence of external sources of stress, which contrast with the internal physical pressures in the head reported by respondents in South Asian groups that are

described in the next section. And migrants from Bangladesh with high CIS-R scores described fighting and pulling inside the body ("shorill taan mareh").

***Physical symptoms***

A range of physical, or somatic, symptoms were described by respondents across all of the ethnic groups. Particularly prominent were discussions of pain. These included pain in the chest, feeling tightness in the chest and having palpitations, which were fairly universal across groups. Headaches and backaches were also a common experience across ethnic groups. For example, a Bangladeshi man who had migrated to the UK described how he avoided situations that would cause him "too much headache". "Too much headache" was also caused by the children of a Black Caribbean mother, adding to the other problems she had "round my head", suggesting that some of this discussion was metaphorical.

However, less specific experiences of general aches and pains, or more specific experiences of heat or burning in the body or head, or feeling like their head is coming off or splitting ("maatar fatail-lar" in Bengali), were more typically described by non-English speaking respondents in South Asian groups. Related to this were descriptions of intense pressure focussed in the head or brain (the head "steaming" or "boiling" or "pressure" in the head), perhaps because of dwelling on problems too much, which were present in the discussions of people with high CIS-R scores who had migrated from South Asian countries. For example, an Indian woman, who moved to the UK aged 21, and who had a high CIS-R score, when talking about the way her grief manifested itself said: "the pressure stays in my head all the time ... sometimes after thinking and thinking I get this tugging at the back of my neck". And a 48-year-old Pakistani man who moved to the UK aged 14 and had a high CIS-R score, described how he feels "like my head's going to burst".

A sense of blood pressure rising was another experience described by migrants from South Asia, but by those with both high and low CIS-R scores. This experience was not in response to any formal diagnosis, at least for most of these respondents, so it is unclear whether it was indicative of an actual physical symptom, or associated with something more emotional in origin, such as the feelings of "pressure" in the head or brain described above.

A range of digestive problems was described by respondents in all ethnic groups, but typically by those with low CIS-R scores. These included stomach problems, stomach ulcers, irritable bowel syndrome, colitis and constipation.

Although not exclusive to the descriptions of Bangladeshi and Pakistani respondents who had migrated to the UK, a wide range of other physical symptoms were more common to their accounts. These included feeling weak, body being gripped by shaking or pulling ("shorill kaafel" and "shorill taan mareh" in Bengali), restlessness, dizziness ("maatar fatail koreh") and breathlessness. These symptoms were particularly common among those with high CIS-R scores. More fundamental physical changes were described by a few respondents with high CIS-R scores who had migrated from South Asian countries: looking ill or changing colour (an experience of migrants from India); paralysis (an experience of migrants from Pakistan); and a sense that they might die (though not related to any suicidal tendencies) (also an experience of migrants from Pakistan).

White British, Caribbean and English-speaking Indian respondents discussed having problems functioning. In each instance, functioning problems were related to an inability to do day-to-day things, for example not being able to go to work, attend courses or fulfil responsibilities at home. People talked about not being able to "think" properly, not being able to do anything other than sit at home and cry, or having "no life".

### *Metaphors*

Although above we have identified quite specific experiences of symptoms within the accounts provided by respondents, their accounts were obviously not as 'itemised' as this. Indeed, many of the respondents used quite metaphorical language during the interviews to describe their experiences. Some of these descriptions appeared to fit quite closely with models of mental illness rooted in western psychiatry. For example, a white British woman in her mid-forties, with a high CIS-R score, said:

> "The worst thing about depression ... it puts you into this spiral and once you get so far down it's hard to get ... out ... you go down this little whirlpool ... it's like pulling yourself up the rungs of a ladder and your arms aren't strong enough to pull you right the way up".

And an Irish man of 47 years, who also had a high CIS-R score, described how he is "treading water", trying not to "sink" into his depression, but that he cannot see the "light at the end of the tunnel at the moment". A 31-year-old Irish woman spoke of her marital break-up that:

> "stressed me out to the point where I thought there was nothing ahead of me ... everything was grinding to a halt ... it's just like being in a dark tunnel ... seeing the light so far away, it felt like you were fighting to get to the light".

Other descriptions, however, were further removed from the idioms of western psychiatry. One 44-year-old Bangladeshi man, for example, who had moved to the UK aged 24 and had a low CIS-R score, spoke of how: "my body gets really weak when I stress and fall into a spell ... I go into another world" ("Diyan"). And a Bangladeshi woman, who had moved to the UK as a young child and also had a low CIS-R score, described how: "sometimes I have a funny feeling in my head ... one kind of silver dust like elements float in front of my eyes". A UK-born Black Caribbean woman, also with a low score on the CIS-R, said "I would just be sitting here sometimes and a sunset would come down and my mind would go 'I wish I was doing that'". And a 38-year-old Indian woman who moved to Britain aged 18 and had a low CIS-R score described her insides as being "made of stone" because they had become hardened by the distress she had experienced.

As suggested by the descriptions above, a range of metaphors were used to describe the emotional and physical symptoms experienced by respondents. For example, respondents from all ethnic groups talked about experiences such as: the "world is closing in on you"; feeling that their world had collapsed; feeling that everything had gone "dark"; a sensation of drowning; being in limbo; feeling empty; and feeling devastated.

Respondents, from all groups, also talked about their head or mind being "too high" (one white British woman describing her head as "touching the ceiling"), although respondents could also be "on a low", their "mind feel[ing] small". Also universal across groups, but mainly among respondents with high CIS-R scores, was experiencing problems associated with the heart, heartache, the heart feeling "heavy", or claustrophobic, for example. One Bangladeshi man, with a high CIS-R score, said "my heart was almost a black heart".

### *Summary*

In summary, and in terms of the applicability of a western psychiatric model of mental distress, emotional experiences of distress appeared to be broadly universal, rather than culturally specific. The idioms used to represent mental distress seemed to be fairly common across ethnic groups, while the more striking expressions were most commonly used by those with high CIS-R scores. However, some diagnostically important experiences (loss of confidence or self esteem, guilt and shame) seemed less prominent, or even absent, from the accounts provided by Bangladeshi respondents and, in some cases,

other respondents in South Asian groups who were not interviewed in English. So, while overall accounts were similar, the fit of particular symptoms, or items of experience, was less good for some cultural groupings than others. The apparent absence of suicidal ideation among those with strong religious beliefs is also worth noting.

Physical symptoms and idioms were common across all groups, although experiences appeared to be more fully and richly described by respondents in South Asian groups, particularly those who were migrants and interviewed in languages other than English.

This study, therefore, gives no support to claims that there is widespread 'misunderstanding' of the category 'mental health' among ethnic minority groups,[9,20] and that 'Asian patients', rather than others, somatise. The fact that the broad narratives are remarkably similar across ethnic groups would suggest that, once contact has been established with appropriate medical services, there should be no reason for differentials in the diagnosis of mental health problems. However, respondents also clearly have an elaborate language for describing mental and emotional symptoms and some specific symptoms do not appear to be universal across ethnic groups. This suggests that an itemised approach to measurement (as adopted by structured survey instruments, such as the CIS-R) might not be culturally neutral and may have a poorer fit for the experiences of some ethnic minority groups, particularly non-English speaking people in South Asian groups. The additional implication is that an itemised approach to diagnosis will also fail to adequately capture experiences of mental distress.

## 8.5 **Conclusions**

The qualitative interviews have been very instructive for two particular reasons: they have illustrated the language in which people describe illness, emotion and physical states; and they can place 'itemised' factors (such as experience of racism) within a narrative context, which often makes 'the way racism works in peoples' lives', for example, more understandable. The narrative accounts also indicate what the respondents see as important causes and experiences. In the structured survey interviews, respondents usually respond to all questions, questions that are then 'equal in value' (in the sense that each produces a response). Of course, it is also possible to ask respondents to 'rate' the comparative importance of factors that are asked about, but this can often be an artificial exercise. By contrast, in an open-ended topic-guided interview the 'priorities' of the respondent are evident in the narrative and these can be picked up by the analyst. These then stand out to the reader in a very striking way.

In this way we would suggest that the qualitative data alerts us to:

- The language used to describe physical and emotional states.
- The way in which respondents see the physical and emotional/mental as intimately linked, such that they are often described together.
- How, in terms of narrative accounts there is little variation in experiences across ethnic groups, idioms of distress and discussions of cause bore great similarity across ethnic groups, but at the level of particular symptoms those who have migrated from South Asian countries, particularly those in the Bangladeshi group and those not interviewed in English, appear to have experiences that are in some ways quite different from those of other respondents.
- The importance of family tensions. Difficult relationships are prominent in all groups, although recent migrants may have particular 'versions' of family problems which need to be understood.

- Experiences of racism are pervasive and powerful. It is distressing to read of the impact of racial hostility and violence, the experience of which, in a considerable number of cases, strikes right at the heart of peoples' ability to live tolerable lives; and finally.

- The importance of the impact of financial difficulties as a key component of personal distress.

Our overall conclusion is that qualitative accounts are an excellent tool for augmenting quantitative data. They both provide ways of improving our understanding of quantitative data and placing it in context and in some areas provide understandings which are not available in the quantitative data. Importantly, they indicate that the itemised approach to measuring experiences and symptoms does not fully represent the situation of respondents, as illustrated by the narrative accounts collected by qualitative interviews. This might be particularly important in terms of attempts to measure the extent of mental distress experienced by respondents, with itemised assessments of symptoms not fully capturing the range of idioms used by respondents in all ethnic groups, but particularly those respondents who had migrated from South Asia, even if central components of these idioms are captured.

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# 8 Context, cause and meaning: qualitative insights

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## Table

Table 8.1

**Number of people included in the qualitative study**

| | | Ethnic group | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Bangladeshi | Black Caribbean | Indian | Irish | Pakistani | White British | Total |
| **Gender** | | | | | | | | |
| | Male | 9 | 9 | 7 | 8 | 8 | 8 | 49 |
| | Female | 9 | 11 | 12 | 13 | 11 | 11 | 67 |
| **Age** | | | | | | | | |
| | 25-30 | 5 | 3 | 3 | 2 | 5 | 4 | 22 |
| | 31-35 | 4 | 4 | 3 | 3 | 3 | 4 | 21 |
| | 36-40 | 4 | 4 | 7 | 2 | 3 | 6 | 26 |
| | 41-45 | 2 | 7 | 5 | 5 | 5 | 2 | 26 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 46-50 | 3 | 2 | 1 | 9 | 3 | 3 | 21 |
| **Migration** | | | | | | | |
| Was born in UK or moved prior to age 11 | 6 | 14 | 10 | 16 | 9 | 19 | 74 |
| Moved to UK at age 11 or later | 12 | 6 | 9 | 5 | 10 | 0 | 42 |
| **CIS-R score** | | | | | | | |
| Survey identified mental distress | 7 | 10 | 11 | 9 | 11 | 9 | 57 |
| Survey did not identify mental distress | 11 | 10 | 8 | 12 | 8 | 10 | 59 |
| Language of interview | | | | | | | |
| Bengali | 11 | 0 | 0 | 0 | 0 | 0 | 11 |
| Bengali/English | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| Sylheti | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Punjabi | 0 | 0 | 4 | 0 | 1 | 0 | 5 |
| Urdu | 0 | 0 | 2 | 0 | 5 | 0 | 7 |
| Urdu/English | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Pothari | 0 | 0 | 0 | 0 | 5 | 0 | 5 |
| Pothari/English | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Hindi/English | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| English | 4 | 20 | 12 | 21 | 6 | 19 | 82 |
| **Religion** | | | | | | | |
| Christian | 0 | 11 | 0 | 7 | 0 | 7 | 25 |
| Muslim | 18 | 0 | 3 | 0 | 19 | 0 | 40 |
| Sikh | 0 | 0 | 5 | 0 | 0 | 0 | 5 |
| Hindu | 0 | 0 | 6 | 0 | 0 | 0 | 6 |
| Buddhist | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Rastafarian | 0 | 2 | 0 | 0 | 0 | 0 | 2 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | 0 | 7 | 5 | 13 | 0 | 12 | 37 |
| **Social class** | | | | | | | |
| Manual | 8 | 9 | 7 | 5 | 9 | 6 | 44 |
| Non-Manual | 3 | 10 | 12 | 16 | 4 | 13 | 58 |
| Not applicable* | 7 | 1 | 0 | 0 | 6 | 0 | 14 |
| **Marital status** | | | | | | | |
| Married | 15 | 6 | 15 | 13 | 15 | 11 | 75 |
| Divorced/Separated | 2 | 4 | 2 | 5 | 2 | 1 | 16 |
| Widowed | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| Single | 1 | 10 | 2 | 3 | 1 | 7 | 24 |

*This includes those who had never had paid employment, and therefore could not be coded into an occupational class.

# 9 Methods

*Kerry Sproston and Sally McManus*

## 9.1 Overview of research

The overall aim of the EMPIRIC survey was to estimate the prevalence of psychiatric morbidity, as measu by standard screening instruments, among minority ethnic populations resident in England, and to compare prevalence rates between groups. Also, the survey aimed to examine use of related services and to examine key factors that may be associated with mental disorder and ethnic differences in risk of mental disorder.

In addition to the quantitative survey, EMPIRIC included a qualitative study. This followed a purposively selected sub-sample of survey respondents, with the intention of investigating the cross-cultural validity of standard screening instruments, which were designed and validated in a Western context. By encouraging informants to use their own words, the study explored the terms and definitions that they used to describe mental health.

The sample for the survey was drawn from informants to the Health Survey for England, 1999, which focu on minority ethnic groups.[1] The following ethnic minority groups were included in both the quantitative ar qualitative studies:

- Black Caribbean
- Indian
- Pakistani
- Bangladeshi
- Irish
- White

The quantitative survey achieved interviews with 4280 individuals. The qualitative study involved intervie with 117 informants, purposively selected from each ethnic group, and, within each ethnic group, accordin CIS-R score.

## 9.2 Sampling

The EMPIRIC study included all HSE 1999 informants aged 16-74, who agreed, during the HSE interview be re-contacted, from the Black Caribbean, Indian, Pakistani, Bangladeshi and Irish groups. Ethnic origin a the HSE 1999 survey was self-defined (using the Census classificatory system[2] from a showcard) except fo the Irish group which was defined as born in Ireland or with a parent born in Ireland. The White group at H 1998 was defined using the same census classificatory system as that used in 1999.

The re-contact question was asked at the end of the HSE interview, and was worded as follows:

If at some future date we wanted to talk to you further about your health, may we contact you to see if you willing to help us again?

All those who answered 'no' to this question (about 8%) were excluded from the sample for the EMPIRIC study. Age was calculated from the HSE data, so that the selected sample was aged between 16 and 74 at tl time of the EMPIRIC interview. Those who were found, upon re-contact, to be out of this age range, were coded as 'ineligible for interview'.

Since the potential sample for the White group was considerably larger than that for the ethnic minority groups, it was necessary to sub-select members of this group. The White group was sub-sampled from HSI 1998 informants, as the general population questionnaire and measures for HSE 1998 were very similar to those for the ethnic minority questionnaire in HSE 1999. The question that classified informants as 'White' during the HSE 1998 did not establish self-perceived cultural origins or parents' country of birth. Therefore is likely that a small percentage of the EMPIRIC White group will comprise of Irish-origin informants. Ba on calculations from the HSE 1998 and 1999 data sets, it is possible to make an informed estimate of the si of this sub-group. Of the general population informants interviewed in HSE 1999 and who described themselves as 'White', 1.3% were born in Ireland and 3.1% were not born in Ireland, but did have an Irish mother or father. From this we can estimate that about 3% of the EMPIRIC White sample drawn from HSI 1998 is in fact second generation Irish, and that about 1% were born in Ireland.

## 9.3 **The questionnaire**

For the most part, the questions were taken from existing instruments, as outlined below:

- Use of health services and the Short Explanatory Model Interview.[3]
  Explanatory models (EMs) denote the 'notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process' .[4] They contribute to the research of respondents' own perspectives of illness and elicit local cultural perspectives of the sickness episode.

- Close persons questionnaire to measure social support taken from Whitehall II Study of British Civil Servants.[5]

- Social networks questions derived from the Alameda County Study.[6]

- Questions on carers taken from the General Household Survey.[7]

- Control at home and work taken from Whitehall II Study of British Civil Servants.[5]

- Chronic strains questions on problems with relatives, with financial problems over providing necessities and payment of bills, housing problems, and difficulties in the local neighbourhood taken from Whitehall II Study of British Civil Servants.[5]

- Discrimination/harassment taken from the Fourth National Survey.[8]

- SF12 Physical and Mental Health Summary Scales (Ware et al).

- Clinical Interview Schedule Revised.[9]

- Psychosis Screening Questionnaire (PSQ) was used to assess psychotic symptoms.[11]
- Social Functioning questionnaire.[12]
- Language and ethnic identity adapted from the Fourth National Survey.[13]

## 9.4 Obtaining ethical approval

Ethical approval for the 1999 survey was obtained from the North Thames Multi-Centre Research Ethics Committee and from all Local Research Ethics Committees (LRECs) in England.

The pilot study, which began in February 2000, required the receipt of ethical approval from thirteen LREC The seeking of ethical approval from the other LRECs in England, for the main stage fieldwork, began in February 2000. On the whole, the receipt of committee approval from each LREC was straightforward and did not compromise the fieldwork.

## 9.5 Provision for non-English speaking informants

All survey materials and questionnaires were translated into five languages: Hindi, Gujarati, Punjabi, Urdu Bengali. Interviewers who could speak and read these languages (as well as English) were recruited and trained in the survey procedures. Other people in a household were never used as interpreters for informan who could not speak English sufficiently well to be interviewed in English. The procedure was to allocate interviewer who could speak the appropriate language to a non-English speaking informant so that the interview could be conducted in the informant's own language. Since it is not possible to incorporate non-English letter script onto the CAPI programme, the translated version consisted of a paper document, whic was used alongside the computer.

## 9.6 Fieldwork procedures

### 9.6.1 **Briefings**

All interviewers were personally briefed, at 16 briefing sessions, by the research team.

### 9.6.2 **Advance letters**

Every sampled individual was sent a personalised advance letter which introduced the survey and stated th an interviewer would be calling to seek permission to interview.

### 9.6.3 **Making contact**

Initial contact was made by the interviewers in person. The first step was to identify the named informant, this was done by checking name and age. Once the correct informant had been identified and had agreed tc take part, the interview began.

### 9.6.4 **Quality control**

A large number of quality control measures were built into the survey at both data collection and subseque stages to check on the quality of interviewer performance. Recalls to check on the work of both interviewe and nurses were carried out at 10% of productive households. The computer program used by interviewers had in-built soft and hard checks, which included messages querying uncommon or unlikely answers (see Data Preparation).

## 9.7 Data preparation

### 9.7.1 The CAPI programme

The National Centre uses Blaise software to programme and run its CAPI questionnaires. Blaise allows interviewers ease of navigation around the programme and enables changes to be made without threatening the integrity of the interview data. Most of the questions in EMPIRIC were pre-coded, with a list of answer categories shown to the interviewer on the computer screen. The interviewer entered the numeric code that corresponded with a given response, which was then highlighted on screen to confirm that the interviewer had selected the correct value. For questions that permitted more than one response, a list of values could be entered separated by spaces.

Blaise has good facilities for dealing with dates and numeric data, which are assigned a range of columns for the number of digits required. Hard and soft checks were incorporated for numeric entries. A hard check prevents an out-of-range value being entered into the programme, while a soft check brings a display box up on the screen, prompting the interviewer to query an unexpected or unusual response. With a soft check the interviewer must either alter the value or confirm that it is correct before being able to proceed.

### 9.7.2 Coding

The coding team was fully briefed on the questionnaire and editing and coding procedures by an experienced supervisor. All of the initial work of each coder was checked by the supervisor or her assistant until satisfied that the coder had fully grasped the rules and was applying them correctly. Coders were required to record queries in a standardised way and these were examined by the supervision team on completion of each batch of work.

SIC and SOC coding was done for those informants who had changed jobs since their HSE interview and for whom details of their new job had been collected.

### 9.7.3 Editing

Computer assisted interviewing considerably reduces the need for office editing but does not eliminate it entirely. Some intervention by editors was necessary to take appropriate action where interviewers recorded a note in the computer record because they had encountered an unexpected situation. Final batch edit checks were also run to confirm that the integrity of data had been maintained during transit to the office and that no errors had been introduced during office operations.

Manual checking of all cases flagged because there was a possible mismatch between the person interviewed at HSE and at EMPIRIC was carried out, and six cases were deleted from the data set because of an apparent incompatibility.

### 9.7.4 Linking with HSE data

A number of variables from HSE 98 and HSE 99 were fed forward with the sample before interviewing took place. This included name, ethnicity and date of birth details, used by interviewers to ensure that they had selected the correct individual for interview. Where informants' details did not match those collected at the HSE interview, a query appeared on screen to prompt the interviewer to check the selection. To enable appropriate language interviewers to be pre-assigned to informants, language of interview at HSE was attached to the sample.

After fieldwork was complete a large number of variables and entire modules from HSE 98 and HSE 99 were merged in with the EMPIRIC data set and used in the analysis reported here. The modules included self-reported general health, self-reported long-standing illness, GHQ scores and social support. Demographic

variables brought over included country of birth, dwelling type, tenure, social class of head of household, income and education. A number of variables, such as main spoken language, age at migration and religion were only asked in 1999 and so could only be added to the sample drawn from that year.

### 9.7.5 **SPSS data file and derived variables**

The outcome at the end of data preparation was an SPSS data file, with one record per informant and no da at the household level. A number of complex variables were derived for use in the report analysis.

## 9.8 Survey response

### 9.8.1 **Response analysis**

The sample design, outlined above, describes how the sample consisted of named individuals drawn from informants who took part in the Health Survey for England in 1998 or 1999. In HSE, interviews were attempted with all of the adults resident in a selected household, which meant that some of the EMPIRIC sample lived in the same household as another informant. Because this is a survey of individuals rather tha of households, no response analysis is presented on the household level. The overall median interview leng was 42 minutes.

This section looks at individual response for the total sample (Table 9.1) and then at variations in response ethnic group.

Only productive informants who agreed to be followed up at HSE were included in the EMPIRIC sample. This means that, as a follow-up survey, the sample has experienced two waves of non-response. The individual level response rate for achieved interviews at HSE was lower for minority ethnic groups (from 8 to 90% within co-operating households) than for the 'general population' sample (92% within co-operating households). For more details of the non-response experienced at HSE, refer to the 1998 and 1999 HSE reports.[14]

### 9.8.2 **Total response**

Table 9.1 reports the detailed breakdown of response for the total issued sample. The Summary Table 9a below shows that due to various factors, including the informant having moved out of the survey area or to unknown new address; or the informant having died or having become 75 after the sample was drawn, 11% the sample was no longer eligible for interview. Out of the 7009 issued names, 6271 were found to be in sc (89%).

Table 9a: **Summary of response rate for total sample**

| Response | Number | % |
|---|---|---|
| Total issued names | 7009 | 100 |
| Not eligible (including movers) | 738 | 10.5 |
| Total in scope | 6271 | 89.4 |
| Refusal | 1473 | |
| No contact | 241 | |
| Other non-response | 276 | |
| Total interviews | 4281 | 6 |

Most refusals were received in person directly from the selected informant (17.6% of those in scope) with

further 2.2% refusing by post 2.2% being proxy refusals and 1.5% broken appointments. Most non-contact resulted from the interviewer being unable to make contact with the selected informant, though there were also cases where no contact was made with anyone at the household after 4 or more call attempts. The most common reason for any other unproductive outcome was that the informant was away on holiday or in hospital throughout the survey period.

The overall response rate achieved was 68.2%. This figure was calculated with the allocation of movers who we were unable to trace or follow-up within the survey area to the category of 'not eligible' to the survey. If this group is considered to be 'non contact', the revised overall response rate would be 62.3%.

9.8.3 **Response by ethnic group**

As Table 9b below shows, response varied by ethnic group with the highest rates being achieved amongst the White (71%) and Irish (72%) HSE informants, and the lowest rate amongst Indian informants (62%). The proportions of Black Caribbean, Bangladeshi and Pakistani selected sample participating were very similar around 68% and 69%.

Table 9b: **Summary of response rates by ethnic group**

| | White | | Irish | | Black Caribbean | | Bangladeshi | | Indian | | Pakistani | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | |
| **Total issued** | **1389** | **100** | **1133** | **100** | **1146** | **100** | **1035** | **100** | **1141** | **100** | **1165** | | | | | |
| Not eligible | 203 | 14.6 | 118 | 10.4 | 116 | 10.2 | 85 | 8.7 | 101 | 8.9 | 108 | | | | | |
| Total in scope | 1186 | 85.4 | 1015 | 89.6 | 1029 | 89.8 | 945 | 91.3 | 1040 | 91.1 | 1056 | 9 | | | | |
| **Total in scope** | **1186** | **100** | **1015** | **100** | **1029** | **100** | **950** | **100** | **1040** | **100** | **1056** | | | | | |
| Refusal | 288 | 24.3 | 244 | 24.0 | 244 | 23.7 | 192 | 20.2 | 286 | 27.5 | 219 | 2 | | | | |
| No contact | 22 | 1.9 | 21 | 2.1 | 58 | 5.6 | 39 | 4.1 | 47 | 4.5 | 54 | | | | | |
| Other non-response | 38 | 3.2 | 17 | 1.7 | 32 | 3.1 | 64 | 6.7 | 66 | 6.4 | 59 | | | | | |
| Completed interviews | 838 | 70.7 | 733 | 72.1 | 695 | 67.5 | 650 | 68.4 | 641 | 61.7 | 724 | 6 | | | | |

More of the White group white were found to be not eligible than was the case for the other ethnic groups (15% compared with 8% to 10%). This was due to the elapse of about two years between interview at HSE and follow-up at EMPIRIC, rather than the one year elapse for the rest of the sample.

9.8.4 **Language of interview**

The majority of interviews were conducted in English. The questionnaire was available in six other langua for informants whose first language was not English. As table 9c below shows, Bengali was the non-Englis language most frequently used, followed by Punjabi and Sylheti. Just 13 informants were interviewed in Hindi.

Table 9c: **Language of interview**

| | English | Gujarati | Hindi | Punjabi | Urdu | Bengali | Sylheti | No sta |
|---|---|---|---|---|---|---|---|---|
| Full interview | 3553 | 43 | 13 | 251 | 73 | 366 | 114 | |
| Proportion of total interviews % | 83.0 | 1.0 | 0.3 | 5.9 | 2.1 | 10.3 | 3.2 | |

# 9.9 Weighting

## 9.9.1 **Weighting in HSE 98 and 99**

Adults from the sample drawn from HSE 98 were not weighted at the HSE stage. This follows the standard approach in the HSE series not to weight the general population sample for variable non-response.

Weighting at HSE 99 was required for the minority ethnic group boost samples. Before the data could be u as a representative sample of the minority ethnic groups included, the imbalances created by the use of different probabilities of selection had to be removed. This was done by applying three sets of weights: the first to correct for the unequal probabilities of selection for postcode sectors, the second to correct for the varying probabilities of selection of adults within households, and the third to correct for the varying probabilities of selection of adults within households. These corrections were made by applying weights th were inversely proportional to the selection probabilities for the relevant postcode sectors, addresses and number of adults.

## 9.9.2 **Weighting in 'EMPIRIC'**

***Weighting the data***

Weighting has been applied to the data in all report tables in the analysis chapters (excluding tables which examine response rates). If weights had been applied to a particular case at the HSE stage (see above), thes were retained. In addition, weights were applied to all cases to adjust for non-response at the follow-up sta

In order to correct for bias by non-response to the follow-up, we took full advantage of the HSE data (available for both respondents and non-respondents to the follow-up) in an attempt to analyse the nature o non-response.

Logistic stepwise regression modelling was utilised to identify significant predictors of non-response. Response to the study (binary variable) was modelled as the dependent variable. A number of HSE variabl were included as possible predictors (independent variables). These included demographic indicators (eg a sex, marital status, ethnicity, etc.) health-related variables (eg self-assessed health, long-standing illness, smoking, blood pressure, etc) as well as PSU (eg NHS region) and household level indicators (eg social cla of head of household, household income, household type etc). To identify (and subsequently correct for) different response patterns by different minority ethnic groups, interactions with ethnicity were also includ

in the model.

The 'follow-up' weight was the product of the reciprocal of the model-predicted probability for every respondent to the follow-up and the weight at the HSE stage. The final weight was trimmed (below 2[1]Ž2th and above the 97[1]Ž2th percentile) to avoid excess variance inflation due to weighting and each sample gro was scaled by a constant factor to reflect its relative population size.

***Weighting the bases***

Both unweighted and weighted bases are shown on all tables. The unweighted cases show the actual numb of respondents in the cell. The weighted bases show the relative sizes of the various sample elements after weighting. Scaling factors have been applied so that the weighted size of each sample group should reflect relative population size. Thus the weighted base for the white group is very large relative to the minority ethnic group samples. The weighted sample sizes have no absolute significance, and should be interpreted solely as indicting relative sizes (which can be useful if, for example, it is required to combine data from different columns in their correct proportions).

## 9.10 **Age standardisation and risk ratios**

Apart from the Irish group, all the minority ethnic groups sampled had a younger age profile than the whi group, as the table below illustrates.

Table 9d: **Age, by minority ethnic group**

| | | | Black | | | |
|---|---|---|---|---|---|---|
| | White | Irish | Caribbean | Bangladeshi | Indian | Pakist |
| | % | % | % | % | % | |
| **Men** | | | | | | |
| 16-34 | 32 | 25 | 42 | 52 | 36 | |
| 35-54 | 43 | 48 | 29 | 31 | 44 | |
| 55+ | 26 | 27 | 29 | 18 | 19 | |
| **Women** | | | | | | |
| 16-34 | 31 | 31 | 37 | 64 | 40 | |
| 35-54 | 42 | 46 | 41 | 27 | 42 | |
| 55+ | 27 | 22 | 22 | 9 | 18 | |

Due to the variation in minority ethnic groups' age distribution from the white informants and from each other, differences in their psychiatric morbidity, health status or service use may result partly from age differences. Age standardisation is applied to remove the age element of the difference when comparing groups. For analysis purposes in this report, the age distribution to which all non-white ethnic groups have been standardised is an artificial distribution which was designed to minimise the increase in standard erro that the standardised weighting introduces.

When comparing groups, the age-standardised 'risk ratio' is shown in the case of a prevalence. With the Wh group having a base value of 1, a group with a risk ratio of 1.5 is 50% more likely (after allowing for age differences) to have that condition as the White group. Similarly, a risk ratio of 0.7 would mean that, after allowing for age differences, the prevalence of the condition is 30% lower in that group than in the populat

as a whole. The same procedure is used for means, but the ratios are referred to as 'ratios of means' (rather than 'risk ratios').

## 9.11 Estimating standard errors: design factors

The 1999 Health Survey, from which the minority ethnic sample for EMPIRIC was drawn, used an unequa probability stratified multi-stage sample design. The 1998 survey, providing the white sample, also used a multi-stage design involving the stratified selection of a sample of postal sectors. Details of these can be fo in the HSE 1999 report.[1] An effect of using complex sample designs is that standard errors for survey estimates may be higher than the standard errors that would be expected of a simple random sample of the same size.

The standard errors and design factors (defts) for EMPIRIC have been calculated in STATA version 6. The deft values presented in Tables 9.3 to 9.24 (which are themselves estimates subject to random sampling err are for survey estimates based on all males or females, or on males and females combined, within particula ethnic groups.

The tables present standard errors and defts for a number of key variables used in the analysis presented in this report. For each the first column shows the size of the sample or sub-sample on which it is based; the second shows the weighted base size; the third shows the proportion or mean as estimated by the sample; t fourth presents the 95% confidence interval and the final column shows the estimated deft.

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# 9 Methods

*Kerry Sproston and Sally McManus*

## Tables

Table 9.1

### Response rate for total sample

| | N | % |
|---|---|---|
| **Total issued names** | **7009** | **100** |
| **Not eligible** | **738** | **10.5** |
| Demolished/ derelict | 13 | 0.2 |
| Named respondent out of age range/ not eligible | 58 | 0.8 |
| Ineligible respondent  doesn't match HSE | 12 | 0.2 |

| | | |
|---|---|---|
| Insufficient address | 7 | 0.1 |
| Other address problem | 9 | 0.1 |
| Respondent died | 34 | 0.5 |
| Respondent moved to outside survey area | 165 | 2.4 |
| Respondent moved, no new address could be obtained | 440 | 6.3 |
| **Total in scope** | 6271 | 89.4 |
| **Refusal** | 1473 | |
| Office refusal | 136 | |
| Sampling unit information refused | 8 | |
| Refusal by selected person | 1101 | |
| Refusal by proxy | 89 | |
| Broken appointment, no recontact | 139 | |
| **No contact** | 241 | |
| No contact with anyone at the address | 69 | |
| Contact made at the address, but not with selected person | 145 | |
| Reissue not covered | 27 | |
| **Other non-response** | 276 | |
| Ill at home during survey period | 32 | |
| Away/in hospital throughout field period | 139 | |
| Physically or mentally unable / incompetent | 15 | |
| Other non-response | 90 | |
| **Completed interviews** | 4281 | |

Table 9.2

## Response rate by ethnic group

| Response | Ethnic group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | White | | Irish | | Black Caribbean | | Bangladeshi | | Indian | | Pakistar |
| | N | % | N | % | N | % | N | % | N | % | |
| **Total issued names** | **1389** | **100** | **1133** | **100** | **1146** | **100** | **1035** | **100** | **1141** | **100** | **116** |
| **Not eligible** | **203** | **14.6** | **117** | **10.3** | **116** | **10.1** | **85** | **8.2** | **102** | **8.9** | **10** |
| Demolished/ derelict | 0 | 0.0 | 0 | 0.0 | 2 | 0.2 | 1 | 0.1 | 2 | 0.2 | |
| Named respondent out of age range/ not eligible | 3 | 0.2 | 19 | 1.7 | 13 | 1.1 | 4 | 0.4 | 11 | 1.0 | |
| Ineligible respondent - doesn't match HSE | 0 | 0.0 | 2 | 0.2 | 2 | 0.2 | 4 | 0.4 | 1 | 0.1 | |
| Insufficient address | 1 | 0.1 | 0 | 0.0 | 2 | 0.2 | 1 | 0.1 | 2 | 0.2 | |
| Other address problem | 3 | 0.2 | 1 | 0.1 | 0 | 0.0 | 0 | 0.0 | 5 | 0.4 | |
| Respondent died | 12 | 0.9 | 5 | 0.4 | 8 | 0.7 | 4 | 0.4 | 4 | 0.4 | |
| Respondent moved to outside survey area | 47 | 3.4 | 17 | 1.5 | 23 | 2.0 | 20 | 1.9 | 34 | 3.0 | 2 |
| Respondent moved, no new address could be obtained | 137 | 9.9 | 73 | 6.4 | 66 | 5.8 | 51 | 4.9 | 43 | 3.8 | 7 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total in scope** | **1186** | **85.4** | **1016** | **89.7** | **1030** | **89.9** | **950** | **91.8** | **1039** | **91.1** | **105** |
| | | 100 | | 100 | | 100 | 100 | | 100 | | 10 |
| **Refusal** | **288** | **24.3** | **244** | **24.0** | **244** | **23.7** | **192** | **20.2** | **286** | **27.5** | **21** |
| Office refusal | 45 | 3.8 | 23 | 2.3 | 18 | 1.7 | 7 | 0.7 | 34 | 3.3 | |
| Sampling unit information refused | 1 | 0.1 | 1 | 0.1 | 2 | 0.2 | 1 | 0.1 | 0 | 0.0 | |
| Refusal by selected person | 206 | 17.4 | 185 | 18.2 | 185 | 18.0 | 147 | 15.5 | 212 | 20.4 | 16 |
| Refusal by proxy | 21 | 1.8 | 8 | 0.8 | 6 | 0.6 | 19 | 2.0 | 21 | 2.0 | 1 |
| Broken appointment, no recontact | 15 | 1.3 | 27 | 2.7 | 33 | 3.2 | 18 | 1.9 | 19 | 1.8 | 2 |
| **No contact** | **22** | **1.9** | **21** | **2.1** | **58** | **5.6** | **39** | **4.1** | **47** | **4.5** | **5** |
| No contact with anyone at the address | 2 | 0.0 | 7 | 0.0 | 22 | 0.0 | 18 | 0.0 | 8 | 0.0 | 1 |
| Contact made at the address, but not with selected person | 20 | 1.7 | 12 | 1.2 | 34 | 3.3 | 17 | 1.8 | 26 | 2.5 | 3 |
| Reissue not covered | 0 | 0.0 | 2 | 0.0 | 2 | 0.0 | 4 | 0.0 | 13 | 0.0 | |
| Other non-response | 38 | 3.2 | 17 | 1.7 | 32 | 3.1 | 64 | 6.7 | 66 | 6.4 | 5 |
| Ill at home during survey period | 10 | 0.8 | 4 | 0.4 | 4 | 0.4 | 1 | 0.1 | 3 | 0.3 | 1 |
| Away/in hospital throughout field period | 16 | 1.3 | 8 | 0.8 | 12 | 1.2 | 32 | 3.4 | 39 | 3.8 | 3 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Physically or mentally unable / incompetent | 2 | 0.2 | 1 | 0.1 | 2 | 0.2 | 8 | 0.8 | 2 | 0.2 | |
| **Other non-response** | **10** | **0.8** | **4** | **0.4** | **14** | **1.4** | **23** | **2.4** | **22** | **2.1** | **1** |
| Full interview | 838 | | 733 | | 695 | 649 | 641 | | 724 | | |
| Partial interview | - | | - | | - | 1 | - | | - | | |
| Total interviews | **838** | **70.7** | **733** | **72.1** | **695** | **67.5** | **650** | **68.4** | **641** | **61.7** | **72** |

Table 9.3

## True standard errors and 95% confidence intervals for confiding/emotional support, by minority ethnic group

| Confiding/emotional support | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 365 | 36735 | 14.3 | 0.26 | 13.8 | 14.8 |
| Irish | 322 | 1430 | 14.4 | 0.26 | 13.9 | 14.9 |
| Black Caribbean | 271 | 325 | 13.4 | 0.34 | 12.7 | 14.1 |
| Bangladeshi | 306 | 133 | 14.3 | 0.30 | 13.8 | 14.9 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Indian | 309 | 549 | 14.4 | 0.30 | 13.8 | 15.0 |
| | Pakistani | 328 | 337 | 14.4 | 0.26 | 13.9 | 14.9 |
| **Women** | | | | | | | |
| | White | 467 | 48965 | 15.1 | 0.18 | 14.7 | 15.4 |
| | Irish | 402 | 1846 | 15.6 | 0.21 | 15.2 | 16.0 |
| | Black Caribbean | 407 | 481 | 14.7 | 0.22 | 14.2 | 15.1 |
| | Bangladeshi | 334 | 136 | 14.8 | 0.22 | 14.3 | 15.2 |
| | Indian | 322 | 580 | 14.7 | 0.25 | 14.2 | 15.2 |
| | Pakistani | 380 | 370 | 15.0 | 0.20 | 14.6 | 15.3 |
| **Total** | | | | | | | |
| | White | 832 | 85700 | 14.7 | 0.16 | 14.4 | 15.0 |
| | Irish | 724 | 3276 | 15.1 | 0.18 | 14.7 | 15.4 |
| | Black Caribbean | 678 | 806 | 14.1 | 0.21 | 13.7 | 14.6 |
| | Bangladeshi | 640 | 269 | 14.6 | 0.23 | 14.1 | 15.0 |
| | Indian | 631 | 1129 | 14.5 | 0.19 | 14.2 | 14.9 |
| | Pakistani | 708 | 707 | 14.7 | 0.19 | 14.3 | 15.1 |

Table 9.4

## True standard errors and 95% confidence intervals for practical social support, by minority ethnic group

| Practical social support | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | 365 | 36735 | 4.8 | 0.15 | 4.5 | 5.0 |
| | Irish | 322 | 1430 | 5.0 | 0.17 | 4.6 | 5.3 |
| | Black Caribbean | 271 | 325 | 4.4 | 0.18 | 4.1 | 4.8 |
| | Bangladeshi | 306 | 133 | 5.7 | 0.18 | 5.4 | 6.1 |
| | Indian | 309 | 549 | 5.2 | 0.22 | 4.7 | 5.6 |
| | Pakistani | 329 | 338 | 5.0 | 0.24 | 4.6 | 5.5 |
| **Women** | | | | | | | |
| | White | 467 | 48965 | 4.5 | 0.12 | 4.3 | 4.8 |
| | Irish | 403 | 1851 | 4.9 | 0.15 | 4.6 | 5.2 |
| | Black Caribbean | 409 | 484 | 4.3 | 0.15 | 4.0 | 4.6 |
| | Bangladeshi | 335 | 137 | 5.6 | 0.19 | 5.3 | 6.0 |
| | Indian | 322 | 580 | 4.8 | 0.21 | 4.4 | 5.2 |
| | Pakistani | 380 | 370 | 5.2 | 0.19 | 4.8 | 5.6 |
| **Total** | | | | | | | |
| | White | 832 | 85700 | 4.6 | 0.10 | 4.4 | 4.8 |
| | Irish | 725 | 3281 | 5.0 | 0.12 | 4.7 | 5.2 |
| | Black Caribbean | 680 | 809 | 4.3 | 0.12 | 4.1 | 4.6 |
| | Bangladeshi | 641 | 270 | 5.7 | 0.15 | 5.4 | 6.0 |
| | Indian | 631 | 1129 | 5.0 | 0.16 | 4.7 | 5.3 |
| | Pakistani | 709 | 708 | 5.1 | 0.18 | 4.8 | 5.5 |

Table 9.5

## True standard errors and 95% confidence intervals for negative aspects of close personal relationships, by minority ethnic group

| Negative aspects of close personal relationships | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 365 | 36735 | 2.0 | 0.10 | 1.8 | 2.2 |
| Irish | 322 | 1430 | 2.2 | 0.11 | 2.0 | 2.4 |
| Black Caribbean | 271 | 325 | 2.7 | 0.18 | 2.4 | 3.1 |
| Bangladeshi | 306 | 133 | 3.8 | 0.16 | 3.5 | 4.2 |
| Indian | 309 | 549 | 2.8 | 0.14 | 2.5 | 3.0 |
| Pakistani | 329 | 338 | 2.4 | 0.14 | 2.1 | 2.7 |
| **Women** | | | | | | |
| White | 467 | 48965 | 2.4 | 0.10 | 2.2 | 2.6 |
| Irish | 403 | 1851 | 2.6 | 0.15 | 2.3 | 2.9 |
| Black Caribbean | 408 | 483 | 2.7 | 0.16 | 2.3 | 3.0 |
| Bangladeshi | 334 | 136 | 3.9 | 0.16 | 3.6 | 4.2 |
| Indian | 321 | 580 | 2.9 | 0.18 | 2.5 | 3.2 |
| Pakistani | 379 | 369 | 3.1 | 0.13 | 2.8 | 3.4 |
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| White | 832 | 85700 | 2.2 | 0.07 | 2.1 | 2.4 |
| Irish | 725 | 3281 | 2.4 | 0.10 | 2.2 | 2.6 |
| Black Caribbean | 679 | 808 | 2.7 | 0.15 | 2.4 | 3.0 |
| Bangladeshi | 640 | 269 | 3.9 | 0.12 | 3.6 | 4.1 |
| Indian | 630 | 1129 | 2.8 | 0.14 | 2.6 | 3.1 |
| Pakistani | 708 | 707 | 2.8 | 0.11 | 2.5 | 3.0 |

Table 9.6

## True standard errors and 95% confidence intervals for number of friends seen per month, by minority ethnic group

| Number of friends or acquaintances seen each month | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 363 | 36954 | 9.8 | 1.23 | 7.4 | 12.2 |
| Irish | 323 | 1459 | 9.2 | 1.04 | 7.1 | 11.2 |
| Black Caribbean | 277 | 331 | 9.3 | 1.05 | 7.2 | 11.4 |
| Bangladeshi | 319 | 134 | 7.1 | 0.84 | 5.4 | 8.7 |
| Indian | 315 | 562 | 8.1 | 1.06 | 6.0 | 10.2 |
| Pakistani | 345 | 345 | 9.5 | 1.04 | 7.5 | 11.6 |
| **Women** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | 469 | 49047 | 9.0 | 0.78 | 7.5 | 10.5 |
| | Irish | 409 | 1850 | 8.6 | 0.95 | 6.7 | 10.5 |
| | Black Caribbean | 405 | 483 | 7.8 | 0.81 | 6.2 | 9.4 |
| | Bangladeshi | 329 | 139 | 5.1 | 0.54 | 4.0 | 6.2 |
| | Indian | 330 | 589 | 4.6 | 0.65 | 3.3 | 5.9 |
| | Pakistani | 378 | 378 | 5.0 | 0.69 | 3.6 | 6.3 |
| **Total** | | | | | | | |
| | White | 832 | 86001 | 9.3 | 0.88 | 7.6 | 11.1 |
| | Irish | 732 | 3309 | 8.9 | 0.72 | 7.4 | 10.3 |
| | Black Caribbean | 682 | 814 | 8.4 | 0.75 | 6.9 | 9.9 |
| | Bangladeshi | 648 | 273 | 6.1 | 0.62 | 4.9 | 7.3 |
| | Indian | 645 | 1151 | 6.3 | 0.76 | 4.8 | 7.8 |
| | Pakistani | 723 | 723 | 7.2 | 0.71 | 5.8 | 8.6 |

Table 9.7

## True standard errors and 95% confidence intervals for number of relatives seen per month, by minority ethnic group

| Number of relatives seen each month | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | 365 | 37072 | 3.5 | 0.23 | 3.0 | 3.9 |
| | Irish | 323 | 1459 | 3.8 | 0.35 | 3.1 | 4.5 |
| | Black Caribbean | 279 | 334 | 3.8 | 0.31 | 3.2 | 4.4 |
| | Bangladeshi | 318 | 134 | 5.3 | 0.53 | 4.2 | 6.3 |
| | Indian | 316 | 565 | 4.6 | 0.47 | 3.7 | 5.5 |
| | Pakistani | 342 | 343 | 6.9 | 0.77 | 5.4 | 8.4 |
| **Women** | | | | | | | |
| | White | 470 | 49103 | 4.1 | 0.22 | 3.6 | 4.5 |
| | Irish | 410 | 1854 | 4.3 | 0.42 | 3.5 | 5.1 |
| | Black Caribbean | 411 | 489 | 4.6 | 0.40 | 3.8 | 5.4 |
| | Bangladeshi | 329 | 139 | 5.6 | 0.42 | 4.7 | 6.4 |
| | Indian | 331 | 591 | 5.8 | 0.72 | 4.4 | 7.3 |
| | Pakistani | 376 | 376 | 6.0 | 0.64 | 4.7 | 7.2 |
| **Total** | | | | | | | |
| | White | 835 | 86175 | 3.8 | 0.19 | 3.4 | 4.2 |
| | Irish | 733 | 3313 | 4.1 | 0.30 | 3.5 | 4.7 |
| | Black Caribbean | 690 | 823 | 4.3 | 0.30 | 3.7 | 4.9 |
| | Bangladeshi | 647 | 273 | 5.4 | 0.41 | 4.6 | 6.2 |
| | Indian | 647 | 1156 | 5.2 | 0.54 | 4.2 | 6.3 |
| | Pakistani | 718 | 719 | 6.4 | 0.58 | 5.3 | 7.6 |

Table 9.8

## True standard errors and 95% confidence intervals for positive on hypomania, by minority ethnic group

| Presence of hypomania | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Total** | | | | | | |
| White | 837 | 86294 | 0.8 | 0.34 | 0.2 | 1.5 |
| Irish | 733 | 3313 | 1.2 | 0.46 | 0.3 | 2.1 |
| Black Caribbean | 694 | 826 | 1.5 | 0.49 | 0.6 | 2.5 |
| Bangladeshi | 650 | 274 | 0.2 | 0.24 | -0.2 | 0.7 |
| Indian | 643 | 1156 | 1.4 | 0.87 | -0.3 | 3.1 |
| Pakistani | 724 | 724 | 1.0 | 0.36 | 0.3 | 1.7 |

Table 9.9

## True standard errors and 95% confidence intervals for positive on thought interference, by minority ethnic group

| Presence of thought interference | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| White | 837 | 86294 | 1.8 | 0.53 | 0.7 | 2.8 |
| Irish | 733 | 3313 | 1.0 | 0.41 | 0.2 | 1.7 |
| Black Caribbean | 694 | 826 | 2.6 | 0.64 | 1.3 | 3.8 |
| Bangladeshi | 650 | 274 | 1.4 | 0.60 | 0.2 | 2.6 |
| Indian | 643 | 1156 | 2.2 | 0.69 | 0.8 | 3.5 |
| Pakistani | 724 | 724 | 2.3 | 0.65 | 1.1 | 3.6 |

Table 9.10

## True standard errors and 95% confidence intervals for positive on delusions of persecution, by minority ethnic group

| Presence of delusions of persecution | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Total** | | | | | | |
| White | 837 | 86294 | 1.7 | 0.70 | 0.3 | 3.0 |
| Irish | 733 | 3313 | 1.8 | 0.55 | 0.7 | 2.9 |
| Black Caribbean | 694 | 826 | 3.5 | 0.68 | 2.1 | 4.8 |
| Bangladeshi | 650 | 274 | 2.0 | 0.70 | 0.7 | 3.4 |
| Indian | 643 | 1156 | 1.3 | 0.49 | 0.3 | 2.2 |
| Pakistani | 724 | 724 | 4.3 | 0.77 | 2.8 | 5.8 |

Table 9.11

## True standard errors and 95% confidence intervals for positive on feeling that 'something strange is taking place', by minority ethnic group

| Positive on feeling that 'something strange is taking place' | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Total** | | | | | | |
| White | 837 | 86294 | 3.7 | 0.93 | 1.9 | 5.5 |
| Irish | 733 | 3313 | 4.3 | 0.79 | 2.8 | 5.9 |
| Black Caribbean | 694 | 826 | 6.8 | 1.10 | 4.7 | 9.0 |
| Bangladeshi | 650 | 274 | 1.8 | 0.63 | 0.5 | 3.0 |
| Indian | 643 | 1156 | 5.7 | 1.25 | 3.3 | 8.2 |
| Pakistani | 724 | 724 | 5.3 | 0.98 | 3.4 | 7.2 |

Table 9.12

## True standard errors and 95% confidence intervals for positive on auditory hallucinations, by minority ethnic group

| Positive on auditory halucinations | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| White | 837 | 86294 | 1.5 | 0.47 | 0.6 | 2.4 |
| Irish | 733 | 3313 | 1.4 | 0.47 | 0.5 | 2.3 |
| Black Caribbean | 694 | 826 | 2.5 | 0.59 | 1.3 | 3.6 |
| Bangladeshi | 650 | 274 | 0.6 | 0.28 | 0.0 | 1.2 |
| Indian | 643 | 1156 | 0.6 | 0.29 | 0.1 | 1.2 |
| Pakistani | 724 | 724 | 0.9 | 0.45 | 0.1 | 1.8 |

Table 9.13

## True standard errors and 95% confidence intervals for screening positive on psychosis, by minority ethnic group

| | Positive on psychosis | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|---|
| **Total** | | | | | | | |
| | White | 837 | 86294 | 6.0 | 1.04 | 4.0 | 8.0 |
| | Irish | 733 | 3313 | 7.9 | 1.10 | 5.7 | 10.1 |
| | Black Caribbean | 694 | 826 | 12.1 | 1.34 | 9.5 | 14.7 |
| | Bangladeshi | 650 | 274 | 4.9 | 1.17 | 2.6 | 7.2 |
| | Indian | 643 | 1156 | 8.7 | 1.69 | 5.4 | 12.0 |
| | Pakistani | 724 | 724 | 9.9 | 1.49 | 7.0 | 12.8 |

Table 9.14

**True standard errors and 95% confidence intervals for presence of a common mental disorder, by minority ethnic group**

| | Presence of a CMD | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|---|
| **Men** | | | | | | | |
| | White | 368 | 37072 | 11.6 | 1.8 | 8.0 | 15.2 |
| | Irish | 329 | 1459 | 18.4 | 2.4 | 13.7 | 23.1 |
| | Black Caribbean | 280 | 335 | 13.8 | 2.3 | 9.3 | 18.2 |
| | Bangladeshi | 312 | 135 | 12.9 | 2.3 | 8.5 | 17.4 |
| | Indian | 315 | 565 | 12.1 | 2.0 | 8.1 | 16.1 |
| | Pakistani | 337 | 345 | 12.6 | 2.1 | 8.5 | 16.7 |
| **Women** | | | | | | | |
| | White | 469 | 49222 | 19.0 | 2.4 | 14.4 | 23.7 |
| | Irish | 404 | 1854 | 18.6 | 2.1 | 14.6 | 22.7 |
| | Black Caribbean | 414 | 491 | 19.8 | 2.3 | 15.2 | 24.3 |
| | Bangladeshi | 338 | 139 | 12.3 | 2.5 | 7.4 | 17.2 |
| | Indian | 328 | 591 | 23.8 | 3.0 | 18.0 | 29.6 |
| | Pakistani | 387 | 379 | 26.0 | 2.2 | 21.6 | 30.4 |
| **Total** | | | | | | | |
| | White | 837 | 86294 | 15.8 | 1.7 | 12.5 | 19.0 |
| | Irish | 733 | 3313 | 18.5 | 1.5 | 15.6 | 21.5 |
| | Black Caribbean | 694 | 826 | 17.3 | 1.7 | 13.9 | 20.8 |
| | Bangladeshi | 650 | 274 | 12.6 | 1.9 | 8.9 | 16.4 |
| | Indian | 643 | 1156 | 18.1 | 1.8 | 14.5 | 21.6 |
| | Pakistani | 724 | 724 | 19.6 | 1.6 | 16.6 | 22.7 |

Table 9.15

## True standard errors and 95% confidence intervals for any anxiety disorder, by minority ethnic group

| Presence of any anxiety disorder | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 368 | 37072 | 3.0 | 0.83 | 1.4 | 4.6 |
| Irish | 329 | 1459 | 5.9 | 1.35 | 3.3 | 8.5 |
| Black Caribbean | 280 | 335 | 4.7 | 1.51 | 1.7 | 7.7 |
| Bangladeshi | 312 | 135 | 3.6 | 1.11 | 1.4 | 5.8 |
| Indian | 315 | 565 | 1.4 | 0.54 | 0.3 | 2.5 |
| Pakistani | 337 | 345 | 4.4 | 1.22 | 2.0 | 6.8 |
| **Women** | | | | | | |
| White | 469 | 49222 | 3.9 | 1.08 | 1.8 | 6.0 |
| Irish | 404 | 1854 | 5.4 | 1.18 | 3.1 | 7.7 |
| Black Caribbean | 414 | 491 | 4.0 | 1.00 | 2.0 | 6.0 |
| Bangladeshi | 338 | 139 | 1.9 | 0.78 | 0.4 | 3.5 |
| Indian | 328 | 591 | 7.3 | 1.75 | 3.8 | 10.7 |
| Pakistani | 387 | 379 | 5.4 | 1.33 | 2.8 | 8.0 |
| **Total** | | | | | | |
| White | 837 | 86294 | 3.5 | 0.71 | 2.1 | 4.9 |
| Irish | 733 | 3313 | 5.6 | 0.89 | 3.9 | 7.4 |
| Black Caribbean | 694 | 826 | 4.3 | 0.84 | 2.6 | 5.9 |
| Bangladeshi | 650 | 274 | 2.8 | 0.74 | 1.3 | 4.2 |
| Indian | 643 | 1156 | 4.4 | 0.93 | 2.6 | 6.2 |
| Pakistani | 724 | 724 | 4.9 | 0.98 | 3.0 | 6.8 |

Table 9.16

## True standard errors and 95% confidence intervals for presence of any depressive disorder, by minority ethnic group

| Presence of any depressive disorder | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 368 | 37072 | 2.4 | 0.79 | 0.9 | 4.0 |
| Irish | 329 | 1459 | 1.8 | 0.78 | 0.2 | 3.3 |
| Black Caribbean | 280 | 335 | 2.2 | 0.85 | 0.6 | 3.9 |
| Bangladeshi | 312 | 135 | 2.1 | 0.84 | 0.5 | 3.7 |
| Indian | 315 | 565 | 1.7 | 0.68 | 0.3 | 3.0 |
| Pakistani | 337 | 345 | 2.4 | 0.93 | 0.6 | 4.2 |
| **Women** | | | | | | |
| White | 469 | 49222 | 3.3 | 1.06 | 1.2 | 5.4 |
| Irish | 404 | 1854 | 3.5 | 1.10 | 1.4 | 5.7 |
| Black Caribbean | 414 | 491 | 2.5 | 0.77 | 1.0 | 4.0 |
| Bangladeshi | 338 | 139 | 1.6 | 0.83 | 0.0 | 3.3 |
| Indian | 328 | 591 | 5.7 | 1.41 | 3.0 | 8.5 |
| Pakistani | 387 | 379 | 6.3 | 1.54 | 3.3 | 9.3 |
| **Total** | | | | | | |
| White | 837 | 86294 | 2.9 | 0.77 | 1.4 | 4.4 |
| Irish | 733 | 3313 | 2.8 | 0.70 | 1.4 | 4.1 |
| Black Caribbean | 694 | 826 | 2.4 | 0.59 | 1.3 | 3.6 |
| Bangladeshi | 650 | 274 | 1.9 | 0.59 | 0.7 | 3.0 |
| Indian | 643 | 1156 | 3.8 | 0.85 | 2.1 | 5.4 |
| Pakistani | 724 | 724 | 4.5 | 0.89 | 2.7 | 6.2 |

Table 9.17

## True standard errors and 95% confidence intervals for presence of mixed anxiety and depressive disorder, by minority ethnic group

| | Presence of MADD | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|---|
| **Men** | | | | | | | |
| | White | 368 | 37072 | 7.4 | 1.48 | 4.5 | 10.3 |
| | Irish | 329 | 1459 | 11.5 | 2.25 | 7.1 | 15.9 |
| | Black Caribbean | 280 | 335 | 8.3 | 1.72 | 4.9 | 11.6 |
| | Bangladeshi | 312 | 135 | 8.7 | 1.95 | 4.8 | 12.5 |
| | Indian | 315 | 565 | 9.7 | 1.82 | 6.1 | 13.2 |
| | Pakistani | 337 | 345 | 7.1 | 1.42 | 4.3 | 9.9 |
| **Women** | | | | | | | |
| | White | 469 | 49222 | 13.7 | 1.89 | 10.0 | 17.4 |
| | Irish | 404 | 1854 | 11.7 | 1.73 | 8.3 | 15.1 |
| | Black Caribbean | 414 | 491 | 14.5 | 2.12 | 10.3 | 18.6 |
| | Bangladeshi | 338 | 139 | 9.4 | 2.27 | 5.0 | 13.9 |
| | Indian | 328 | 591 | 14.1 | 2.35 | 9.5 | 18.7 |
| | Pakistani | 387 | 379 | 17.0 | 1.88 | 13.4 | 20.7 |
| **Total** | | | | | | | |
| | White | 837 | 86294 | 10.9 | 1.26 | 8.5 | 13.4 |
| | Irish | 733 | 3313 | 11.6 | 1.37 | 8.9 | 14.3 |
| | Black Caribbean | 694 | 826 | 12.0 | 1.46 | 9.1 | 14.8 |
| | Bangladeshi | 650 | 274 | 9.0 | 1.56 | 6.0 | 12.1 |
| | Indian | 643 | 1156 | 11.9 | 1.40 | 9.2 | 14.7 |
| | Pakistani | 724 | 724 | 12.3 | 1.16 | 10.0 | 14.6 |

Table 9.18

## True standard errors and 95% confidence intervals for the summary indicator exploring problems with social functioning, by minority ethnic group

| Social functioning | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|
| White | 825 | 84951 | 3.9 | 0.18 | 3.5 | 4.2 |
| Irish | 725 | 3278 | 4.0 | 0.14 | 3.7 | 4.3 |
| Black Caribbean | 672 | 802 | 4.6 | 0.16 | 4.3 | 4.9 |
| Bangladeshi | 629 | 266 | 5.6 | 0.16 | 5.3 | 5.9 |
| Indian | 630 | 1134 | 4.5 | 0.19 | 4.1 | 4.9 |
| Pakistani | 693 | 690 | 5.0 | 0.26 | 4.5 | 5.5 |
| **Total** | 4174 | 91121 | 4.5 | 0.08 | 4.4 | 4.7 |

Table 9.19

## True standard errors and 95% confidence intervals for the summary indicator exploring the existence of chronic strains, by minority ethnic group

| Chronic strain | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Upper 95% CI |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| White | 835 | 86078 | 1.3 | 0.06 | 1.2 | 1.5 |
| Irish | 732 | 3308 | 1.4 | 0.07 | 1.3 | 1.6 |
| Black Caribbean | 689 | 818 | 1.7 | 0.07 | 1.6 | 1.9 |
| Bangladeshi | 643 | 270 | 2.3 | 0.10 | 2.2 | 2.5 |
| Indian | 638 | 1142 | 1.4 | 0.06 | 1.3 | 1.5 |
| Pakistani | 717 | 717 | 1.6 | 0.07 | 1.4 | 1.7 |
| **Total** | 4254 | 92333 | 1.6 | 0.03 | 1.6 | 1.7 |

Table 9.20

## True standard errors and 95% confidence intervals for SF12 physical health score, by minority ethnic group

| | SF12 physical health score | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Lower 95% CI |
|---|---|---|---|---|---|---|---|
| **Total** | | | | | | | |
| | White | 295 | 30560 | 44.4 | 0.83 | 42.7 | 46.0 |
| | Irish | 304 | 1334 | 43.6 | 0.91 | 41.8 | 45.4 |
| | Black Caribbean | 245 | 284 | 41.2 | 1.04 | 39.2 | 43.2 |
| | Bangladeshi | 149 | 64 | 37.5 | 1.21 | 35.1 | 39.9 |
| | Indian | 212 | 369 | 41.0 | 0.97 | 39.1 | 42.9 |
| | Pakistani | 239 | 225 | 38.6 | 0.92 | 36.8 | 40.4 |

Table 9.21

## True standard errors and 95% confidence intervals for saw doctor about stress or emotional problems in last year, by minority ethnic group

| Saw doctor about stress or emotional problems | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Lower 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 368 | 37072 | 5.0 | 1.27 | 2.6 | 7.5 |
| Irish | 329 | 1459 | 5.2 | 1.67 | 1.9 | 8.5 |
| Black Caribbean | 280 | 335 | 3.5 | 1.23 | 1.1 | 5.9 |
| Bangladeshi | 312 | 135 | 4.0 | 1.42 | 1.2 | 6.8 |
| Indian | 315 | 565 | 4.3 | 1.11 | 2.1 | 6.5 |
| Pakistani | 337 | 345 | 3.8 | 1.19 | 1.4 | 6.1 |
| **Women** | | | | | | |
| White | 469 | 49222 | 9.3 | 1.42 | 6.5 | 12.1 |
| Irish | 404 | 1854 | 11.6 | 1.89 | 7.9 | 15.3 |
| Black Caribbean | 414 | 491 | 6.9 | 1.26 | 4.5 | 9.4 |
| Bangladeshi | 338 | 139 | 3.4 | 1.21 | 1.0 | 5.8 |
| Indian | 328 | 591 | 8.4 | 1.79 | 4.9 | 11.9 |
| Pakistani | 387 | 379 | 5.4 | 1.27 | 2.9 | 7.9 |
| **Total** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| White | 837 | 86294 | 7.4 | 0.85 | 5.8 | 9.1 |
| Irish | 733 | 3313 | 8.8 | 1.26 | 6.3 | 11.2 |
| Black Caribbean | 694 | 826 | 5.5 | 0.85 | 3.9 | 7.2 |
| Bangladeshi | 650 | 274 | 3.7 | 0.86 | 2.0 | 5.4 |
| Indian | 643 | 1156 | 6.4 | 1.15 | 4.1 | 8.7 |
| Pakistani | 724 | 724 | 4.6 | 0.90 | 2.8 | 6.4 |

Table 9.22

## True standard errors and 95% confidence intervals for seeing doctor in the last six months, by minority ethnic group

| Saw doctor in last 6 months | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Lower 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 368 | 37072 | 55.7 | 3.25 | 49.4 | 62.1 |
| Irish | 329 | 1459 | 62.7 | 3.16 | 56.5 | 68.9 |
| Black Caribbean | 280 | 335 | 62.2 | 3.75 | 54.9 | 69.6 |
| Bangladeshi | 312 | 135 | 76.5 | 2.76 | 71.1 | 82.0 |
| Indian | 315 | 565 | 73.1 | 3.01 | 67.2 | 79.0 |
| Pakistani | 337 | 345 | 68.4 | 3.37 | 61.8 | 75.0 |
| **Women** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | 469 | 49222 | 70.7 | 2.16 | 66.4 | 74.9 |
| | Irish | 404 | 1854 | 72.4 | 2.61 | 67.3 | 77.5 |
| | Black Caribbean | 414 | 491 | 74.1 | 2.42 | 69.3 | 78.8 |
| | Bangladeshi | 338 | 139 | 85.1 | 2.15 | 80.9 | 89.3 |
| | Indian | 328 | 591 | 76.9 | 2.78 | 71.4 | 82.3 |
| | Pakistani | 387 | 379 | 78.7 | 2.49 | 73.8 | 83.6 |
| **Total** | | | | | | | |
| | White | 837 | 86294 | 64.2 | 2.02 | 60.2 | 68.1 |
| | Irish | 733 | 3313 | 68.1 | 2.13 | 64.0 | 72.3 |
| | Black Caribbean | 694 | 826 | 69.3 | 2.34 | 64.7 | 73.9 |
| | Bangladeshi | 650 | 274 | 80.9 | 1.91 | 77.1 | 84.6 |
| | Indian | 643 | 1156 | 75.0 | 1.94 | 71.2 | 78.8 |
| | Pakistani | 724 | 724 | 73.8 | 2.37 | 69.1 | 78.4 |

Table 9.23

## True standard errors and 95% confidence intervals for difficulties getting on with people, by minority ethnic group

| Difficulties getting on with people | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Lower 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | White | 368 | 37072 | 26.3 | 2.38 | 21.7 | 31.0 |
| | Irish | 329 | 1459 | 31.9 | 2.74 | 26.6 | 37.3 |
| | Black Caribbean | 280 | 335 | 23.8 | 3.33 | 17.3 | 30.3 |
| | Bangladeshi | 312 | 135 | 23.3 | 3.07 | 17.3 | 29.3 |
| | Indian | 315 | 565 | 23.6 | 2.52 | 18.6 | 28.5 |
| | Pakistani | 337 | 345 | 26.5 | 3.41 | 19.8 | 33.2 |
| **Women** | | | | | | | |
| | White | 467 | 48981 | 23.4 | 2.12 | 19.3 | 27.6 |
| | Irish | 403 | 1853 | 20.7 | 2.72 | 15.4 | 26.0 |
| | Black Caribbean | 413 | 490 | 22.4 | 2.16 | 18.2 | 26.7 |
| | Bangladeshi | 338 | 139 | 21.2 | 3.06 | 15.2 | 27.1 |
| | Indian | 328 | 591 | 25.1 | 3.34 | 18.5 | 31.6 |
| | Pakistani | 387 | 379 | 22.2 | 3.18 | 16.0 | 28.4 |
| **Total** | | | | | | | |
| | White | 835 | 86053 | 24.7 | 1.67 | 21.4 | 28.0 |
| | Irish | 732 | 3312 | 25.6 | 2.03 | 21.7 | 29.6 |
| | Black Caribbean | 693 | 825 | 23.0 | 1.89 | 19.3 | 26.7 |
| | Bangladeshi | 650 | 274 | 22.2 | 2.30 | 17.7 | 26.7 |
| | Indian | 643 | 1156 | 24.3 | 2.35 | 19.7 | 28.9 |
| | Pakistani | 724 | 724 | 24.3 | 2.76 | 18.8 | 29.7 |

Table 9.24

## True standard errors and 95% confidence intervals for whether have caring responsibilities, by minority ethnic group

| Caring responsibilities | Unwt base | Wted base (by scale wt) | Value % (wted by nonreswt) | True standard error | Lower 95% CI | Lower 95% CI |
|---|---|---|---|---|---|---|
| **Men** | | | | | | |
| White | 364 | 36744 | 15.4 | 2.19 | 11.1 | 19.7 |
| Irish | 328 | 1456 | 15.3 | 2.11 | 11.2 | 19.4 |
| Black Caribbean | 276 | 330 | 15.6 | 2.41 | 10.9 | 20.3 |
| Bangladeshi | 310 | 134 | 17.3 | 2.73 | 12.0 | 22.7 |
| Indian | 314 | 565 | 22.6 | 2.96 | 16.8 | 28.4 |
| Pakistani | 335 | 344 | 21.3 | 2.77 | 15.9 | 26.8 |
| **Women** | | | | | | |
| White | 468 | 49129 | 22.6 | 2.06 | 18.6 | 26.6 |
| Irish | 400 | 1840 | 25.5 | 2.34 | 21.0 | 30.1 |
| Black Caribbean | 409 | 484 | 20.5 | 2.20 | 16.2 | 24.9 |
| Bangladeshi | 335 | 137 | 19.3 | 2.97 | 13.5 | 25.1 |
| Indian | 326 | 588 | 22.9 | 2.83 | 17.3 | 28.4 |
| Pakistani | 383 | 375 | 27.4 | 3.06 | 21.4 | 33.4 |
| **Total** | | | | | | |
| White | 832 | 85873 | 19.5 | 1.81 | 15.9 | 23.0 |
| Irish | 728 | 3296 | 21.0 | 1.66 | 17.8 | 24.3 |
| Black Caribbean | 685 | 814 | 18.5 | 1.49 | 15.6 | 21.5 |
| Bangladeshi | 645 | 271 | 18.3 | 2.37 | 13.7 | 22.9 |
| Indian | 640 | 1153 | 22.8 | 2.39 | 18.1 | 27.4 |
| Pakistani | 718 | 719 | 24.5 | 2.12 | 20.3 | 28.6 |

# 2 Common mental disorders

*Scott Weich and Sally McManus*

## 2.1 Introduction

The most common mental disorders (CMD), anxiety and depression, have a combined prevalence rate of about 15% in the community.[1,2] They account for one-third of days lost from work due to ill health and one-fifth of all consultations with general practitioners in the UK.[3] Those affected experience increased mortality[4] and impairments in physical and social functioning as severe as those associated with chronic physical disorders.[5] The public health importance of these disorders, even in mild form, is further demonstrated by the finding that low levels of depression resulted in 51% more days lost from work than major depression.[6] Ten years ago the annual cost of CMD in the UK was estimated to exceed £6 billion.[7] While this figure certainly represents an underestimate of the current societal costs associated with these disorders, the finding that two-thirds of this sum was due to lost productivity is likely to remain valid.

Although 'major' psychiatric disorders such as schizophrenia (which has a community prevalence of less than 1%) are certainly more disabling for individual sufferers, and more distressing for their families and carers, their rarity means that these conditions place less of a burden on the public health than CMD. Despite this, the dearth of studies of CMD among members of ethnic minorities in Britain contrasts with an extensive literature on differences in rates of psychotic disorders.[8,9,10,11] The lack of evidence about rates of CMD in ethnic minority groups in the UK is thrown into sharper relief by the burgeoning literature on socio-economic inequalities in the prevalence and outcome of these disorders.[12,13] As Nazroo[14] pointed out, the hypothesis that the higher rate of psychosis among Black Caribbean individuals in England and Wales is due to 'social exclusion' (including harassment and discrimination) should also predict increased rates of CMD in this group, and among other ethnic groups who are similarly disadvantaged, such as those of Pakistani and Bangladeshi extraction. Although previous research indicated that Black Caribbean and Irish groups have higher rates of psychiatric admissions, and South Asian groups lower rates than the White population, such findings were likely to have been prone to bias, particularly by factors that differentially affect access to treatment. The absence of a robust, population-based evidence base in this area represents a major lacuna in our understanding of the processes that contribute to the aetiology and outcome of the most common psychiatric disorders.

In common with the Black Caribbean population, very little is known about the epidemiology of the common mental disorders among South Asian groups, who comprise over 3% of the UK population. In the Fourth National Survey of Ethnic Minorities,[14] Pakistani informants had similar rates of depression to the White group, while rates among Indian and Bangladeshi informants were lower than both of these groups. The latter group had especially low rates of depression, among both men and women. When the study findings were disaggregated by gender, it was found that Pakistani women

had lower rates of depression than their White counterparts, while Pakistani men were more likely than White informants to be depressed. All of the South Asian groups, both men and women, had lower rates of anxiety than White informants. Irish informants had consistently, and significantly, higher rates of depression and anxiety than all other groups, with the exception of Black Caribbean men and women. One important limitation of this study was the finding that the psychometric performance of the case-finding methodology varied between ethnic groups. In particular, South Asian informants who scored positively on the brief depression screening items were significantly less likely than their White, Irish and Black Caribbean counterparts to meet diagnostic criteria for an anxiety or depressive disorder using a standardised clinical interview. The reasons for this remain unknown, but may have included the choice of Revised Clinical Interview Schedule (CIS-R) items used to screen for depression, and the decision to omit items concerning somatic symptoms.

There is also a dearth of population-based studies of psychiatric disorder among those born in Ireland (and those of Irish descent) living in Britain, despite the fact that these groups may constitute up to 5% of the UK population.[15] The latter is perhaps due in part to the tendency to equate ethnicity with skin colour,[15,16] and the difficulty of establishing valid criteria for defining ethnicity among members of this group, some of whom may have lived in this country for several generations. Understanding differences in health outcomes and the experiences of living in the UK within, as well as between, 'South Asian', 'Black Caribbean' and 'White' groups is vital, and underlines the need to view ethnicity as a complex social, economic and cultural matrix.[17]

Two notable recent surveys were carried out in a national sample,[15] and among a random sample of individuals registered with General Practitioners in Manchester.[16] While the latter was smaller (n=612) and restricted to Black Caribbean and White individuals, the former was the first to simultaneously compare rates of psychotic and non-psychotic psychiatric morbidity among White, Irish, Black Caribbean, Indian, Pakistani, Bangladeshi and Chinese groups in the UK. The study by Nazroo (1997) was limited, however, by the use of an abbreviated two-stage assessment procedure, in which a number of questions were omitted from the CIS-R, making direct comparisons with other studies difficult. Both studies concluded that the prevalence of anxiety and depression among Black Caribbean informants was broadly similar to that found among the White group. Both studies went on to report small, post hoc differences between these groups, in that depression was slightly more common, and anxiety less common, in the Black Caribbean group. A further limitation of the study by Shaw et al (1999) was the inclusion of Irish and other White European informants in the same group as White British people.[18] It was notable also that the two samples differed in their demographic characteristics, a finding that probably reflects the difference in geographical coverage of the two studies. Interestingly, the national survey by Nazroo (1997) found that the excess in depression among Black Caribbean informants was confined largely to those who were married or cohabiting.

In an epidemiological survey of individuals living in a multi-ethnic, inner city area in the West Midlands, Commander et al (1997)[19] found significantly higher rates of the common mental disorders among Asian residents compared with those of White or Black ethnicity. The elevated prevalence of these disorders among Asian residents (nearly twice that found in the other two groups) was observed in both community (37%) and primary care settings (30%). Although Bhui (2001)[20] found a similar case rate (41%) among Punjabi patients attending General Practices in a single electoral ward in South London, the prevalence of these disorders was almost identical (39%) among English controls. A very similar prevalence was reported from a study of Pakistani primary care attenders in Manchester.[21]

An interesting area of enquiry is the contrast between rates of the common mental disorders among ethnic minority groups living in the UK, and rates observed in their countries of origin.[22] Although

none of the studies can claim to be representative of the general population of any of the countries in question, there are a number of interesting findings from South Asia. In Goa, one of the richest states in India, Patel et al (1998)[23] reported that 46% of primary care attenders were cases of the common mental disorders using the CIS-R. Even higher rates have been observed in different settings in Pakistan, and in rural areas in particular.[24,25,26,27] While nearly all studies from around the world report that women experience roughly double the prevalence of the common mental disorders found among men, this difference was nearer to three-fold in rural Pakistan. In a rural setting in the Punjab, Mumford and his colleagues (1997) found that 66% of women were suffering from the common mental disorders.

The assessment of psychiatric morbidity in groups of differing ethnicity and culture has been beset by philosophical debate about the appropriateness of applying diagnostic and conceptual models of disorder across settings and populations. This issue is highlighted among individuals of South Asian origin, who are said to sometimes 'somatise' psychological distress, by expressing this in the form of physical complaints.[25] As Bhui (1999) and others have pointed out, this is an extremely complex matter, and may reflect differences in the ways societies and cultures conceptualise the relationship between mind and body, as well as differences in the perceived stigma associated with mental illness.[28] It is also likely that the manner in which psychological distress is expressed will be influenced by the configuration of services, and the most effective or pragmatic means of seeking help in a given setting. Finally, although most attention has been paid to the excess of somatic complaints among South Asian individuals who experience psychological distress, it is also widely recognised that the psychological idioms of distress may also differ across cultures. It is therefore possible that rates of the common mental disorders may be underestimated in cross-cultural research not only by failing to give sufficient weight to somatic symptoms, but also by overlooking different types of psychological symptoms.[22] The qualitative study reported in chapter 8 attempted to address these issues.

The present study represents the most comprehensive investigation of the mental health of ethnic groups in the UK to date. This chapter will consider the main study findings concerning the prevalence of the common mental disorders.

## 2.2 Measures

Psychiatric morbidity was assessed using the Revised Clinical Interview Schedule (CIS-R).[29,30,31] The original Clinical Interview Schedule (CIS) was the first standardised interview designed specifically to assess common mental disorders in community settings, among informants who may not see themselves as psychiatrically disturbed.[32] The original was revised for use by lay interviewers,[29] by removing all but the systematic and highly standardised items inquiring about non-psychotic psychiatric symptoms. Lewis and Williams (1989)[33] found that these changes did not alter the validity of the CIS. More recently, the CIS-R was successfully administered to over 10,000 informants in the UK National Survey of Psychiatric Morbidity.[1,2,34,35,36]

The CIS-R enquires about the presence and severity of fourteen different non-psychotic psychiatric symptoms during the week prior to interview. These are: somatic complaints associated with low mood or anxiety, fatigue, problems with memory and/or concentration, sleep disturbance, irritability, worry about physical health, depressed mood, depressive thoughts, non-health related worry, generalised anxiety, phobic anxiety, panic attacks, compulsive behaviours, and obsessional thoughts. Item scores for each of these symptoms range from 0 to 4 (except depressive thoughts, which ranges from 0 to 5), resulting in a measure with a potential score ranging from 0 to 57. The CIS-R score may be analysed

in two ways: as a continuous measure of psychiatric morbidity, along a single continuum of severity (range 0 to 57), or as a dichotomous variable ('case' v 'non-case'). The latter is defined using a case threshold of 11/12, identified by the authors of the instrument in their validation study.[29] See Appendix B for the items used to calculate CIS-R symptom and total scores.

In addition, individuals scoring above the case threshold on the CIS-R were allocated ICD-10 diagnoses according to an algorithm for the CIS-R based on ICD-10 criteria,[37,38] written by one of the authors of this chapter[39] (Weich 2001), and adopted by ONS for use in the two National Psychiatric Morbidity Surveys of Great Britain.[1,40] The algorithms are shown in Appendix A. The ten ICD-10 categories derived from responses to the CIS-R were: Mild Depressive Episode, with and without somatic symptoms (F32.0), Moderate Depressive Episode, with and without somatic symptoms (F32.1), Severe Depressive Disorder (F32.2), Agoraphobia, with and without panic disorder (F40.0), Social Phobias (F40.1), Specific (isolated) Phobias (F40.2), Panic Disorder (F41.0), Generalised Anxiety Disorder (GAD) (F41.1), Mixed Anxiety and Depressive Disorder (MADD) (F41.2), and Obsessive-Compulsive Disorder (F42). Each diagnosis was recorded as present or absent. A diagnosis of MADD was allocated to all individuals who scored above the case threshold on the CIS-R but who did not meet criteria for any other diagnosis. Hence, although MADD could not be comorbid with any other disorder, the method for allocating diagnoses meant that it was possible for other ICD-10 disorders (apart from Panic Disorder and Phobias) to co-occur in the same individuals.

It should be noted that the ONS surveys applied the diagnostic algorithms in a slightly different way from this survey, and did not include the CIS-R case threshold of 12 or more in the criteria for any diagnosis other than MADD. In keeping with the original formulation of these criteria,[40] we chose to include the criterion of CIS-R score of 12 or more, to ensure that our case estimates were consistent whether using the CIS-R case threshold or ICD-10 diagnoses. Furthermore, this avoided the anomaly of individuals who were not eligible for a diagnosis of MADD meeting criteria for other disorders, such as GAD or a mild depressive episode.

While there may be individuals who have a relatively greater disturbance on the dimension of anxiety than on the dimension of depression (and vice versa),[41] there is consistent evidence that the symptoms of anxiety and depression co-occur, particularly in community settings.[3] These symptoms occur in the same individuals both consecutively and concurrently, to a degree far in excess of that predicted by chance alone. Failure of the main classificatory systems to agree on a common set of diagnostic criteria for the common mental disorders reflects the genuine difficulty of imposing points of cleavage where none would appear to exist in nature. There is increasing evidence from sophisticated studies of comorbidity that individuals commonly meet criteria for multiple lifetime diagnoses, and move between categories of disorder at different times in their lives.[3] The main categories of the non-psychotic psychiatric disorders also share many aetiological risk factors, most notably a genetic predisposition that appears to be non-specific with respect to symptoms of anxiety and depression. A recent study using CIS-R data collected in four countries (including a sample of Indian informants living in the UK) found scores in each sample were equally well explained by one- and two-factor models, and that both models fitted well with each of the four datasets.[42] The term 'common mental disorders' (CMD),[40] defined in this study as a score of 12 or more on the CIS-R,[1,29] will therefore be used to denote those conditions most commonly encountered in primary care and community settings, considered as a single dimension. Findings concerning the prevalence of the common mental disorders as a whole will be described, before considering individual diagnostic categories.

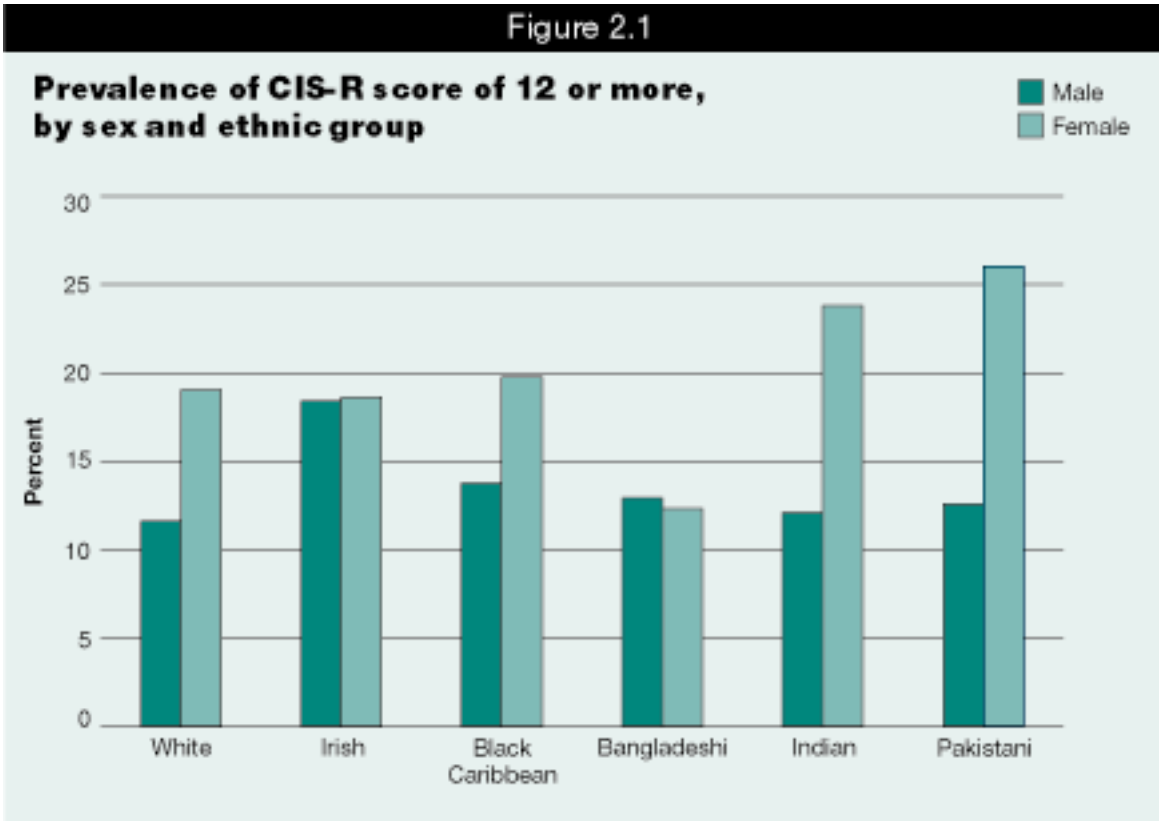
Finally, to explore the possibility that the CIS-R may have under-estimated the prevalence of the common mental disorders among South Asian groups, separate analyses were undertaken to compare

scores on the somatic symptoms section of the CIS-R across ethnic groups. This section (range 0 to 4) asks about the severity and frequency of somatic complaints (such as aches and pains) that were 'brought on or made worse because you were feeling low, anxious or stressed'. The score on this section was compared across ethnic groups, before and after adjusting for the score on the rest of the CIS-R.

## 2.3 **Prevalence of the common mental disorders**

The figure and inset table below, along with Table 2.1, show the proportions of informants in each ethnic group who scored above the case threshold for CMD on the CIS-R, before adjusting for age or any other potential confounders. Among men, the prevalence of CMD was very similar in all groups apart from the Irish, for whom this rate was increased to a statistically significant degree compared with the White group. Among women, the pattern was somewhat more complex, with similar rates in the White, Irish and Black Caribbean groups, but significantly higher rates among Indian and Pakistani women, and a very low rate among Bangladeshi women. Of these differences, only those for Bangladeshi and Pakistani women reached statistical significance, before adjusting for age.

Figure 2.1




As described in the introductory chapter to this volume, the age structure of the ethnic groups differed considerably. In particular, Pakistani and Bangladeshi men and women, and Black Caribbean men, were significantly younger than those from other ethnic groups. However, Table 2.2 shows that there was relatively little variation in the association between CMD and age across ethnic groups. Among White, Irish, Black Caribbean and Indian men, the prevalence of CMD did not vary with age to a significant degree. By contrast, CMD increased with age to a significant extent among Pakistani and Bangladeshi men, predominantly because of the very low rates observed among those aged 16-34 in these groups. Among women, the rate of CMD only varied with age among Indian informants, for whom these disorders became more common with advancing age.

After adjusting for the differences in age structure between these groups, the excess in cases of the common mental disorders among Irish men (compared with White men) no longer reached statistical significance (Table 2.1). Table 2.1 also shows that only the lower prevalence of CMD among Bangladeshi women (compared with White women) remained statistically significant after adjusting for differences in age structure between ethnic groups.

**Prevalence of CIS-R score of 12 or more, by ethnic group within gender (see Table 2.1) , before adjusting for age**

| | Observed % | Unadjusted RR (95% CI) | P |
|---|---|---|---|
| **Men** | | | |
| White | 11.6 | 1.00 | |
| Irish | 18.4 | 1.59 (1.11-2.28) | 0.02 |
| Black Caribbean | 13.8 | 1.19 (0.80-1.79) | 0.46 |
| Bangladeshi | 12.9 | 1.10 (0.73-1.64) | 0.74 |
| Indian | 12.1 | 1.03 (0.69-1.56) | 0.97 |
| Pakistani | 12.6 | 1.07 (0.72-1.59) | 0.84 |
| **Women** | | | |
| White | 19.0 | 1.00 | |
| Irish | 18.6 | 0.98 (0.74-1.29) | 0.95 |
| Black Caribbean | 19.8 | 1.04 (0.80-1.37) | 0.82 |
| Bangladeshi | 12.3 | 0.65 (0.47-0.92) | 0.02 |
| Indian | 23.8 | 1.25 (0.96-1.64) | 0.12 |
| Pakistani | 26.0 | 1.37 (1.07-1.77) | 0.02 |

## 2.4 Prevalence of ICD-10 diagnostic categories

Table 2.1 shows the distribution of ICD-10 diagnoses by ethnic group and gender. In all ethnic groups,

the most common ICD-10 diagnosis was Mixed Anxiety Depressive Disorder (MADD), which accounted for 60% to 70% of all diagnoses on average, ranging from a low of 56% (Pakistani men) to a high of 80% (Indian men).

### 2.4.1 **Depressive episodes**

Among men, White and Pakistani informants reported depressive episodes most often, although the prevalence of (any) depressive episodes did not vary between ethnic groups to a statistically significant degree. Interestingly, although the Irish group had the highest prevalence of CMD, only 10% of Irish men with any ICD-10 diagnosis met criteria for a depressive episode, compared with 14% to 21% of other informants. (Table 2.1)

Among women, depressive episodes were most common among Indian and Pakistani informants, and least common in the Bangladeshi and Black Caribbean groups. Among Indian and Pakistani women, around one-quarter of all cases met criteria for depressive episodes, compared with 12% of Bangladeshi and Black Caribbean women. (Table 2.1)

Like episodes of CMD, the gender difference in the prevalence of depressive episodes was greatest among Indian (RR 3.65, 95% CI 1.38-9.66) (p=0.009) and Pakistani groups (RR 2.58, 95% CI 1.18-5.67)(p=0.02). There was no gender difference in other groups. Thus, in contrast to CMD, the gender difference in the prevalence of depressive episodes did not vary to a statistically significant degree for either the White or Black Caribbean groups.

### 2.4.2 **Anxiety disorders**

In contrast to depressive episodes, the highest rate of anxiety disorders among men was found in the Irish group. It was also notable that the rate in the Indian group was significantly lower than that observed in all but White and Bangladeshi men. Like Irish men and depression, a very small proportion of Indian men (11%) with any ICD-10 diagnosis met the criteria for an anxiety disorder, compared with 25% to 35% in other groups.
(Table 2.1)

The pattern of ICD-10 anxiety disorders among women was similar to that observed for depressive episodes. The lowest rate was found among Bangladeshi women, and the highest rates among Indian, Pakistani and Irish women. Although the prevalence of anxiety episodes among ethnic minority informants did not differ from that observed among White women to a statistically significant degree, the rates in the Indian, Pakistani and Irish groups were all significantly higher than among Bangladeshi women. (Table 2.1)

In general, gender differences in the prevalence of anxiety disorders were much smaller than for depressive episodes, and were non-significant. The one exception to this was among Indian informants, for whom the rate in women far exceeded that in men (RR 5.76, 95% CI 2.02-16.42) (p=0.0004).

### 2.4.3 **Mixed anxiety depressive disorder (MADD)**

Among men, the lowest rates of MADD were found in the White and Pakistani groups. The variation across ethnic groups in the prevalence of MADD among men was not statistically significant.

Like the other types of disorder, MADD was least common in the Bangladeshi group compared with other women. While the rate of MADD in ethnic minority groups did not differ from the White group to a statistically significant degree, the rate among Pakistani women was significantly higher than in the Bangladeshi group. (Table 2.1)

### 2.4.4 **Somatic symptoms**

Among men, the somatic symptom scores were increased to a statistically significant degree only in the Bangladeshi group, even after adjusting for score on the rest of the CIS-R (difference in mean score compared to White group 0.19, 95% CI 0.09-0.29)($p<0.001$).

Among women, somatic symptom scores were elevated among all three South Asian groups, and were greatest among Pakistani women. This difference (compared with White women) did not reach statistical significance among the Bangladeshi group after adjusting for score on the rest of the CIS-R. The adjusted differences in mean somatic symptom scores (compared with the White group) were 0.16 (95% CI 0.04-0.28)($p=0.008$) for Indian women, and 0.23 (95% CI 0.11-0.35)($p<0.001$) for Pakistani women (data not shown in tables).

### 2.4.5 **Gender**

The ratio of women: men who were cases of CMD approached unity for the Irish and Bangladeshi groups, was a little (but not significantly) higher for the Black Caribbean group, and was about 60% higher among the White group and twice as high for the Indian and Pakistani groups. The differences for the White, Indian and Pakistani groups were all statistically significant.

### 2.4.6 **Marital status**

Table 2.3 shows the relationship between marital status and CMD. Too few informants were separated, divorced or widowed to fully explore the association between this risk factor and the prevalence of the common mental disorders. As described in the introductory chapter to this volume, South Asian informants (and particularly South Asian men) were particularly unlikely to be separated, divorced or widowed, while few Black Caribbean men were married. As anticipated in the light of previous research, the highest rates of CMD were generally found among those who were divorced, separated or widowed, although the precision with which these rates have been estimated was of course limited by the small sample size. Among both men and women, the lowest rates of CMD were generally found among those who were married and cohabiting, a finding that was most marked among Black Caribbean men. The notable exceptions to this trend were Pakistani men and women, and Bangladeshi men, for whom the lowest rates of CMD were observed among those who had never married.

### 2.4.7 **Socio-economic status**

There were marked differences in the housing circumstances of the different ethnic groups. Apart from Black Caribbean (54%) and Bangladeshi informants (28%), more than 70% of informants in all groups were owner-occupiers. However, the size of the association between living in rented accommodation and the prevalence of CMD varied from RR 2.10 (95% CI 1.11-3.91)($p=0.04$) and 2.73 (95% CI 1.76-4.29)($p<0.0001$) among White men and women, respectively, to near unity for Bangladeshi men and women (Table 2.4). Indeed, this association only reached statistical significance for White men and women, and Pakistani women (RR 1.61, 95% CI 1.16-2.27)($p=0.009$).

Using other measures of socio-economic status produced slightly different results. Although a significantly higher proportion of Bangladeshi informants (73%) were living in households where the occupational social class of the head of the household was classified as 'manual', compared with other groups no statistically significant associations were found between this variable and the prevalence of CMD (Table 2.5). Apart from Black Caribbean men, the prevalence of CMD was lowest among informants whose head of household was classified as 'non-manual'. Although this pattern was reversed among Black Caribbean men, the social class gradient in this group was not statistically significant (RR 0.50, 95% CI 0.25-1.12)($p=0.12$).

As with marital status, the sample was too homogenous in terms of employment status to permit the effects of this variable to be studied in detail. In particular, rates of unemployment were very low, and precluded robust estimates of associations with the prevalence of CMD. As described previously, Bangladeshi men and women were the least likely, and White men the most likely to be employed (Table 2.6).

The proportion of informants without any educational qualifications was broadly similar across groups, with the exception of the Bangladeshi and Pakistani samples. Among women, around 25% to 30% of informants had no such qualifications, rising to 52% and 68% of Pakistani and Bangladeshi women, respectively. The figures were similar among men (Table 2.7). There were few statistically significant associations between education and CMD. Black Caribbean men without any educational qualifications had a significantly elevated rate of CMD (RR 2.01, 95% CI 1.13-3.57)(p=0.03). Among Bangladeshi women, the lowest prevalence of CMD (just 7%) was found among those without educational qualifications.

### 2.4.8 **Household composition**

The composition of households varied with ethnic group. Although Table 2.8 does not contain information about household size, it shows marked differences in the proportions of households with children, ranging from around 30% among White, Irish and Black Caribbean informants to 70% to 80% of Pakistani and Bangladeshi informants, respectively. In general, the presence of children at home was associated with a lower rate of CMD among men (but not women), although this gradient was not statistically significant for any ethnic group. The presence of children at home was associated with a significantly lower rate of disorder among Indian women (RR 0.58, 95% CI 0.38-0.90)(p=0.02), but with a higher rate of CMD among White (RR 1.59, 95% CI 1.09-2.30)(p=0.02) and Pakistani (RR 1.54, 95% CI 1.02-2.33)(p=0.04) women.

### 2.4.9 **Age at migration**

The migratory status of informants varied across ethnic groups, with 82% of both Irish and Black Caribbean individuals and around half of South Asian individuals being born in the UK or having migrated here before the age of 11. Migratory status was similar for men and women within each ethnic group. To reduce the effects of confounding by age, the findings in Table 2.9 have been restricted to those obtained from informants aged 16 to 54 at the time of interview. Among women, with the exception of the Black Caribbean group, higher rates of CMD were found among those who were born in the UK or who came to this country very early in life, although this difference was only significant for Bangladeshi women (RR 3.15, 95% CI 1.61-6.16)(p=0.0007). The pattern among men was somewhat harder to interpret, in part because of small numbers of informants who had emigrated to the UK after the age of 10. Perhaps the most notable finding was the lower prevalence of CMD among Bangladeshi men who were born in the UK or who came here before the age of 11, an association which differed in its direction compared with that found among Bangladeshi women.

### 2.4.10 **Comparison with the National Survey of Psychiatric Morbidity**

We compared findings in the White group with the results of the two National Surveys of Psychiatric Morbidity in the UK, carried out by ONS. Although the two ONS surveys included members of ethnic minorities, these individuals comprised less than 5% of the sample.[1,2] The first of these surveys was conducted in 1993, while the second was contemporaneous with the present survey. Since there were few significant differences between the findings of the two ONS surveys, comparisons were made with the most recent findings.

The prevalence of CMD in the most recent ONS survey was very similar to that found in the White

group in the present survey.[2] In the national survey, 12.4% of men and 18.1% of women aged 16-74 scored 12 or more on the CIS-R, compared with 11.6% of men and 19.0% of women in the present study. Although closer examination revealed modest differences in the age structure of the two samples, adjusting for this did not appear to significantly alter these rates. Very few differences were found in rates of specific ICD-10 diagnoses, although it should be noted that the ONS surveys applied the diagnostic algorithms in a slightly different way from this survey, and did not require a minimum CIS-R score of 12 or more for any diagnosis other than MADD. The only substantial differences that were observed from the present study were the slightly lower rates of Generalised Anxiety Disorder (GAD) among men (1.5%) and women (1.4%), compared with the national survey (4.6% and 4.3%, respectively).

Although the National Survey sample was predominantly white (96%), the investigators reported findings for three self-identified ethnic groups: a white group, a black group and a South Indian group comprising individuals who described themselves as being of Indian, Pakistani or Bangladeshi origin. The National Survey did not distinguish between Irish and other White informants. The proportions of White men (12%) and women (18%) scoring 12 or more on the CIS-R were almost identical to the results for the sample as a whole.

Among men, similar case rates for the common mental disorders were found among the White (12%) and Black (11%) groups, as in the present survey. In contrast to the present findings, the National Survey found a slightly higher case rate (16%) among South Asian men, although this did not differ from other ethnic groups to a statistically significant degree.

Among women, the National Survey found similar case rates for the common mental disorders among White (18%) and Black informants (18%). There was also evidence of a moderately increased case rate among South Asian women (23%), although this gradient was not statistically significant. Since our own findings suggest that case rates among women may vary considerably between the different South Asian cultural groups, direct comparison between studies is likely to be problematic.

#### 2.4.11 **Comparison with the Fourth National Survey**

Direct comparison with the Fourth National Survey[14] is also difficult, particularly given the different measures used to assess common mental disorders. However, the present findings were consistent with the results of this survey in a number of respects. The most striking similarities were the consistently low rates of the common mental disorders among Bangladeshi informants, and the high rates of anxiety disorders among Irish men and women.

In contrast to the Fourth National Survey, we found no evidence of increased rates of depression among Black Caribbean or Pakistani men. Similarly, the present survey found no evidence of lower rates of either anxiety or depression among Indian or Pakistani informants. Indeed, our results suggest that Indian and Pakistani women had rates of both disorders that were significantly higher than those found among Bangladeshi and, to a lesser extent, White women. Finally, it is worth noting that Black Caribbean men who were married or cohabiting in the present study had very low rates of CMD, in contrast to the findings from the Fourth National Survey.

## 2.5 **Conclusions**

The present findings represent probably the most comprehensive assessment to date of the prevalence of the common mental disorders (CMD) among ethnic minority groups in the UK. Although our study was restricted to England, rates of CMD in our White group were very similar to those reported by both UK National Surveys of Psychiatric Morbidity,[1,2] the last of which was carried out

contemporaneously with this survey. Overall, our findings indicate relatively modest differences in the rates of these disorders between individuals of White, Irish, Black Caribbean, Bangladeshi, Indian and Pakistani ethnicity. In general, the clearest ethnic differences in the prevalence of non-psychotic psychiatric disorders were observed when the common mental disorders (CMD) were considered as a whole. We found that there were small but statistically significant variations in the prevalence of common mental disorders (CMD) across ethnic groups. Compared with White informants of the same gender, Irish men and Pakistani women had significantly higher, and Bangladeshi women lower rates of CMD. Although only the lower prevalence of CMD among Bangladeshi women reached statistical significance after adjusting for age, this may have been due to the relatively small sample sizes within each ethnic group.

Among men, no statistically significant differences were found between ethnic groups when individual ICD-10 diagnoses were considered. Using these categories, we found a very low prevalence of anxiety disorders among the Indian group, while Irish men had the highest rate of anxiety disorders but the lowest rate of depressive episodes. Among women, the prevalence of all types of ICD-10 disorder were least common in the Bangladeshi group, while depressive episodes and anxiety disorders were most common among Indian and Pakistani women.

There was evidence that somatic symptom scores were elevated among Bangladeshi men, and South Asian women (especially those of Indian and Pakistani origin), after adjusting for the severity of symptoms elicited in the rest of the CIS-R. While this does not constitute direct evidence of a tendency for these groups to express psychological distress by means of somatic symptoms, failure to give added weight to these symptoms may have resulted in under-estimates of the prevalence of the common mental disorders among some South Asian groups. Since this finding was not observed to the same extent among Bangladeshi women, it could not explain the very low prevalence of these disorders in this group, compared with other South Asian women.

Interesting differences were found between ethnic groups in both the distribution of social and economic risk factors for the common mental disorders, and in patterns of association with this outcome. In general, Bangladeshi informants were the most socially disadvantaged, although associations between standard indices of socio-economic deprivation and CMD were often weakest in this group. These findings require further investigation.

The variation in the gender difference in the prevalence of CMD across ethnic groups was also notable. We found that the risk ratio for CMD associated with female gender varied considerably, from 1.5-2.0 among White, Black Caribbean, Indian and Pakistani groups, to near unity for Irish and Bangladeshi informants. This finding certainly warrants further investigation, particularly given previously consistent evidence of a significantly higher prevalence of these disorders among women, using different measures of depression, and across a range of settings. It should be noted, however, that previous studies have been almost exclusively restricted to (predominantly) White samples.

Interpretation of these findings is challenging. Although there were significant differences in the demographic and socio-economic characteristics of the different ethnic groups, preliminary statistical adjustment for these made relatively little difference to our findings. Given the very high levels of socio-economic deprivation among the Bangladeshi group in particular, these findings would appear to run counter to the hypothesis that members of this ethnic minority group should, as a consequence, experience higher rates of severe mental illness than less deprived groups.[17] It is possible, however, that employment status, education and housing tenure fail to capture the most stressful aspects of life among the different ethnic minority groups in the UK. Conversely, it may be that the effects of these types of socio-economic deprivation are offset by other, unmeasured, factors such as social support or community social capital.

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# Appendix A: Questionnaire

## APPENDIX A: PROGRAMME DOCUMENTATION

### INTRODUCTORY SECTION

**SerialNo**
SERIAL NUMBER

**AdrChk**
ADDRESS CHECK INDICATOR

**RespSex**
Before I start the interview, I need to check that I have opened the right file for you.
INTERVIEWER: CODE RESPONDENT'S SEX
(1) Male
(2) Female

**RespAge**
Can I just check, what is your date of birth?

**RespName**
Can I check, is your name still ... (READ FROM ARF) or have you changed it for any reason?

**IF sex and date of birth details do not match those from HSE feed forward data THEN**

**NoMatch**
Please check that you have opened the correct serial number. This serial number is for a (*respondent name*) whose birthday is on (*respondent birthday*). If incorrect press CTRL and ENTER and QUIT this form to return to the address menu and then select the correct serial number.

**ENDIF**

**RespMar**
Are you ...READ OUT...
CODE FIRST TO APPLY
(1) ... married
(2) living as married,
(3) separated,
(4) widowed,
(5) divorced,
(6) or, single and never married?

**IF ((Init.SEthnicX <> RESPONSE) OR (Init.SEthnicX = Other)) THEN**

**NEthni**

Which ethnic group do you consider you belong to. Would you say you are

... READ OUT ...

INTERVIEWER : THIS IS AN IMPORTANT QUESTION, PLEASE AVOID THE USE OF CODE 10 IF AT ALL POSSIBLE.

CODE ONE ONLY

(1) ... White,
(2) Black - Caribbean,
(3) Black - African,
(4) Black - Other,
(5) Indian,
(6) Pakistani,
(7) Bangladeshi,
(8) Chinese,
(9) or, Irish?
(10) (None of these - specify)

**IF NEthni is other ethnic group THEN**

**EthOth**

Which ethnic group do you consider you belong to?

**ENDIF**

**ENDIF**

**EMPLOYMENT**

**IF not 'retired' at HSE THEN**

**EActiv**

SHOW CARD A. Which of these descriptions applies to what you were doing last week, that is in the seven days ending *(name of day)*?

CODE FIRST TO APPLY.

(1) Going to school or college full-time (incl on vacation)
(2) In paid employment or self-employed (or temporarily away)
(3) On a Government scheme for employment training
(4) Doing unpaid work for a business that you own, or that a relative owns
(5) Waiting to take up paid work already obtained
(6) Looking for paid work or a Government training scheme
(7) Temporarily out of work
(8) Intending to look for work but prevented by temporary sickness or injury
(9) Permanently unable to work because of long-term sickness or disability
(10) Retired from paid work
(11) Looking after home or family
(12) Doing something else
(13) Other, please specify

**ENDIF**

**IF EactIv is 'other'**

**EActivO**

OTHER: PLEASE SPECIFY.

**ENDIF**

**IF (EActiv = School) THEN**

**EStWrk**

Did you do any paid work in the seven days ending *(name of day)*, either as an employee or self-employed?

(1) Yes
(2) No

**ENDIF**

**IF ((EActiv IN [TempSick, Retire..Other] OR (EStWrk = No)) AND ((RAge IN [16..64] AND (Init.RespSex = Male)) OR (RAge IN [16..59] AND (Init.RespSex = Female))) THEN**

**E4WkLok**

Thinking now of the four weeks ending *(name of day)*. Were you looking for any paid work or Government training scheme at any time in those four weeks?

(1) Yes
(2) No

**ENDIF**

**IF ((EActiv = Look) OR (E4WkLok = Yes)) THEN**

**E2WkStt**
If a job or a place on a Government training scheme had been available in the *(time period)* ending *(name of day)*, would you have been able to start within two weeks?
(1) Yes
(2) No

**ENDIF**

**IF (EActiv IN [Look..Other] OR (EStWrk = No)) THEN**

**EvJob**
Have you ever been in paid employment or self-employed?
(1) Yes
(2) No

**ENDIF**

**IF (EActiv = Wait) THEN**

**OthJob**
Apart from the job you are waiting to take up, have you ever been in paid employment or self-employed?
(1) Yes
(2) No

**ENDIF**

**IF ((Init.SActivB = Job) AND (EActiv = Job)) THEN**

**SameJob**
Are you still in the same job that you were in when we interviewed you in *(month and year of HSE interview)*?
(1) Yes
(2) No

**ENDIF**

**IF ((((EvJob = Yes) OR ((EActiv = Job) AND (SameJob <> Yes))) OR EActiv IN [Govsch..Wait]) OR (EStWrk = Yes)) THEN**

**JobTtle**
I'd like to ask you some details about your/that job
What is/was the name or title of the job?

**Hours**
Are/were you working full-time or part-time?
(1) Full-time
(2) Part-time

**EWtWrk**
What kind of work do/did you do most of the time?

**EMat**
IF RELEVANT: What materials or machinery do/did you use?
IF NONE USED, WRITE IN 'NONE'.

**ESkills**
What skills or qualifications are/were needed for the job?

**Employ**
Are/were you ...READ OUT...
(1) an employee,
(2) or, self-employed?

**IF (Employ = SelfEmp) THEN**
**Direct**
Can I just check, in this job are/were you a Director of a limited company?
(1) Yes
(2) No
**ENDIF**

**IF ((Employ = Employee) OR (Direct = Yes)) THEN**
**EmpSt**
Are you a ...READ OUT...
(1) Manager,
(2) foreman or supervisor,
(3) or other employee?

**NoEmps**
Including yourself, about how many people are/were employed at the place where you usually work/worked?
(1) 1 or 2
(2) 3 - 24
(3) 25 - 499
(4) 500 +

**ELSEIF ((Employ = SelfEmp) AND (Direct = No)) THEN**
**HaveEmp**
Do/did you have any employees?
(1) None
(2) 1-24
(3) 25-499
(3) 500+
**ENDIF**

IF (Employ = Employee) THEN
Ind
What does/did your employer make or do at the place where you usually work/worked?

ELSEIF (Employ = SelfEmp) THEN
SEInd
What do/did you make or do in your business?
ENDIF
ENDIF
ENDIF

## HEALTH AND USE OF HEALTH SERVICES

**LastDr**
The following questions are about your health and use of health services.
When did you last speak to a doctor on your own behalf?
(1) In the last week
(2) Over 1 week, within last month
(3) Over 1 month, within last 2 months
(4) Over 2 months, within last 4 months
(5) Over 4 months, within last 6 months
(6) Over 6 months, within last 12 months
(7) Over 1 year, within last 3 years
(8) Over 3 years, within last 5 years
(9) Over 5 years, within last 10 years
(10) Over 10 years
(11) Never

**IF LastDr IN [1'week..6mnths] THEN**
**WhereDr**
SHOW CARD B
In the last six months, which of these doctors have you spoken to on your own behalf?
CODE ALL THAT APPLY
(1) GP
(2) A hospital doctor at an out-patient's clinic
(3) A hospital doctor (while an in-patient)
(97) Some other kind of doctor

**IF SOME IN WhereDr THEN**
**OthDr**
INTERVIEWER: WRITE IN OTHER KIND OF DOCTOR
**ENDIF**

**SemiA**
SHOW CARD C
I would like to ask you about the last time you spoke to or visited a doctor on your own behalf. What was the matter with you?
CODE ALL THAT APPLY
(1) A physical problem
(2) A stress related or emotional problem
(97) Other

**IF Other IN SemiA THEN**
**SemiB**
What was the matter with you?
INTERVIEWER: WRITE IN VERBATIM
**ENDIF**
**ENDIF**

**SemiC**
Over the past 6 months, have you had any illness or health problems you did not see your doctor about?
(1) Yes
(2) No

**IF (SemiC = Yes) THEN**
**SemiD**
SHOW CARD C
What was the matter with you?
INTERVIEWER: DO NOT INTERPRET FOR THE RESPONDENT – MAKE THEM CHOOSE AN ANSWER FROM THE CARD.
CODE ALL THAT APPLY
(1) A physical problem
(2) A stress related or emotional problem
(97) Other

**IF Other IN SemiD THEN**
**SemiE**
What was the matter with you?
INTERVIEWER: WRITE IN VERBATIM
**ENDIF**
**ENDIF**

**ServicA**
SHOW CARD D.
Here is a list of health services. Have you used any of these services in the past 6 months? PROBE: What else? CODE ALL THAT APPLY
(1) Child health/ baby clinic
(2) Well woman clinic
(3) Travel vaccination clinic
(4) Practice based nurse
(5) District nurse
(6) Midwife
(7) Health visitor
(8) Community psychiatric nurse
(96) None of these

**ServicB**

SHOW CARD E. And what about the health services on this card, have you used any of these in the past 6 months?
PROBE: What else?
CODE ALL THAT APPLY
(1) Physiotherapist
(2) Chiropodist
(3) Dietician
(4) Counsellor/psychologist
(5) Cervical screening
(6) Breast screening
(95) None of these

**FRIENDS AND RELATIVES**

**Intro**
The following questions are about people in your life who you feel close to and from whom you can obtain support (either emotional or practical) including close relatives and good friends.

**NumClose**
How many people do you feel very close to. It does not matter where they live or whether you have seen them recently?
INTERVIEWER ENTER NUMBER
Range: 0–200

**IF (NumClose >= 1) THEN**
**WhoClos1**
SHOW CARD F
Who have you felt closest to in the last 12 months?
Please describe in terms of their relationship to you and take your answer from this card.
(1) Grandfather
(2) Grandmother
(3) Father
(4) Mother
(5) Husband/wife
(6) Partner
(7) Brother
(8) Sister
(9) Son
(10) Daughter
(11) Other male relative
(12) Other female relative
(13) Male friend
(14) Female friend
(97) Other (Specify)
**ENDIF**

**IF (NumClose >= 2) THEN**
**WhoClos2**
SHOW CARD F
Who have you felt next closest to in the last 12 months?
Please describe in terms of their relationship to you and take your answer from this card.
(1) Grandfather
(2) Grandmother
(3) Father
(4) Mother
(5) Husband/wife
(6) Partner
(7) Brother
(8) Sister
(9) Son

# Appendix B: CIS-R and common mental disorders measurement

## B.1 Calculation of CIS-R symptom scores

By attributing points to certain responses to the Clinical Interview Schedule Revised (CIS-R), a total score can be derived as well as separate scores for each of 14 symptoms. The calculation of these scores is described below. Item scores for each symptom range from 0 to 4, apart from depressive thoughts, which rhas amaximum score of 5. The total score ranges from 0 to 57, with a non-case/ case distinction made at 11/ 12.

See the methods section of chapter two for a full discussion of the CIS-R.

### Somatic symptoms

Scores relate to the respondent's experience of any ache, pain or discomfort which was associated with low mood or anxiety in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present for four days or more | SomaD = 1 |
| Symptom lasted more than three hours on any day | SomaE = 1 |
| Symptom had been very unpleasant | SomaF = 1 |
| Symptom bothered respondent when doing something interesting | SomaG = 1 |

### Fatigue

Scores relate to fatigue or feeling tired or lacking in energy in the past week.

| *Score one for each:* | *Variable* |
|---|---|

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present for four days or more | SomaE = 1 |
| Symptom lasted more than three hours on any day | SomaF = 1 |
| Had to push him/herself to get things done on at least one occasion FatigG = 1 | SomaG = 1 |
| Symptom present when respondent doing things he/she enjoys or used to enjoy at least once | FatigH = 1 or FatigI = 1 |

## Concentration and forgetfulness

Scores relate to the respondent's experience of problems with memory and/or concentration in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present for four days or more | ForgetC = 1 |
| Could not always concentrate on a TV programme, read a newspaper article or talk to someone without mind wandering | ForgetD = 2 |
| Problems with concentration stopped respondent from getting on with things he/she used to do or would have liked to do | ForgetE = 1 |
| Forgot something important | ForgetF = 1 |

## Sleep disturbance

Scores relate to problems with getting to sleep or with sleeping more than is usual for the respondent in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Had problems with sleep for four nights or more | SleepC = 1 |
| Spent at least $^{1}Ž4$ hour trying to get to sleep on the night with least sleep | SleepF = 2 |
| Spent at least 1 hour trying to get to sleep on the night with least sleep | SleepF = 3 or 4 |

| | |
|---|---|
| Spent three hours or more trying to get to sleep on four nights or more | SleepG = 1 |
| Slept for at least 1Ž4 hour longer than usual for respondent on any night | SleepI = 2 |
| Slept for at least 1Ž4 hour longer than usual for respondent on any night | SleepI = 3 or 4 |
| Slept for more than three hours longer than usual for respondent on four nights or more | SleepJ = 1 |

## Irritability

Scores relate to feelings of irritability, being short-tempered or angry in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present for four days or more | IrritC = 1 |
| Symptom present for more than one hour on any day | IrritE = 1 |
| Wanted to shout at someone (even if respondent had not actually shouted) | IrritF = 1 |
| Had arguments, rows or quarrels or lost temper with someone and felt it was unjustified on at least one occasion | IrritI = 2 |

## Worry about physical health

Scores relate to experience of the symptom in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present on four days or more | PhysB = 1 |
| Felt he/she had been worrying too much in view of actual health | PhysD = 1 |
| Symptom had been very unpleasant | PhysE = 1 |
| Could not be distracted by doing something else | PhysF = 2 |

## Depressed mood

Applies to respondents who felt sad, miserable or depressed or unable to enjoy or take an interest in things as much as usual, in the past week. Scores relate to the respondent's experience in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Unable to enjoy or take an interest in things as much as usual | DepD = 2 |
| Symptom present on four days or more | DepE = 1 |
| Symptom lasted for more than three hours in total on any day | DepF = 1 |
| When sad, miserable or depressed respondent did not become happier when something nice happened, or when in company | DepI = 1 |

## Depressive thoughts

Scores relate to experience in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Felt guilty or blamed him/herself at least once when things went wrong when it had not been his/her fault | IdeasF = 1 |
| Felt not as good as other people | IdeasG = 1 |
| Felt hopeless | IdeasH = 1 |
| Felt that life isn't worth living | SelfHmB = 1 |
| Thought of killing him/herself | SelfHmD = 1 |

## Worry

Scores relate to respondent's experience of worry in the past week, other than worry about physical health.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present on four or more days | WorryE = 1 |

| | |
|---|---|
| Has been worrying too much in view of circumstances | WorryF = 1 |
| Symptom has been very unpleasant | WorryG = 1 |
| Worried for more than 3 hours on one day | WorryH = 1 |

## Anxiety

Scores relate to feeling generally anxious, nervous or tense in the past week. These feelings were not the result of a phobia.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present on four or more days | AnxE = 1 |
| Symptom had been very unpleasant | AnxF = 1 |
| When anxious, nervous or tense, had one or more of following symptoms:<br>• Heart racing or pounding<br>• Hands sweating or shaking<br>• Feeling dizzy<br>• Difficulty getting breath<br>• Butterflies in stomach<br>• Dry mouth<br>• Nausea or feeling as though he/she wanted to vomit | AnxG = 1, 2, 3, 4, 5, 6, or 7 |
| Symptom present for more than three hours in total on any one day | AnxH = 1 |

## Phobic anxiety

Scores relate to respondent's experience of phobias or avoidance in the past week

| *Score one for each:* | *Variable name:* |
|---|---|
| Felt nervous/anxious about a situation or thing four or more times | PhobD = 1 |
| On occasions when felt anxious, nervous or tense, had one or more of<br>following symptoms:<br>• Heart racing or pounding | |

- Hands sweating or shaking
- feeling dizzy
- Difficulty getting breath
- Butterflies in stomach
- Dry mouth
- Nausea or feeling as though he/she wanted to vomit

PhobE = 1, 2, 3, 4, 5, 6 or 7

| | |
|---|---|
| Avoided situation or thing at least once because it would have made | PhobG = 1 |
| Avoided situation or thing four times or more because it would have made respondent anxious, nervous or tense | PhobG = 2 |

## Panic attacks

Applies to respondents who felt anxious, nervous or tense in the past week and the scores relate to the resultant feelings of panic, or of collapsing and losing control in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom experienced once | PanicB = 1 |
| Symptom experienced more than once | PanicB = 2 |
| Symptom had been very unpleasant or unbearable | PanicC = 2 |
| An episode lasted longer than 10 minutes | PanicD = 1 |

## Compulsive behaviours

Scores relate to respondent's experience of doing things over again when respondent had already done them in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|

| | |
|---|---|
| Symptom present on four days or more | CompB = 1 |
| Tried to stop repeating behaviour | CompD = 1 |
| Symptom made respondent upset or annoyed with him/herself | CompE = 1 |
| Repeated behaviour three or more times when it had already been done | CompG = 1 |

### Obsessional thoughts

Scores relate to the respondent's experience of having repetitive unpleasant thoughts or ideas in the past week.

| *Score one for each:* | *Variable name:* |
|---|---|
| Symptom present on four or more days | ObsessD = 1 |
| Tried to stop thinking any of these thoughts | ObsessE = 1 |
| Became upset or annoyed when had these thoughts | ObsessF = 1 |
| Longest episode of the symptom was [1]Ž4 hour or longer | ObsessG = 1 |

## B.2 Algorithms to produce ICD-10 psychiatric disorders

Respondents scoring above the case threasehold of 11/12 on the CIS-R schedule were allocated ICD-10 diagnoses. Six categories of disorder are reported in chapter 2 and these were calculated in two stages. Firstly the informants' responses to the CIS-R were used to produce specific ICD-10 diagnoses of neurosis by applying the algorithms described below. Secondly, the range of ICD-10 diagnoses were grouped together to produce the six categories used in the calculation of prevalence.

Some studies have arranged the six neurotic disorders hierarchically so that an individual included in the prevalence rates for one neurotic or psychotic disorder is not included in calculation of the rate for any other neurotic or psychotic disorder, with only the highest disorder taking prevalence. We have not followed that practice here due to the low prevalence of some disorders and because of interest in co-morbidity.

Questions on diminished appetite and weight loss were included in the ONS definition of Depression but not here. More discussion of calculation of the ICD-10 psychiatric disorders is in the methods section of chapter two.

# F32.00 Mild Depressive Episode without somatic symptoms

| | |
|---|---|
| 1. Symptom duration >= 2 weeks | DepJ > = 2 weeks |
| 2. Two or more from: | |
| • Depressed mood | DepC = 1 and DepE>4 and DepF = 1 and DepI = 2 |
| • Loss of interest | DepD = 1 |
| • Fatigue | Fatsum >=2 |
| 3. Two or three from: | |
| • Reduced concentration | Forgsum >=2 |
| • Reduced self-esteem | IdeasG = 1 |
| • Ideas of guilt | IdeasF = 1 |
| • Pessimism about future | IdeasH = 1 |
| • Suicidal ideas or acts | SelfHmE = 1 or SelfHmG = 1 |
| • Disturbed sleep | Slpsum >=2 |
| 4. Social impairment | OverallA = 1 |
| 5. Fewer than four from: | |
| • Lack of normal pleasure/ interest | DepD = 1 |
| • Loss of normal emotional reactivity | DepI = 1 |
| • A.M. waking >= 2 hours early | SleepH = 1 |
| • Loss of libido | IdeasB = 2 |
| • Diurnal variation in mood | IdeasA = 1 or 2 |

| | |
|---|---|
| • Psychomotor agitation<br>• Psychomotor retardation | IdeasC=1<br>IdeasD = 1 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F32.01 Mild Depressive Episode with somatic symptoms

| | |
|---|---|
| 1. Symptom duration >= 2 weeks | DepJ > = 2 weeks |
| 2. Two or more from: | |
| • Depressed mood | DepC = 1 and DepE>4 and DepF = 1 and DepI = 2 |
| • Loss of interest | DepD = 1 |
| • Fatigue | Fatsum >=2 |
| 3. Two or three from: | |
| • Reduced concentration | Forgsum >=2 |
| • Reduced self-esteem | IdeasG = 1 |
| • Ideas of guilt | IdeasF = 1 |
| • Pessimism about future | IdeasH = 1 |
| • Suicidal ideas or acts | SelfHmE = 1 or SelfHmG = 1 |
| • Disturbed sleep | Slpsum >=2 |
| 4. Social impairment | OverallA = 1 |

| | |
|---|---|
| 5.Four or more from:: | |
| • Lack of normal pleasure/ interest | DepD = 1 |
| • Loss of normal emotional reactivity | DepI = 1 |
| • A.M. waking >= 2 hours early | SleepH = 1 |
| • Loss of libido | IdeasB = 2 |
| • Diurnal variation in mood | IdeasA = 1 or 2 |
| • Psychomotor agitation | IdeasC=1 |
| • Psychomotor retardation | IdeasD = 1 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F32.10 Moderate Depressive Episode without somatic symptoms

| | |
|---|---|
| 1. Symptom duration >= 2 weeks | DepJ > = 2 weeks |
| 2. Two or more from: | |
| • Depressed mood | DepC = 1 and DepE>4 and DepF = 1 and DepI = 2 |
| • Loss of interest | DepD = 1 |
| • Fatigue | Fatsum >=2 |
| 3. Four or more from: | |
| • Reduced concentration | Forgsum >=2 |
| • Reduced self-esteem | IdeasG = 1 |
| • Ideas of guilt | IdeasF = 1 |
| • Pessimism about future | IdeasH = 1 |

| | |
|---|---|
| • Suicidal ideas or acts | SelfHmE = 1 or SelfHmG = 1 |
| • Disturbed sleep | Slpsum >=2 |
| 4. Social impairment | OverallA = 1 |
| 5. Four or more of: | |
| • Lack of normal pleasure/ interest | DepD = 1 |
| • Loss of normal emotional reactivity | DepI = 1 |
| • A.M. waking >= 2 hours early | SleepH = 1 |
| • Loss of libido | IdeasB = 2 |
| • Diurnal variation in mood | IdeasA = 1 or 2 |
| • Psychomotor agitation | IdeasC=1 |
| • Psychomotor retardation | IdeasD = 1 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F32.11 Moderate Depressive Episode with somatic symptoms

| | |
|---|---|
| 1. Symptom duration >= 2 weeks | DepJ > = 2 weekssf |
| 2. Two or more from: | |
| • Depressed mood | DepC = 1 and DepE>4 and DepF = 1 and DepI = 2 |
| • Loss of interest | DepD = 1 |
| • Fatigue | Fatsum >=2 |

| | |
|---|---|
| 3. Four or more from:<br>• Reduced concentration<br>• Reduced self-esteem<br>• Ideas of guilt<br>• Pessimism about future<br>• Suicidal ideas or acts<br>• Disturbed sleep | Forgsum >=2<br>IdeasG = 1<br>IdeasF = 1<br>IdeasH = 1<br>SelfHmE = 1 or SelfHmG = 1<br>Slpsum >=2 |
| 4. Social impairment | OverallA = 1 |
| 5. Fewer than four from:<br>• Lack of normal pleasure/ interest<br>• Loss of normal emotional reactivity<br>• A.M. waking >= 2 hours early<br>• Loss of libido<br>• Diurnal variation in mood<br>• Psychomotor agitation<br>• Psychomotor retardation | DepD = 1<br>DepI = 1<br>SleepH = 1<br>IdeasB = 2<br>IdeasA = 1 or 2<br>IdeasC=1<br>IdeasD = 1 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F32.2 Severe Depressive Disorder

| | |
|---|---|
| 1. Symptom duration >= 2 weeks | DepI >= 2 weeks |

| | |
|---|---|
| | DepJ >= 2 weeks |
| 2. Two or more from: | |
| • Depressed mood | DepC = 1 and DepE>4 and DepF = 1 and DepI = 2 |
| • Loss of interest | DepD = 1 |
| • Fatigue | Fatsum >=2 |
| 3. Three or more from: | |
| • Reduced concentration | Forgsum >=2 |
| • Reduced self-esteem | IdeasG = 1 |
| • Ideas of guilt | IdeasF = 1 |
| • Pessimism about future | IdeasH = 1 |
| • Suicidal ideas or acts | SelfHmE = 1 or SelfHmG = 1 |
| • Disturbed sleep | Slpsum >=2 |
| 4. Social impairment | OverallA = 1 |
| 5. Fewer than four from: | |
| • Lack of normal pleasure/ interest | DepD = 1 |
| • Loss of normal emotional reactivity | DepI = 1 |
| • A.M. waking >= 2 hours early | SleepH = 1 |
| • Loss of libido | IdeasB = 2 |
| • Diurnal variation in mood | IdeasA = 1 or 2 |
| • Psychomotor agitation | IdeasC=1 |
| • Psychomotor retardation | IdeasD = 1 |

| | |
|---|---|
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F40.00 Agrophobia without Panic Disorder

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Fear of open spaces and related aspects: crowds, distance from home, travelling alone | PhobB = 1 or 2 |
| 2. Social impairment | OverallA = 1 |
| 3. Avoidant behaviour must be prominent feature | PhobF = 1 |
| 4. Overall phobia score >= 2 | Phobsum>= 2 |
| 5. No panic attacks | Panic = 1 or 2, but PanicB = 0 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F40.01 Agrophobia with Panic Disorder

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Fear of open spaces and related aspects: crowds, distance from home, travelling alone | PhobB = 1 or 2 |
| 2. Social impairment | OverallA = 1 |
| 3. Avoidant behaviour must be prominent feature | PhobF = 1 |
| 4. Overall phobia score >= 2 | Phobsum>= 2 |
| 5. Panic score >= 2 | Pansum >= 2 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F40.1 Social Phobias

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Fear of scrutiny by other people: eating or speaking in public etc. | PhobB = 2 |
| 2. Social impairment | OverallA = 1 |
| 3. Avoidant behaviour must be prominent feature | PhobF = 1 |
| 4. Overall phobia score >= 2 | Phobsum>= 2 |
| 5. Panic score >= 2 | Pansum >= 2 |
| 6. Overall CIS-R score is significant | CISband2 = 2 |

## F40.2 Specified (isolated) Phobias

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Fear of specific situations or things, e.g. animals, insects, heights, blood, flying, etc | PhobB =4 or 5 |
| 2. Social impairment | OverallA = 1 |
| 3. Avoidant behaviour must be prominent feature | PhobF = 1 |
| 4. Overall phobia score >= 2 | Phobsum>= 2 |
| 5. Overall CIS-R score is significant | CISband2 = 2 |

## F41.0 Panic Disorder

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Criteria for phobic disorders not met. | F40_00 = 2 and F40_01 = 2 and F40_1 = 2 and F40_2 = 2 |
| 2. Recent panic attacks | PanicB > 0 |
| 3. Anxiety-free between attacks PanicE = 1 | PanicE = 1 |
| 4. Overall panic score >= 2 | Phobsum>= 2 |
| 5. Overall CIS-R score is significant | CISband2 = 2 |

CISband2 = 2

## F41.1 Generalised Anxiety Disorder (GAD)

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Duration >= 6 months | AnxI = 3, 4 or 5 |
| 2. Free-floating anxiety AnxD = 2 | AnxD = 2 |
| 3. Autonomic overactivity | AnxG = 1 to 7 |
| 4. Overall anxiety score >= 2 | Anxsum >= 2 |
| 5. Overall CIS-R score is significant | CISband2 = 2 |

## F41.2 Mixed Anxiety and Depressive Disorder (MADD)

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Overall CIS-R score is significant | CISband2 = 2 |
| 2. Criteria for other categories not met | F40_00 = 2 and F40_01= 2 and F40_10 = 2 and F40_20 = 2 and F41_00 = 2 and F41_10 = 2 and F41_20 = 2 and F42_00 = 2 |

## F42.0 Obsessive-Compulsive Disorder

All the following criteria must be met for a positive diagnosis:

| | |
|---|---|
| 1. Duration >= 2 weeks | CompH = 2, 3, 4 or 5, or ObessG = 2, 3, 4 or 5 |
| 2. At least one act/thought resisted | CompD = 1 or ObessD = 1 |
| 3. Social impairment | OverallA = 1 |
| 4. Obsession score = 4, or Compulsion score = 4, or | |

| | |
|---|---|
| Compulsion score = 4, or<br>Ob + Comp scores >= 6 | Obssum = 4, or Compsum = 4, or<br>Obssum + Compsum >= 6 |
| 5. Overall CIS-R score is significant | CISband2 = 2 |

## B.3 Grouping neurotic and psychotic disorders into broad categories

The next step was to group some of the above diagnoses into broad diagnostic categories prior to analysis.

For this report, all types and severities of depressive episode (F32.00, F32.01, F32.10, F32.11 and F32.2) have been combined to produce a single variable. The ICD-10 phobic diagnoses F40.00, F40.01, F40.1 and F40.2 were combined into one category of phobia.

This produced six categories of neurosis for analysis:

1. Mixed anxiety and depressive disorder (MADD)
2. Generalised Anxiety Disorder (GAD)
3. Depressive episode
4. All phobias
5. Obsessive Compulsive Disorder
6. Panic disorder

**Previous**

# Appendix A: Questionnaire

(10) Daughter
(11) Other male relative
(12) Other female relative
(13) Male friend
(14) Female friend
(97) Other (Specify)
ENDIF

IF (NumClose >= 1) THEN
CIDist
Thinking about the person you are close/closest to, how far away from you does this person live.
Do they live ... READ OUT ... CODE ONE ONLY
(1) with you
(2) within walking distance,
(3) within half an hour's drive,
(4) more than half an hour but under one hour's drive,
(5) more than one hour's drive or
(6) do they live overseas?

CIPersA
SHOW CARD G
Still thinking about the person you are closest to, please say how you would rate the practical and emotional support they have provided for you in the last twelve months.
How much in the last 12 months did this person give you information, suggestions and guidance that you found helpful?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

CIPersB
SHOW CARD G
How much in the last 12 months could you rely on this person. Was this person there when you needed them?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersC**
SHOW CARD G
How much in the last 12 months did this person make you feel good about yourself?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersD**
SHOW CARD G
How much in the last 12 months did you share interests, hobbies and fun with this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CLPersE**
SHOW CARD G
How much in the last 12 months did this person give you worries, problems and stress?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersF**
SHOW CARD G
How much in the last 12 months did you want to confide in, talk frankly or share feelings with this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CLPersG**
SHOW CARD G
How much in the last 12 months did you confide in this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CIPersH**
SHOW CARD G
How much in the last 12 months did you trust this person with your most personal worries and problems?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CIPersI**
SHOW CARD G
How much in the last 12 months would you have liked to have confided more in this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CIPersJ**
SHOW CARD G
How much in the last 12 months did talking to this person make things worse?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CIPersK**
SHOW CARD G
How much in the last 12 months did he/she talk about his/her personal worries with you?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CIPersL**
SHOW CARD G
How much in the last 12 months did you need practical help from this person with major things, for example looking after you when ill, help with finances, children?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersM**
SHOW CARD G
How much in the last 12 months did this person give you practical help with major things?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersN**
SHOW CARD G
How much in the last 12 months would you have liked more practical help with major things from this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersO**
SHOW CARD G
How much in the last 12 months did this person give you practical help with small things when you needed it, for example chores, shopping, watering plants, etc
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ENDIF**

**IF (NumClose >= 2) THEN**

**ClDist**
Thinking about the person you are closest to, how far away from you does this person live.
Do they live ... READ OUT ... CODE ONE ONLY
(1) with you
(2) within walking distance,
(3) within half an hour's drive,
(4) more than half an hour but under one hour's drive,
(5) more than one hour's drive or
(6) do they live overseas?

**ClPersA**
SHOW CARD G
Still thinking about the person you are closest to, please say how you would rate the practical and emotional support they have provided for you in the last twelve months.
How much in the last 12 months did this person give you information, suggestions and guidance that you found helpful?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersB**
SHOW CARD G
How much in the last 12 months could you rely on this person. Was this person there when you needed them?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersC**
SHOW CARD G
How much in the last 12 months did this person make you feel good about yourself?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersD**
SHOW CARD G
How much in the last 12 months did you share interests, hobbies and fun with this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CLPersE**
SHOW CARD G
How much in the last 12 months did this person give you worries, problems and stress?
Please take your answer from this card.
(1) Not at all
(2) A little

(3) Quite a lot
(4) A great deal

**ClPersF**
SHOW CARD G
How much in the last 12 months did you want to confide in, talk frankly or share feelings with this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**CLPersG**
SHOW CARD G
How much in the last 12 months did you confide in this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersH**
SHOW CARD G
How much in the last 12 months did you trust this person with your most personal worries and problems?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersI**
SHOW CARD G
How much in the last 12 months would you have liked to have confided more in this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersJ**
SHOW CARD G
How much in the last 12 months did talking to this person make things worse?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot

(4) A great deal

**ClPersK**
SHOW CARD G
How much in the last 12 months did he/she talk about his/her personal worries with you?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersL**
SHOW CARD G
How much in the last 12 months did you need practical help from this person with major things, for example looking after you when ill, help with finances, children?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersM**
SHOW CARD G
How much in the last 12 months did this person give you practical help with major things?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersN**
SHOW CARD G
How much in the last 12 months would you have liked more practical help with major things from this person?
Please take your answer from this card.
(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal

**ClPersO**
SHOW CARD G
How much in the last 12 months did this person give you practical help with small things when you needed it, for example chores, shopping, watering plants, etc
Please take your answer from this card.

(1) Not at all
(2) A little
(3) Quite a lot
(4) A great deal
**ENDIF**

**RelA**
Are there any relatives outside your household with whom you have regular contact, either by visit, telephone, or letters?
(1) Yes
(2) No

**IF (RelA = Yes) THEN**
**RelB**
SHOW CARD H
How often do you have contact with any relatives outside your household?
Please take your answer from this card.
INTERVIEWER NOTE: Not necessarily the same person each time
(1) Almost daily
(2) About once a week
(3) About once a month
(4) Once every few months
(5) Never/ almost never

**RelC**
SHOW CARD H
How often do you regularly visit or are visited by these relatives?
Please take your answer from this card.
(1) Almost daily
(2) About once a week
(3) About once a month
(4) Once every few months
(5) Never/ almost never

**RelD**
How many relatives do you see once a month or more?
ENTER NUMBER BETWEEN 0 AND 100. IF MORE THAN 100, ENTER 100
Range: 0..100
**ENDIF**

**FrenA**
Are there any friends or acquaintances with whom you have regular contact, either by visit, telephone, or letters?
(1) Yes
(2) No

**IF (FrenA = Yes) THEN**

**FrenB**
SHOW CARD H
How often do you have contact with any friends or acquaintances? Please take your answer from this card.
(1) Almost daily
(2) About once a week
(3) About once a month
(4) Once every few months
(5) Never/ almost never

**FrenC**
SHOW CARD H
How often do you regularly visit or are visited by these friends or acquaintances?
Please take your answer from this card.
(1) Almost daily
(2) About once a week
(3) About once a month
(4) Once every few months
(5) Never/ almost never

**FrenD**
How many friends or acquaintances do you see once a month or more?
ENTER NUMBER BETWEEN 0 AND 100. IF MORE THAN 100, ENTER 100
Range: 0..100

**ENDIF**

## INFORMAL CARE RESPONSIBILITIES

**CareA**
I'd like to talk now about caring informally for others. Some people have extra responsibilities because they look after someone who is physically or mentally sick, handicapped or elderly. May I check, is there anyone either living with you or not living with you who is sick, handicapped or elderly whom you look after or give special help to, other than in a professional capacity (-for example, a sick or handicapped (or elderly) relative/ husband/ wife/ child/ friend etc)?
IF YES, PROBE FOR WHERE
(1) Yes, in this household
(2) Yes, in another household
(3) No
(4) Not sure

**CareB**
And does anyone look after, or give special help to you because of sickness, disability or old age, other than in a professional capacity?
(1) Yes
(2) No

# Appendix A: Questionnaire

**IF (MarView = Yes) THEN**
**ViewMind**
Would they mind very much or just a little?
(1) Very much
(2) A little
(3) Can't say
**ENDIF**

**MarPers**
Would you personally mind if a close relative were to marry a person who was not (race)?
(1) Yes
(2) No

**IF (MarPers = Yes) THEN**
**PersMind**
Would you mind very much or just a little?
(1) Very much
(2) A little
(3) Can't say
**ENDIF**

**VolWork**
In the last year, have you done any unpaid voluntary work to help people or benefit the community through some organisation?
(1) Yes
(2) No

**IF (VolWork = Yes) THEN**
**PplMix**
In your work with this organisation, are/were you mainly in contact with people from *(ethnic minority groups, or mainly with white people)* or about equally with both?
(1) Mainly ethnic minority people
(2) Equally with both
(3) Mainly with white/English people
(4) Can't say
**ENDIF**

**Clubs**
Apart from this, in the last year, have you taken part in activities run by clubs or organisations?
(1) Yes
(2) No

IF (Clubs = Yes) THEN

**Activ**

Do (did) your activities with this organisation bring you mainly into contact with people (*from ethnic minority groups, or mainly with white people*) or about equally with both?

IF MORE THAN ONE ORGANISATION, ASK ABOUT ONE RESPONDENT SPENT MOST TIME INVOLVED IN

(1) Mainly ethnic minority people
(2) Equally with both
(3) Mainly with (*white/English people*)
(4) Can't say

ENDIF

**AUXTEXT**

SHOW CARD AC

I am now going to read out some statements. Please tell me for each whether you agree or disagree, taking your answer from this card.

**ThBrit**

SHOW CARD AC

In many ways, I think of myself as being British.

(1) Strongly agree
(2) Agree
(3) Neither agree nor disagree
(4) Disagree
(5) Strongly disagree

IF (Init.EthnicX <> WHITE) THEN

**ThEth**

SHOW CARD AC

In many ways I think of myself as (*race*).

(1) Strongly agree
(2) Agree
(3) Neither agree nor disagree
(4) Disagree
(5) Strongly disagree

ENDIF

**IdPres**

SHOW CARD AC

(People of *respondent's own origin*) should try to preserve as much as possible of their culture and way of life.

(1) Strongly agree
(2) Agree
(3) Neither agree or disagree
(4) Disagree
(5) Strongly disagree

**AdCult**

SHOW CARD AC

(People of *ethnic origin*) should adopt more the culture and way of life of (*white/English people*).

(1) Strongly agree
(2) Agree
(3) Neither agree or disagree
(4) Disagree
(5) Strongly disagree

**RepCult**

SHOW CARD AC

(People of *race origin*) are seeing their way of life and culture being replaced by the culture of (*white people/ethnic minority*).

(1) Strongly agree
(2) Agree
(3) Neither agree or disagree
(4) Disagree
(5) Strongly disagree

**END OF INTERVIEW**

**THANK**
INTERVIEWER: THE INTERVIEW IS FINISHED
This is the end of interview.
THANK THE RESPONDENT FOR THEIR CO-OPERATION
THEN ENTER '1' TO CLOSE THE INTERVIEW
(1) FINISH

**ReInter**
If at some future date we wanted to talk to you further about your health, may we contact you to see if you are willing to help us again?
(1) Yes
(2) No

**TelNo**
Some interviews in any survey are checked to make sure that people are satisfied with the way the interview was carried out. Just in case yours is one of the interviews that is checked, it would be helpful if we could (have/confirm) your telephone number.
IF GIVEN, WRITE TELEPHONE NUMBER ON ARF.

# Appendix A: Questionnaire

**SENSE OF CONTROL**

**IntroCon**
SHOWCARD I
I am now going to read out a list of statements. Please tell me how much you agree or disagree with each statement.
Please take your answers from this card.
PRESS SHIFT F2 TO SAVE AND 1 TO CONTINUE
(1) Strongly disagree
(2) Moderately disagree
(3) Slightly disagree
(4) Slightly agree
(5) Moderately agree
(6) Strongly agree

**CONHOMA**
SHOW CARD I
At home, I feel I have control over what happens in most situations.
(1) Strongly disagree
(2) Moderately disagree
(3) Slightly disagree
(4) Slightly agree
(5) Moderately agree
(6) Strongly agree

**IF (Demog.Eactiv = Job) THEN**
    **CONHOMB**
    SHOW CARD I
    At work, I feel I have control over what happens in most situations.
    (1) Strongly disagree
    (2) Moderately disagree
    (3) Slightly disagree
    (4) Slightly agree
    (5) Moderately agree
    (6) Strongly agree
**ENDIF**

**CONHOMC**
SHOW CARD I
I feel that what happens in my life is often determined by factors beyond my control.
(1) Strongly disagree
(2) Moderately disagree
(3) Slightly disagree
(4) Slightly agree
(5) Moderately agree
(6) Strongly agree

**CONHOMD**
SHOW CARD I
Over the next 5-10 years I expect to have many more positive than negative experiences.
(1) Strongly disagree
(2) Moderately disagree
(3) Slightly disagree
(4) Slightly agree
(5) Moderately agree
(6) Strongly agree

**GENCONA**
SHOW CARD J
In general, do you have different demands that you think are hard to combine?
(1) Often
(2) Sometimes
(3) Seldom
(4) Never

**GENCONB**
SHOW CARD J
In general, do you have enough time to do everything?
(1) Often
(2) Sometimes
(3) Seldom
(4) Never

**IF (Demog.Esctlv = Job) THEN**
    **GENCONC**
    SHOW CARD J
    Considering the things you have to do at work, do you have to work very fast?
    (1) Often
    (2) Sometimes
    (3) Seldom
    (4) Never
**ENDIF**

**GENCOND**
SHOW CARD J
Considering the things you have to do at home, do you have to work very fast?
(1) Often
(2) Sometimes
(3) Seldom
(4) Never

**STRAINA**
SHOW CARD K
How often do you have any worries or problems with other relatives, for example parents or in-laws?

(1) Always
(2) Often
(3) Sometimes
(4) Seldom
(5) Never

**STRAINB**
SHOW CARD K
How often does it happen that you do not have enough money to afford the kind of food or clothing you or your family should have?
(1) Always
(2) Often
(3) Sometimes
(4) Seldom
(5) Never

**STRAINC**
SHOW CARD L
How much difficulty do you have in meeting the payment of bills?
(1) Very great
(2) Great
(3) Some
(4) Slight
(5) Very little

**STRAIND**
SHOW CARD L
To what extent do you have problems with your housing, for example too small, repairs, damp, etc?
(1) Very great problems
(2) Great
(3) Some
(4) Slight
(5) Very little

**STRAINE**
SHOW CARD L
To what extent do you have problems with the neighbourhood in which you live, for example noise, unsafe street, few local facilities?
(1) Very great problems
(2) Great
(3) Some
(4) Slight
(5) Very little

**EXPERIENCE OF DISCRIMINATION**

**Attack**
The next few questions are *about* things that may have happened to you in the last twelve months, that is, since (date 12 months ago).
During that time, has anyone physically attacked you?
(1) Yes
(2) No

**IF (Attack = Yes) THEN**
**Attnumb**
How many times have you been attacked in the last twelve months?
(1) Once
(2) More

**IF (Attnumb = More) THEN**
**AttackNo**
INTERVIEWER: ENTER NUMBER OF TIMES RESPONDENT HAS BEEN ATTACKED IN THE LAST TWELVE MONTHS
**ENDIF**

**Attrace**
Do you think (you were attacked) for reasons to do with your ethnicity?
(1) Yes
(2) No
**ENDIF**

**DamProp**
In the last twelve months, has anyone deliberately damaged any property that belonged to you?
(1) Yes
(2) No

**IF (DamProp = Yes) THEN**
**Damnum**
How many times has this happened in the last twelve months?
(1) Once
(2) More

**IF (Damnum = More) THEN**
**PropNumb**
INTERVIEWER: ENTER NUMBER OF TIMES RESPONDENT HAS HAD PROPERTY DAMAGED IN THE LAST TWELVE MONTHS
**ENDIF**

**Damrace**
Do you think *any of* those attacks *on your property* were for reasons to do with your ethnicity?
(1) Yes
(2) No
**ENDIF**

**Insult**
In the last twelve months, has anyone insulted you for reasons to do with your ethnicity? By insulted, I mean verbally abused, threatened, or been a nuisance to you?
(1) Yes
(2) No

**IF (Insult = Yes) THEN**
**InsNum**
How many times has this happened in the last twelve months?
INTERVIEWER: ENTER NUMBER OF TIMES RESPONDENT HAS BEEN INSULTED IN THE LAST TWELVE MONTHS
**ENDIF**

**EmpBrit**
Do you think there are employers in Britain who would refuse a job to a person because of their race, colour, religion or ethnic background?
(1) Yes
(2) No

**IF (EmpBrit = Yes) THEN**
**EmpTrue**
Do you think this is true of most employers, about half, fewer than half or hardly any?
(1) Most
(2) About half
(3) Fewer than half
(4) Hardly any
**ENDIF**

**RtJob**
Have you yourself ever been refused a job for reasons which you think were to do with your (race, colour, or) religious or ethnic background?
(1) Yes
(2) No

**FairWork**
Have you yourself ever been treated unfairly at work with regard to promotion or a move to a better position for reasons which you think were to do with your religious or ethnic background?
I don't mean when applying for a new job
(1) Yes
(2) No

**SHORT FORM 12 QUESTIONNAIRE**

**SF12A**
The following questions are about your health now and your current daily activities.
In general, would you say your health is ...READ OUT...
(1) ... excellent,
(2) very good,
(3) good,
(4) fair,
(5) or poor?

**Lsi**
Do you have any long-standing illness, disability or infirmity. By long-standing I mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?
(1) Yes
(2) No

**IF (Lsi = Yes) THEN**
**Limit**
Does this illness or disability limit your activities in any way?
(1) Yes
(2) No
**ENDIF**

**SF12B**
Now I'm going to read a list of activities that you might do during a typical day. As I read each item, please tell me if your health now limits you a lot, limits you a little, or does not limit you at all in these activities?
Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
(1) Yes, limited a lot
(2) Yes, limited a little
(3) No, not limited at all

**SF12C**
Climbing several flights of stairs?
(Does your health now limit you a lot, limit you a little, or not limit you at all?)
(1) Yes, limited a lot
(2) Yes, limited a little
(3) No, not limited at all

**SF12D**
The following questions are about your physical health and your daily activities.
During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?
(1) Yes
(2) No

**SF12E**
During the past 4 weeks, were you limited in the kind of work or other regular daily activities you do as a result of your physical health?
(1) Yes
(2) No

**SF12F**
The following questions are about your emotions and your daily activities.
During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems such as feeling depressed or anxious?
(1) Yes
(2) No

**SF12G**
During the past 4 weeks, did you do work or other regular daily activities less carefully than usual as a result of any emotional problems, such as feeling depressed or anxious?
(1) Yes
(2) No

**SF12H**
During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework. Did it interfere ...READ OUT...
(1) ...not at all,
(2) a little bit,
(3) moderately,
(4) quite a bit,
(5) or, extremely?

**SF12I**
SHOW CARD M
These next questions are about how you feel and how things have been with you during the past 4 weeks. As I read each statement, please give me the one answer that comes closest to the way you have been feeling: is it all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time.

How much of the time during the past 4 weeks have you felt calm and peaceful?
Please take your answer from this card.
(1) All of the time
(2) Most of the time
(3) A good bit of the time
(4) Some of the time
(5) A little of the time
(6) None of the time

**SF12J**
SHOW CARD M
How much of the time during the past 4 weeks did you have a lot of energy?
(1) All of the time
(2) Most of the time
(3) A good bit of the time
(4) Some of the time
(5) A little of the time
(6) None of the time

**SF12K**
SHOW CARD M
How much of the time during the past 4 weeks have you felt downhearted and low?
(1) All of the time
(2) Most of the time
(3) A good bit of the time
(4) Some of the time
(5) A little of the time
(6) None of the time

**SF12L**
SHOW CARD M
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?
(1) All of the time
(2) Most of the time
(3) A good bit of the time
(4) Some of the time
(5) A little of the time
(6) None of the time

**PSYCHOSIS**

**PSQA**
Over the past year, have there been times when you felt very happy indeed without a break for days on end?
(1) Yes
(2) No

**IF (PSQA = Yes) THEN**
    **PSQB**
    Was there an obvious reason for this?
    (1) Yes
    (2) No

    **PSQC**
    Did your relatives or friends think it was strange or complain about it?
    (1) Yes
    (2) No
**ENDIF**

**PSQD**
Over the past year, have you ever felt that your thoughts were directly interfered with or controlled by some outside force or person?
(1) Yes
(2) No

**IF (PSQD = Yes) THEN**
    **PSQE**
    Did this come about in a way that many people would find hard to believe, for instance, through telepathy?
    (1) Yes
    (2) No
**ENDIF**

**PSQF**
Over the past year, have there been times when you felt that people were against you?
(1) Yes
(2) No

**IF (PSQF = Yes) THEN**
    **PSQG**
    Have there been times when you felt that people were deliberately acting to harm you or your interests?
    (1) Yes
    (2) No

# Appendix A: Questionnaire

PSQH
Have there been times when you felt that a group of people were plotting to cause you serious harm or injury?
(1) Yes
(2) No
ENDIF

PSQI
Over the past year, have there been times when you felt that something strange was going on?
(1) Yes
(2) No

IF (PSQI = Yes) THEN
PSQJ
Did you feel it was so strange that other people would find it very hard to believe?
(1) Yes
(2) No
ENDIF

PSQK
Over the past year, have there been times when you heard or saw things that other people couldn't?
(1) Yes
(2) No

IF (PSQK = Yes) THEN
PSQL
Did you at any time hear voices saying quite a few words or sentences when there was no one around that might account for it?
(1) Yes
(2) No
ENDIF

## SOCIAL FUNCTIONING

**SFQA**
SHOW CARD T
I am going to read a list of questions. Please look at this show card and choose the reply that comes closest to how you have been over the past two weeks.
I complete my tasks at work and home satisfactorily?
(1) Most of the time
(2) Quite often
(3) Sometimes
(4) Not at all

**SFQB**
SHOW CARD T
(Over the past two weeks) I find my tasks at work and home very stressful?
(1) Most of the time
(2) Quite often
(3) Sometimes
(4) Not at all

**SFQC**
SHOW CARD U
(Over the past two weeks) I have no money problems?
(1) No problems at all
(2) Slight worries only
(3) Definite problems
(4) Very severe problems

**SFQD**
SHOW CARD V
(Over the past two weeks) I have difficulties in getting and keeping close relationships?
(1) Severe difficulties
(2) Some problems
(3) Occasional problems
(4) No problems at all

**SFQE**
SHOW CARD W
(Over the past two weeks) I have problems in my sex life?
(1) Severe problems
(2) Moderate problems
(3) Occasional problems
(4) No problems at all

**SFQF**
SHOW CARD X
(Over the past two weeks) I get on well with my family and other relatives?
(1) Yes, definitely
(2) Yes, usually
(3) No, some problems
(4) No, severe problems

**SFQG**
SHOW CARD Y
(Over the past two weeks) I feel lonely and isolated from other people?
(1) Very much
(2) Sometimes
(3) Not often
(4) Not at all

**SFQH**
SHOW CARD Y
(Over the past two weeks) I enjoy my spare time?
(1) Very much
(2) Sometimes
(3) Not often
(4) Not at all

**PersDis**
SHOW CARD Z
Do you, in general, have difficulties getting on with people?
(1) Severe difficulties
(2) Some problems
(3) Occasional problems
(4) No problems at all

**RELIGIOUS AND SPIRITUAL BELIEFS**

**Relig**
The following questions concern your religious and spiritual beliefs. In using the word religion, we mean the actual practice of a faith, e.g. going to a temple, mosque, church or synagogue. Some people do not follow a religion but do have spiritual beliefs or experiences. For example, they believe that there is some power or force other than themselves, which might influence their life. Some people think of this as God or Gods, others do not. Some people make sense of their lives without any religious or spiritual belief.

Therefore, would you say that you have a religious or spiritual understanding of your life?
**CODE ALL THAT APPLY**
(1) Religious
(2) Spiritual
(3) Neither

**IF (Religious IN Relig OR Spiritual IN Relig) THEN**

**RStrong**
SHOW CARD AA
How strongly do you hold to your religious/spiritual view of life? Please look at this card and tell me the number that best describes your view, from 0 'weakly held' through to 10 'strongly held'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**SpecRel**
Do you have a specific religion?
(1) Yes
(2) No

**IF (SpecRel = Yes) THEN**

**WhatRel**
Which religion is that?
CODE ONE ONLY. IF MORE THAN ONE CODE THE MAIN RELIGION.
(1) Hindu
(2) Sikh
(3) Muslim
(4) Christian
(5) Buddhist
(6) Confucian
(7) Jain
(8) Parsi/Zoroastrian
(9) Rastafarian
(10) Jewish
(97) Other(SPECIFY)

**IF (WhatRel = Other) THEN**
**OthRel**
ENTER RELIGION
**ENDIF**

**ImpRel**
SHOW CARD AA
How important is religion to the way you live your life?
Please look at this card and tell me the number that best describes your view, from 0 'not at all important' through to 10 'very important'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**ImpPrac**
SHOW CARD AA
How important to you is the practice of your belief (e.g. private meditation, religious services) in your day-to-day life? Please look at this card and tell me the number that best describes your view, from 0 'not necessary' through to 10 'essential'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**Praynum**
SHOW CARD AB
How often do you attend services or prayer meetings or go to a place of worship?
(1) Never
(2) Less than once a year
(3) Once a year, but less than once a month
(4) Once a month, but less than once a week
(5) Once a week or more

**Force**
SHOW CARD AA
Do you believe in a spiritual power or force other than yourself that can influence what happens to you in your day-to-day life? Please look at this card and tell me the number that best describes your view, from 0 'no influence' through to 10 'strongly influence'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**ForCope**
SHOW CARD AA
Do you believe in a power or force other than yourself that can enable you to cope personally with events in your life? Please look at this card and tell me the number that best describes your view, from 0 'no help' through to 10 'a great help'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**ForInfl**
SHOW CARD AA
Do you believe in a power or force other than yourself that can influence world affairs e.g. wars? Please look at this card and tell me the number that best describes your view, from 0 'no influence' through to 10 'strong influence'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**InfDisas**
SHOW CARD AA
Do you believe in a power or force other than yourself that can influence natural disasters, such as earthquakes, floods? Please look at this card and tell me the number that best describes your view, from 0 'no influence' through to 10 'strong influence'.
INTERVIEWER ENTER NUMBER BETWEEN 0 AND 10

**Commun**
Do you communicate in any way with any spiritual power or force, for example by prayer or contact via a medium?
(1) Yes
(2) No

**ENDIF**
**ENDIF**

**ETHNIC IDENTITY AND BACKGROUND**

**IF (INIT.EthnicX <> WHITE) THEN**

**RSpkLang**
The next few questions are about your ethnic identity and background.
Do you regularly speak to anyone in Britain in any language apart from *(English/ or in Patois or Creole)*?
(1) Yes
(2) No

**OSpkLang**
Does anyone regularly speak to you in Britain in any language apart from *(English/ or in Patois or Creole)*?
(1) Yes
(2) No

**IF ((RSpkLang = Yes) OR (OSpkLang = Yes)) THEN**

**RWhatLan**
Apart from English, what languages do you regularly speak in, or do others speak to you in, in Britain?
**CODE ALL THAT APPLY**
SET[13] OF :
(1) Hindi
(2) Gujarati
(3) Punjabi
(4) Urdu
(5) Bengali
(6) Sylhetni
(7) Tamil
(8) Mandarin
(9) Cantonese
(10) Hakka
(11) Patois/Creole
(12) Gaelic
(13) Other language(s) (SPECIFY)

**IF Other IN RWhatLan THEN**

**ROthLan**
INTERVIEWER: WRITE IN OTHER LANGUAGE(S)

**ENDIF**

**SWhatLan**
Do you normally speak *(this language/these languages)* to members of your family who are of your own age?
(1) Yes
(2) No

**OWhatLan**
Do you normally speak (*this language/these languages*) to members of your family who are older than you?
(1) Yes
(2) No

**YWhatLan**
Do you normally speak (*this language/these languages*) to members of your family who are younger than you?
(1) Yes
(2) No

**IF (demog.eactiv = job) THEN**
**WWhatLan**
Do you normally speak (*this language/these languages*) to people at your work?
(1) Yes
(2) No
**ENDIF**

**FWhatLan**
Do you normally speak (*this language/these languages*) to friends outside of work?
(1) Yes
(2) No
**ENDIF**
**ENDIF**

**IF INIT.EthnicX IN [PAK, INDIAN, BANG] THEN**
**AsCloth**
Do you ever wear Asian clothes such as sari, salwar-kamiz, kurta or pyjama?
(1) Yes
(2) No

**IF (AsCloth = Yes) THEN**
**ACINum**
Do you wear Asian clothes all the time or only sometimes?
(1) All the time
(2) Sometimes

**IF (ACINum = Sometimes) THEN**

**ACIHome**
Do you ever wear Asian clothes at home
(1) Yes
(2) No

```
                    ACLOth
                    Do you ever wear Asian clothes in the homes of other Asians?
                    (1) Yes
                    (2) No

                    ACISoc
                    Do you ever wear Asian clothes at social events?
                    (1) Yes
                    (2) No

                    ACIWork
                    Do you ever wear Asian clothes at work?
                    (1) Yes
                    (2) No
                    (3) Does not work

                    AcIshop
                    Do you ever wear Asian clothes to the shops?
                    (1) Yes
                    (2) No
                ENDIF
        ENDIF
ENDIF


IF INIT.EthnicX IN [BLCAR, BLAfr, BLOth] THEN
        CaribCI
        Do you ever wear anything or wear your hair in a style that is meant to show a
        connection with the Caribbean or Africa?
        (1) Yes
        (2) No


        IF (CaribCI = Yes) THEN
                CCINum
                Do you usually do this, or do it just occasionally?
                (1) Usually
                (2) Occasionally
        ENDIF
ENDIF


IF (INIT.EthnicX = IRISH) THEN
        TEXT5 := "English people"
ELSE
        TEXT5 := "white people"
ENDIF


IF (Init.EthnicX = WHITE) THEN
        RACE := "white"
ELSEIF (Init.EthnicX = BLCAR) THEN
        RACE := "Black Caribbean"
ELSEIF (Init.EthnicX = BLAfr) THEN
```

```
        RACE := "Black-African"
ELSEIF (Init.EthnicX = BLOth) THEN
        RACE := "Black"
ELSEIF (Init.EthnicX = Indian) THEN
        RACE := "Indian"
ELSEIF (Init.EthnicX = Pak) THEN
        RACE := "Pakistani"
ELSEIF (Init.EthnicX = Bang) THEN
        RACE := "Bangladeshi"
ELSEIF (Init.EthnicX = Chinese) THEN
        RACE := "Chinese"
ELSEIF (Init.EthnicX = Irish) THEN
        RACE := "Irish"
ELSEIF ((Init.EthnicX = Other) AND (Demog.EthOth = RESPONSE)) THEN
        RACE := Demog.EthOth
ELSE


IF (INIT.EthnicX = White) THEN
        WhiteP := "a person from an ethnic minority group"
        RaceOrWht := "from ethnic minority groups, mainly with white people"
        PO!Race := "white people"
        PO!Eth := "People from ethnic minority groups"
        EMGS := "People from ethnic minority groups"

ELSEIF (INIT.EthnicX = IRISH) THEN
        WhiteP := "an English person"
        RaceOrWht := "of Irish origin, mainly with English people"
        PO!Race := "People of Irish origin"
        PO!Eth := "People of Irish origin"
        EMGS := "English people"

ELSE
        WhiteP := "a white person"
        RaceOrWht := "of " + RACE + " origin, mainly with white people"
        PO!Race := "People of " + RACE + " origin"
        PO!Eth := "People of " + RACE + " origin"
        EMGS := "white people"
ENDIF
```

**MarView**

Now some questions on marriage. Do you think that most people of *(race)* origin would mind if one of their close relatives were to marry a *(white person/person from an ethnic background)*?

(1) Yes
(2) No