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Health Concepts and Illness Behaviour:
the case of some Pathan Mothers in Britain.

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Table of Contents.

List of Tables.	x
Acknowledgements.	xi
Declaration.	xii
Summary.	xiv
Note concerning foreign words.	xv
<u>Chapter One. Introduction.</u>	1
1. The Scope and Contribution of this Work.	1
2. Background to the Study.	9
3. Theoretical Perspectives and Assumptions.	11
A. The Nature of Concepts.	12
B. Lay or Medical Concepts.	14
C. Health Care Encounters: An Interactive Perspective.	16
4. Analytic Framework.	20
5. Definitions.	25
A. Concepts.	25
B. Culture, Ideology, Social Structure.	26
i) Culture.	29
ii) Ideology.	30
iii) Social Structure.	30
C. Ethnicity.	32
D. Mental Illness.	32
6. Layout.	32
<u>PART I. RESEARCH AND SOCIAL PROCESS:</u>	
<u>ISSUES OF METHODOLOGY.</u>	34

<u>Chapter Two. Drawing up the Research Project.</u>	41
1. Identifying the Research Problems.	41
2. Towards a Research Strategy.	44
3. Research Techniques and Instruments.	46
4. The Ordering of the Work.	49
<u>Chapter Three. Entering the Field.</u>	51
1. Discussions with Health Care Practitioners and Research Colleagues.	52
2. The Recruitment of a Research Assistant.	55
3. The Population under Study.	58
4. Translation.	61
<u>Chapter Four. Issues and Revisions.</u>	66
1. Some Unresolved Issues.	66
2. Sampling.	66
3. The Concept of 'Piloting'.	67
4. Initial Contacts.	68
5. Issues that Emerged and their Effects.	69
A. The Consequences of relationships.	69
B. The Issue of Permission.	70
C. The Tape Recording of Material.	73
6. Revision of Research Strategy and Instruments.	74
A. The Issue of Group Discussions: Focus and Additional Respondents.	74
B. Revised Research Instruments and Recording Systems.	75
<u>Chapter Five. The Interviews.</u>	77
1. The Women Included.	77
2. Length of Contacts.	79
3. Ongoing Issues of Relationship and Permission.	81

4. Termination.	82
<u>Chapter Six. The Methodological Issues Reviewed.</u>	84
1. The Overall Definition of the Encounter.	85
2. Language and Concepts.	87
3. The Meaning of the Encounter: the 'game which we play' or Meaningful Relationships?	89
4. Individualism in Research.	91
5. What is Learned from this Study?	94
<u>PART II. SOCIAL SITUATION AND INTERACTION.</u>	97
<u>Chapter Seven. Pathan Culture, Ideology and Overall Social Structure.</u>	102
1. The Honourable Pursuit of Public Affairs.	104
2. The Honourable Use of Material Goods and Hospitality.	105
3. The Honourable Organisation of Domestic Life: the Seclusion of Women.	108
<u>Chapter Eight. The Social Context of Respondents Lives: the Women in Public Domain Terms.</u>	114
1. The Women themselves.	114
2. Their Family of Origin.	116
3. The Families' Status in Britain.	117
A. Employment.	120
B. Housing.	121
C. Standard of Living.	121
<u>Chapter Nine. Patterns of Social Interaction within the Home and Outside.</u>	123
1. The Division of Labour within Households.	123
2. The Women's Social Networks.	126
3. Discussion: Uniformity from Without;	

Differences Within.	132
<u>Chapter Ten. Factors Influencing Interaction and Purdah Observance.</u>	134
1. Concepts of Purdah or of Womanly Behaviour.	135
A. The Women's own Dress and Demeanour.	135
B. The Sexual Division of Labour.	136
C. Movement outside the Home.	138
2. Factors Influencing Concepts.	139
A. Sub-Cultural Variations.	140
B. Differences of Formal Status.	140
C. The Husband's Views.	142
D. Religious Identification.	142
3. Options: Circumstantial Factors Influencing Social Behaviours.	144
A. Arrangement and Location of Houses.	144
B. Migration and Membership of a Minority Ethnic Group.	144
4. Discussion: A Missing Factor?	148
<u>Chapter Eleven. Interests.</u>	149
1. The Maintenance of Social Relations.	150
2. The Receipt of Health Care.	153
3. Learning English.	154
4. Purdah Observance in Context: A Positive View.	157
<u>Chapter Twelve. Work, Seclusion and Isolation.</u>	160
1. The Women's Work.	160
2. Seclusion and Isolation.	164
3. Conclusions.	168
<u>PART III. THE WOMEN AS MOTHERS.</u>	170
<u>Chapter Thirteen. Conception and Contraception.</u>	175

1.	Overall Ideology Concerning Child Bearing.	175
2.	Concepts of Contraception: Process and Change.	175
3.	Contraceptive Options.	178
4.	Interests.	180
5.	Discussion.	182
<u>Chapter Fourteen. Pregnancy and Antenatal Care.</u>		185
1.	Behaviour during Pregnancy.	185
	A. Awareness, announcement and discussion of pregnancy.	185
	B. Preparations for the New Baby.	187
	C. Eating and General Activity.	188
	D. Attendance at Antenatal Clinic.	190
2.	Discussion.	192
<u>Chapter Fifteen. Experiences of Childbirth.</u>		196
1.	The Effect of Past Experiences on Concepts and Interests.	196
2.	Recent Birth Experiences in Bradford.	199
	A. Anaesthesia.	200
	B. Communication and Attention.	200
	C. Food.	201
	D. Company and Visitors.	201
3.	Back to the Domestic Domain.	202
4.	Discussion.	205
<u>Chapter Sixteen. On Being a Pathan Mother in Britain.</u>		208
1.	Overall Determinants.	209
2.	An Extended Sense of Mothering: Informal Placement of Children with other Family Members.	210
3.	The Practicalities of Mothering.	212
4.	Mutual Support in Respect of Mothering.	214

5. Discussion.	216
<u>Chapter Seventeen. Child-Rearing Practices.</u>	219
1. Infant Feeding.	220
A. Breast feeding.	220
B. Bottle feeding and Weaning.	223
2. Sleep times of Children.	224
3. Nappies and Toilet Training.	226
4. Developmental Play.	226
5. Milestones, Behaviour, Schooling and Aspirations.	229
6. Discussion.	233
<u>Chapter Eighteen. Mothering: Medicalisation, Migration and Mental State.</u>	239
1. Concepts.	240
2. The Issue of Medicalisation.	240
3. Migration.	242
4. Mental State.	243
5. Interactions with Health Workers.	244
<u>PART IV. GENERAL AND MENTAL ILLNESS: DEFINITIONS OF NORMALITY AND OF APPROPRIATE BEHAVIOUR.</u>	246
<u>Chapter Nineteen. The Literature Concerning Concepts of Health and Illness: some Major Themes and Questions.</u>	249
1. Disease, Health and Illness.	250
2. Illness and Normality.	252
3. The Distinction Between Medical and Lay Concepts.	253
4. Factors Influencing Popular/Lay Concepts.	256
5. Different Medical Perspectives: the Case of Transcultural Psychiatry.	258
6. Questions of Causality.	262
<u>Chapter Twenty. General Illness: Treatment Options.</u>	267

1.	The General Practitioner.	268
2.	The Child Health Clinic.	272
3.	The Health Visitor.	274
4.	Hospital Services.	277
5.	Religious and other 'folk' healers.	278
6.	Illnesses for which treatment was not sought, or where Options were Ineffective.	281
7.	Womens' Perceptions of Health Workers.	283
<u>Chapter Twenty-One. Concepts of Health and Illness.</u>		286
1.	Disease, Health and Illness.	286
2.	Illness and Normality.	287
3.	The Distinction Between Medical and Lay Concepts.	288
4.	Factors Influencing the Women's Concepts.	292
5.	Different Medical Perspectives.	296
6.	Questions of Causality.	296
<u>Chapter Twenty-Two. Assessments of Mental State.</u>		300
1.	The Bases of Assessment: Medical and Lay EMs.	300
2.	Results of Assessment.	305
A.	The Existence of Illness/Disease.	305
i)	The Women's Self-Assessments.	305
ii)	The Research Workers' Assessments.	306
iii)	The Test Scores.	307
B.	Causative Factors.	309
i)	Isolation.	309
ii)	The Accounts of the Sufferers Themselves.	311
iii)	Peer Views of Causation.	312
iv)	An Outside View.	313
C.	Desire for Treatment.	315

3.	Discussion of the Test Items: the Translation of Meaning.	316
A.	Items and Concepts that were Difficult to Translate or were Queried.	317
B.	Points of Similarity and Difference Between Pathan and Psychiatric Views.	322
C.	Can we Use Such Measures Cross-Culturally?	325
<u>Chapter Twenty-Three. Concepts of Mental Well - and Ill-Being.</u>		330
1.	Disease, Health and Illness.	330
2.	Illness and Normality.	335
3.	Factors Influencing the Womens' Concepts.	338
4.	Questions of Causality and the Issue of Somatisation.	339
<u>Chapter Twenty-Four. Common Themes in Relation to Physical and Mental Disorder.</u>		343
1.	Concepts of Pathan Respondents.	344
2.	Options.	346
3.	Interests.	347
4.	The Importance of Social Relations.	348
5.	Normality.	350
6.	A Relative View of Physical and Mental Ill-Being.	351
<u>Chapter Twenty-Five. Overall Conclusions.</u>		352
1.	The Initial Questions Relating to Practice.	355
2.	Collective Influences on Individual Experience and Behaviour.	358
3.	Theoretical Conclusions.	365
A.	The Nature of Concepts.	365
B.	The Framework.	366
C.	My Aims and Theoretical Perspective.	367

<u>Bibliography.</u>	370
<u>Glossary.</u>	391
1. Terms of Central Importance.	391
2. Places.	393
3. Languages.	394
4. Other Words and Phrases Used in the Text.	394
<u>Appendices.</u>	
A. Statement of my own Assumptions and Values.	A1-A8
B. Research Assistant: Job Description and Criteria for Selection.	B1-B3
C. The Psychiatric Test Scales and Translations.	C1-C21.
D. Interview Guidelines and Recording Sheets.	D1-D32.

List of Tables.

(i)	Number of Visits and Duration of Contacts.	79a
(ii)	Public Domain Social Facts - the women.	114a, 114b.
(iii)	Public Domain Social Facts - husbands' employment, housing.	122a
(iv)	Nature of Household and Division of Labour.	126a
(v)	Women's Patterns of Interaction and Purdah Observance.	127a, 127b.
(vi)	Contraceptive Practices and Views.	182a, 182b.
(vii)	Live Births in England and in Pakistan.	196a
(viii)	Women's Experiences During Delivery and Hospital Stay.	199a, 199b, 199c.
(ix)	Numbers of Children Currently in each Mother's Care, with Ages. Other Children Elsewhere, and Experience of Childrearing in Pakistan.	209a
(x)	Mutual Support in Respect of Mothering.	214a
(xi)	Breast Feeding.	220a
(xii)	Sleep times of Children.	224a, 224b.
(xiii)	Use of N.H.S. Services.	268a
(xiv)	The Use of Alternative Facilities in Sickness.	278a
(xv)	Long standing Health Complaints.	282a
(xvi)	Assessment of Mental State.	305a
(xvii)	Respondents' Scores on Langner and G.H.Q test scales.	308a
(xviii)	The Items of the Langner Scale.	317a
(xix)	The Items of the General Health Questionnaire.	317b, 317c.

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Declaration.

Material used in this thesis has previously appeared in the following:

Curren, C. (1983a).

The Mental Health of Pathan Mothers in Bradford: a case study of migrant Asian women. Final Report to the DHSS.

June 1983. University of Warwick, mimeo.

Curren, C. (1983b).

Pathan Mothers in Bradford. Shortened version of the findings, for use by health and social workers. November 1983.

University of Warwick, Mimeo.

Curren, C. (1984a).

Pathan Women in Bradford - Factors affecting Mental Health

with particular reference to the effects of Racism,
International Journal of Social Psychiatry, 30th
Anniversary Double issue, 30/1 and 2, Spring pp72-76.

Currer, C. (1984b)

'Lay Concepts of illness and depression, and their relation
to illness behaviour, amongst Pathan mothers in an English
city', in B. Tax (ed) Proceedings of Workshop on Lay
Culture and Illness Behaviour, July 2-4 1984. Department
of Social Medicine, Nijmegen, Holland. Mimeo.

Currer, C. (forthcoming)

Concepts of Mental Well - and Ill-Being: the case of Pathan
Mothers in Britain, Chapter 9 in Currer, C. and Stacey, M.
(eds) Concepts of Health, Illness and Disease: A
Comparative Perspective.

Leamington Spa: Berg Publishers.

Summary.

This work started from initial questions in the field of transcultural psychiatry concerning the effects of culture and of seclusion on Asian immigrant women's experiences and on their concepts of mental well - and ill-being and their behaviour in face of this. In presenting data concerning the women's views and interactions with health workers, a tripartite framework is used as a way of understanding the logic of behaviours from the actor's perspective. Theoretical conclusions relate to this framework and to the nature of Concepts, in which the influence of structural and cultural factors are drawn out. Context and process are shown to be important in respect of Concepts, health care interactions and social research.

The research was a small-scale study involving semi-structured discussions with forty-six women, often in a group setting, seventeen of whom were interviewed in depth, and the use (in translation), of two Psychiatric Rating Scales. The women involved were Pathans, currently living in Bradford.

This thesis is divided into four Parts, in addition to an overall introduction and conclusion. In each Part, issues concerning social influences on individual experience and behaviour are addressed through the presentation of data from the interviews. These issues concern research methodology (Part I), social situation and interaction (Part II), the women's role as mothers (Part III) and health and illness experiences, Concepts and behaviours (Part IV).

The work contributes to a number of fields of study, illustrating the dynamics of the processes at work in each area. It is, however, in combination that the Parts of the study demonstrate the contribution that can be made to the understanding of illness behaviours by a sociological analysis which is committed to elucidating the logic of these behaviours from the actor's perspective, in the context of his/her other life experiences.

Note:

Please refer to the Glossary for the meaning of foreign words, most of which are underlined in the text.

Exceptions are place and language names, explanation of which is also to be found in the Glossary, with a justification of my decision to refer to those studied as Pathans, and to their language as Pukhtu.

Chapter One. Introduction .

بہ پینتہ سرے عروستان تہ عم رسی

By enquiring one can even reach India.

Pathan Proverb. (Ahmed 1973: 16)

1. The Scope and Contribution of This Work.

Concepts of health and illness vary across time and from one culture and social situation to another. Within any one situation there may be differences between the conceptual model of a healer and of those s/he is attempting to heal (Kleinman 1978); and change in each due to interaction with the other (Helman 1978). These differences have been described and analysed by authors from a variety of academic traditions, using a number of different methodologies, from the ethnographic (e.g. Lewis 1975; Seabrook 1973) to more closed, quantitative approaches (e.g. Tax 1984; d'Houtaud and Field 1984). That the concepts of the sick person are one influence on his/her illness behaviour is widely accepted. Claudine Herzlich's (1973) discussion of three conceptions of illness; as destructive, as a liberator and as an occupation, each of which involves different models of behaviour in relation to the illness and to treatment, is illustrative of this process and of one such description. The concepts of the healer are also a factor influencing treatment and outcome; Arthur Kleinman (1978) uses the notion of the 'explanatory models' (EMS) of the participants, suggesting that congruence between the models of patient and healer leads to a more successful outcome, and that dissonance may be a factor accounting for lack of therapeutic success.

The issue of therapeutic success is one with which this study was initially concerned. Moreover, the particular situation studied is one where the 'explanatory models' of patients and healers were expected to be dissonant, insofar as it involves members of an ethnic minority group - Pathans - whose religion and social structure are seen to be in contrast to those of dominant British society. In addition, the area of their meeting (or non-meeting) with biomedicine and its representatives is that most theoretically divided area of medical work - psychiatry. (David Ingleby (1981) writes 'significantly, the best recent account bears the title Psychiatry in Dissent (Clare 1976)'.)

Perhaps because of its internal lack of coherence; perhaps because of its focus on issues of communication and meaning, it is within psychiatry (rather than other branches of biomedicine) that we find most interest in the question of alternative concepts of health and illness. Transcultural psychiatry is a distinctive and well established field of study; distinctive in that it has its own agenda and key concerns, and of central importance within psychiatry overall in that large numbers of doctors see the issues raised in cross-cultural work as the tip of the iceberg which concerns the existence and meaning of mental illness in any culture. For if mental illness is not a disorder of the 'mind' of an individual that is universal maybe it is not a disorder of the 'mind' of an individual at all?

These issues have immediate practical relevance for the psychiatrist faced with patients of a different cultural background. It is therefore not surprising that they have received attention from them. It was a transcultural psychiatry conference in 1976 that gave rise to a volume stressing 'the

impatience that was developing among (practitioners) for research directly relevant to their problems and interests...' (Saifullah Khan 1979: ix). A Transcultural Psychiatry Unit which started at a Bradford psychiatric hospital in 1972 was instrumental in leading in 1981 to a Centre for Ethnic Minorities Health Studies linked to the University of Bradford. The following year (1982) saw the publication of two books by leading psychiatrists in this field (Rack 1982; Littlewood and Lipsedge 1982). In 1983, at the Transcultural Psychiatry Society's A.G.M. the differences of approach of members (inherent also in the two volumes just mentioned) clashed in a struggle for a more overtly political agenda from those who challenged 'not only the substance but also the premise of the professional academic wisdom' (Sashidharan 1985). These changes in emphasis are of importance in respect of this work which has been conducted through these years, during which the need for research and its contribution to the issues involved has itself come into question. From a clear plea in 1979 for more research (Saifullah Khan, 1979), Roland Littlewood and Maurice Lipsedge in 1982 conclude their book by saying:

Bearing in mind the record of psychiatry's relations with minorities we should perhaps be rather cautious about the motivations and application of research in this area. Future work will be worthless unless it takes into account the double reflection of black and white in our society, a reflection which sometimes crosses the mirror of psychiatry.

(Littlewood and Lipsedge 1982: 242).

A sociological perspective offers, I would argue, an indispensable contribution to this important debate in ways which are demonstrated by this study. For the debate concerns the relative importance of cultural and structural influences on

behaviour, the relation between ways of viewing the world and behaviour, and the social and political context of the meeting between professionals and lay persons in health care. I show one way of approaching these questions by describing the health and illness concepts of a group of immigrant women living in Britain within a framework which takes account of the interactive nature of health care encounters and beliefs. This enables us to draw out both cultural and structural influences, (within the respondents' own community and within the dominant society in which their lives are set). The approach also explores the extent to which translation is itself a socially influenced and determined process.

It will become clear that the work offers a contribution to disciplines other than transcultural psychiatry. To the growing body of work concerning lay concepts of health and illness (e.g. Kleinman 1978; Herzlich 1973; d'Houtaud 1981; Helman 1978; Blaxter and Patterson 1982; Pill and Stott 1982; Cornwell 1984), it adds a detailed account of the concepts of Pathan immigrant women; an account particularly interesting both because of the contrast between these concepts and those of biomedicine and yet their similarity to some of the lay concepts described by other workers whose respondents are not immigrants. Position in the social structure comes to the fore as an explanation of similarities where none might be otherwise expected.

As ethnography, the work is unique in its focus. The people studied are Pathans, Pukhtu speakers who had migrated from the North-West Frontier Province of Pakistan in the ten years prior to study. (Exceptions to this and a fuller description of the respondents will be found below Chapter Eight). There is no other

account of the lives and views of Pathan people in Britain although some other works do refer to them (e.g. Saifullah Khan 1976; Wilson 1978). This therefore adds to excellent accounts of other Pakistani and Indian settlers; for example those by Ursula Sharma (1971), Verity Saifullah Khan (1974), Patricia Jeffery (1976) and Roger and Catherine Ballard (1977). Because of its special focus of attention on health and illness and mental well - and ill-being, however, the study does not purport to offer a comprehensive ethnography, even of the group of Pathans included within it.

There are a limited number of major works concerning Pathans in their homeland (notably Caroe 1958; Barth 1959, 1969; Ahmed 1976, and 1980) although a further number of specific accounts are written and published locally in Pakistan. International interest in this distinctive people has been fanned by the 1979 Russian invasion of the country of Afghanistan and the Afghani Pathan refugees who have since poured into Pakistan. Various accounts of Pathan life have appeared on television and in newspapers; an attractive and well researched description of life in a Pathan village which includes an account of the lives of women as well as some health and illness practices is that by André Singer and the editors of Time-Life books (1982). The major works do not however focus on women: for such an enterprise a Pukhtu speaking woman is necessary as author, preferably a Pathan. (Akbar Ahmed's work (1980 especially) is an exception; his wife and her sister were involved in field work).

This study would itself have been impossible had I not spoken Pukhtu and had experience amongst Pathans: the conducting of the study illustrates the disincentives to, and difficulties of, producing an account of women in Pathan households, as I shall

show. I know of no study which directly concerns issues of Pathan mental well - and ill-being although there are reports of the setting up of a mental health centre and community psychiatric service for Pathans (Bavington 1984, Currer 1978). Andre Singer's book (1982) touches on the subject and Fredrik Barth's (1969) concerns Pathan identity and will be referred to in what follows. An anthropological account of insanity and devil possession amongst Afghani Pathans has been written by Richard Tapper (n.d.), but is only marginally relevant, since my focus was on concepts of normality and unhappiness rather than extreme disorders.

The study concerns not all Pathans, but Pathan women. Amongst Pathans, observance of purdah is viewed not only as a part of their religion but as 'vital part of the Pathan code of Pukhtunwali' (Singer 1982: 74) - that is, it is part of what it means to be a Pathan. Purdah is a social system by which women are secluded from men and from public life; it is 'an extreme form of sex role differentiation' (Saifullah Khan 1976: 224). A number of authors have studied the lives of women in purdah. Notable examples are Ursula Sharma's account of the daily lives of rural women in Himachal Pradesh, India (1978) and of the use of public space by Hindu women in another Indian village (1980); Patricia Jeffery's description and analysis of a group of women whose lives revolve around a religious shrine due to their membership of a 'holy' family (again in India although the women are Muslims) (1979); Hanna Papanek's review of a number of studies and her analysis of purdah in terms of 'Separate Worlds and Symbolic Shelter' (1973) and Verity Saifullah Khan's description of 'Purdah in the British situation' - as practised by Mirpuri women living in Bradford (1976). This latter is directly

relevant to the present study, and will be referred to at various points, as will the others mentioned. In overall terms this tradition is one to which I would hope this work contributes, although pardah observance is not, per se, my main focus of attention. However, in describing the way in which these Pathan women in Britain observe pardah and variations in observance within the group, I draw attention to other ideals, such as the maintenance of social relations, of which account has to be taken of the women's actual patterns of interaction are to be understood. This is not a new insight. Many writings acknowledge that pardah observing women go out into public space 'with a reason'. I explore this 'reason' in respect of those studied and so show how pardah is redefined in the British context and the part played by the wish to receive some forms of health care in this. This interaction between pardah observance and receipt of health-care can be seen to be two-way - each influences the other. My study enables the logic of apparent contradictions in the women's behaviour to be seen: for example, why will some women not 'go out' to an English class when they will go to hospital to have a baby? Why do all have their babies delivered in hospital but a minority receive health care in person from their General Practitioners? Analysis of both their patterns of interaction and the quality of contacts also helps us to see why it is that those women most isolated did not seem to be depressed whereas others in the centre of close knit networks were. Again, apparent contradictions are clarified when the world is seen from the women's own perspective, and there are important conclusions about the 'work' that these women, never employed outside the home, do.

The women interviewed were all mothers. Those studied in

depth all had a child under five years at the time of study. An initial decision to focus on mothers with young children had been made because this was seen as a time of particular potential stress. Although this turned out not to be the case (an example of an assumption based on a view of mothering which derives from social structures predominating in Britain but far from universal), this is a period of a woman's life when there is, in Britain, increased routine contact with health officials. It also links the work to another body of literature concerning women, mothering and health and to work on puerperal depression. Hilary Graham's work concerning the conflicting responsibilities of mothers in respect of health care (1979, 1982) and Ann Oakley's writings about antenatal care, delivery and postnatal depression (1979, 1980) are particularly relevant, as is Sheila Kitzinger's cross-cultural perspective (1978). From the point of view of psychiatric disorder in women, the work of George Brown and Tirril Harris (1968) and John Cox and his associates in Edinburgh (1984) are of importance.

From my study the dual picture of mothers as victims of their family's health and maintainers of it emerges clearly: they are without doubt 'unpaid health workers' (Stacey 1984). Thus while I do not claim that my analysis of women in purdah or of women as unpaid health workers are new within their own disciplines, their juxtaposition adds to each discussion, and the particular case example is new within each.

As I shall describe, the methods used in this study were drawn from as wide a range of disciplines as those to which it offers a distinctive contribution. Indeed, I would claim that one of the study's main contributions is to questions of research

methodology. The attempt to use certain research strategies in this cross-cultural setting showed up some of the individualistic assumptions on which they are based. The research process itself therefore challenges a number of conventional wisdoms in the field of methodology. These challenges are not without their forerunners (e.g. Deutscher 1968) amongst other authors investigating in cross-cultural settings. This study provides a striking illustration of these issues, however, in that it started from an acceptance of traditional strategies and was forced to modify these. Sociological research can, no less than medicine, be ethnocentric in its assumptions.

Despite the challenges offered within sociology and the contribution to debates the centres of some of which can be seen to lie outside sociology, this analysis remains a sociological one. The focus of attention is neither the individual nor society but behaviour in respect of health care. It concerns the meeting between one category of people (health care providers) and another (specifically Pathan mothers living in Bradford) and the assumptions and concepts that each bring to the encounter. The framework used enables the focus to be on elements of this process while retaining the importance of the whole. Before outlining this framework, however, I will describe the background to the study and then the theoretical perspectives which underlie it.

2. Background to the Study.

The work arose from my own interests in depression amongst two categories of women with whom I had been involved during six years work in Pakistan. The first category was the patients who came to the Mental Health Centre in which I worked - Pathan

women. The second was the expatriate women rearing children in what they saw as an alien environment, amongst whom rates of depression appeared to be abnormally high. I was myself aware of the difficulties of bearing and rearing a child in a cultural environment very different to that in which I had been brought up. Although I did not study rates of mental illness amongst expatriates, I knew that official employing agencies viewed the unhappiness of wives of their employees as 'a problem', such that various strategies were adopted by agencies to combat it.

On returning to England, I became interested in the mental health of Asian migrant women, particularly those with young children. A contradictory picture emerged from the literature, however. On the one hand a number of writings (e.g. Wilson 1978, Schofield 1981, Knight 1978 and Saifullah Khan 1974) suggested that Asian women, particularly the more secluded, were subject to depression. On the other hand, reported mental hospital admission statistics (Cochrane 1977) showed Asian women to be underrepresented in hospital admissions (Later work by L. Carpenter and I. Brockington (1980) conflicts with Cochrane's findings, however.) My training as a Psychiatric Social Worker, my experience in Pakistan and knowledge of Pukhtu, as well as my experience as an immigrant wife and mother, seemed to fit me to investigate the reasons for the discrepancy.

The first Part of this work will show how the initial research questions led to the drawing up of research strategy and techniques, and also how these were subsequently modified and what I learned from this. Here, however, my concern is with an overall introduction of the work, my assumptions and theoretical perspectives.

3. Theoretical Perspectives and Assumptions.

A particular feature of this work is the way in which it has changed during the research process. It is therefore important to distinguish those theoretical perspectives on which it was based from those which became part of its conclusions. This is necessary not least because the framework in terms of which I shall present the data is one which represents categories which emerged as particularly significant during the work. Aspects of it were present from the start, others added. The relative importance of the factors altered or came to be understood in a different way during the course of study.

My purpose was to explain social behaviour (specifically in health care encounters) in terms of the actors' concepts of health and illness. I assumed that these concepts would differ from those of the other primary actors in health care encounters, representing a biomedical perspective. I also set out to investigate the actors' perceptions of previous contacts with medical services, seeing these as a further determinant of potential encounters in respect of mental well- and ill-being.

My initial approach can be described as heuristic, owing much to a 'social action' perspective (Bilton et al 1981: 744) in both its theory and methodology and, perhaps in consequence of this, essentially apolitical. I will elaborate these points (and show how the work changed my perspectives,) in relation to the elements of my overall purpose stated above, i.e.

- A) the exploration of concepts;
- B) the issue of lay vs medical concepts;
- and C) health care encounters: an interactive perspective.

A. The Nature of Concepts.

Although I set out to explore the concepts of respondents, my understanding of this was loose: I was exploring shared ideas concerning health and illness with little preconceived notion of the determinants of these ideas. The study has led me to see the nature of concepts as a key theoretical issue: insofar as I concentrated initially on the role of culture in forming concepts, my understanding was lacking an awareness of structural constraints and considerations. A study of concepts can derive from a number of different (and sometimes contrasting) theoretical perspectives; see for example Ronald Frankenberg's criticism of Arthur Kleinman's approach (Thomas 1978 and Kleinman 1978). I was not initially aware of this, partly due to the funding of the work earlier than anticipated (see below Chapter Two), and my theoretical perspective has been formed by the work rather than informing it.

In my attempt to explore concepts, however, two important considerations guided the work: both represented a *commitment to the actors' perspective*. Firstly, I believed that the behaviours of respondents in health care encounters and in relation to health care would be logical and explicable in terms of the respondents' own world-view. I was committed to an analysis of their explanations of the world as a basis for understanding their actions, particularly in view of the fact that many health and other professionals saw their behaviour as odd, bizarre, inexplicable. Secondly, I assumed that I would learn most of their world - view by acting myself in ways with which the respondents appeared most comfortable; this is close to a participant observer approach. Part I will show how this worked out in

practice.

The problem with social action theories has been identified as their lack of attention to, or acknowledgement of, social structure. A popular textbook of sociology states:

The most pressing theoretical task for sociology is to construct a theory of social life which acknowledges the fact that human activity embodies both social action and social structure simultaneously. (Bilton et al 1981: 744)

My task in this work is not primarily the construction of social theory, although the data does give rise to a loose framework in which both the understandings, intentions and meanings of actors on the one hand, and the effects of their position in the social structure on the other, can be seen to underlie the concepts which emerge from the study. I see it as an important vindication of my commitment to the respondents' own perspective that a study of their world-view has led to an analysis which is markedly different in emphasis to that from which I started, but which retains some important elements. In my view, the study of concepts offers a way of understanding social behaviour in terms of both the influence of structural factors and the actors own understandings. Therefore the focus of my study is not altered, although the content of the notion of 'concepts' is considerably enlarged to the extent that my theoretical perspective can be said to be changed.

In respect of concepts of health and illness, an initial emphasis which was retained and, indeed, endorsed by the study was the view of concepts of health and illness and particularly of mental well- and ill-being as rooted in respondents whole lives (see also Cornwell 1984). This was one reason for my concentration on respondents' everyday experiences; experiences such as having

a baby and rearing young children. While this data was to be important in respect of previous contacts with health services and perceptions of them, I also saw it as essential to an understanding of the women's concepts of unhappiness. This possibly reflects in part my theoretical perspective concerning mental illness which sees it primarily as a response to external everyday situations, rather than an internal 'disease'.

B. Lay or Medical Concepts.

An initial assumption was that the lay concepts and biomedical concepts would be distinct. In view of the fact that my respondents had not grown up in a culture in which biomedicine was as widespread as it has been in Britain for a number of decades, this was not an unreasonable hypothesis.

My assumption of the distinctiveness of lay and medical concepts might be seen to reflect a theoretical perspective which sees the two as inherently conflicting or which sees medicine primarily as an institution of social control. This is not my intention. Jocelyn Cornwell has reviewed the ways in which medical sociologists have approached the question 'of the relationship between medicine and the medical profession on the one hand, and society - "ordinary people" - on the other'. (Cornwell 1984: 17). She takes issue with those medical sociologists who see medicine as an institution of social control, taking as her own starting point an intention of finding out to what extent medicine in practice dominates people's lives and their relationship to health and illness; assuming people's responses to medicine to be rational and realistic when considered from their own points of view, and considering the constraints and medical options actually available to people in specific

situations (Cornwell 1984: 20-22). She also bases her analysis on the premise that medicine is only one of a number of determinants of people's actions in respect of health care: they have other interests deriving from other aspects of their lives. These assumptions are very close to my own as already outlined and my framework can be seen to derive from her work. A process of interaction between lay and medical concepts was observable in my respondents' accounts, as was their use of aspects of medical care to further their interests, and of these interests as themselves determining which medical encounters the women engaged in. Differences between medical and lay premises concerning the nature of health and illness emerge clearly: so too does a process of incorporation of some medical concepts and practices. The study illustrates these processes at work.

Despite my sympathy with Jocelyn Cornwell's theoretical perspectives, I retain the use of the term 'lay concepts'. (She chooses instead to speak of 'commonsense notions'.) This is because I see this work as in the same tradition as other studies which use this terminology, and I see it as helpful rather than otherwise to use the same phrase. However, it is clear that there are major theoretical differences in the way in which the term 'concepts' is used and understood by different writers; differences which go beyond the issue of medical dominance to the heart of sociological theory concerning the relative role of culture and of structure in determining behaviour or being created through it. (See Hall (1981) concerning two paradigms within cultural studies and Bilton et al. (1981) concerning social action perspectives and structural and historical sociology.) The way in which I understand concepts has partly been discussed above and will be illustrated in what follows.

A practical consequence of the distinction which I have assumed between medical and lay concepts is the issue of what to study. Mental illness is, I would argue, a biomedical concept to be understood as used by psychiatrists. Arthur Kleinman points to the need for a new terminology in the investigation of lay concepts (Kleinman 1978). Terminological difficulties are highlighted in cross-cultural work, especially where translation is involved. Initially, I thought the concept of stress might prove helpful as a medium-range term indicating difficulties and disorder but stopping short of full-blown mental illness as recognised by psychiatrists. It is a concept which has been used by others (e.g. in the volume edited by Saifullah Khan 1979) and which is used within psychology (e.g. Kanner et al 1981; Ray et al 1982) and biological anthropology (e.g. Harrison 1982). I found it elusive, however, and as hard to translate as 'mental illness'. I decided to ask about 'unhappiness' and 'unhappiness-illness'. I therefore reserve the terms 'mental illness', and 'depression' for those occasions when I assume a psychiatric understanding.

C. Health Care Encounters: An Interactive Perspective.

Although my focus was on the behaviour and concepts of the Pathan women studied, my initial assumptions included a recognition of the importance of this behaviour as interactive. For health care encounters involve two parties, each of whose behaviour derives from aspects of their culture and social structure. Thus the study was never one in which the concepts and behaviour of health care professionals were viewed as neutral or passive such that any 'problems' in communication must arise from the 'differentness' of the Pathan patients. Such studies abound

and will be referred to in context below. They are rightly criticised. Not only did I see the context of health concepts as that of interaction, I assumed from the start that the health care encounters might themselves be a factor in leading to conflict for immigrant mothers: for example, due to the different ideologies of childrearing informing their practices and those of health professionals (e.g. Health Visitors). Thus I saw the women's concepts and experiences as well as their behaviour as reflecting such interactions; influenced by them and directed towards them. My initial lack of emphasis on structural considerations can be seen in this example, however, in that ideological conflict was seen as to the fore.

Although an awareness of health care encounters as interactive was present from the start of the work, together with the expectation that concepts and experience (of those interviewed) would reflect this, the process of the study draws additional attention to the importance of the interactive perspective. I have already mentioned the interaction that could be seen between lay and medical concepts. Theoretically the inclusion of 'the other side' of the health care encounters is of importance even when my focus is not specifically on them. It is important because it locates health concepts and experiences in time and place; the product of specific social situations and of social structures. My data illustrates well the way in which concepts are at any one time linked to social conditions: they are not some sort of cultural universal changing only with changes in ideology. Other writers have suggested that changes in health care provisions (e.g. the National Health Service's provision of medical care free at the point of delivery) can alter the health and illness concepts of recipients of such care (see Blaxter and

Patterson 1982 and Helman 1978).

In addition, the awareness of health care encounters as essentially interactive leaves room for an analysis of the power relations within the interactions and of the context of the meeting as political. My initial perspective took little account of these power relations possibly because I emphasised cultural rather than structural influences in the interaction. My respondents were in fact in a powerless position on two fronts, as women within a strictly sex segregated society and as immigrants in a majority white society.

Considering the former, it becomes clear from the study that the women's position as powerless within their own society critically affects their concepts, particularly their notions of responsibility: this powerlessness, if accepted, appears to be 'protective' rather than otherwise in respect of mental state, however.

Considering the latter, I have through discussion, reading and meeting with people who stress the effects of the racist nature of society come to see that my analysis of health care encounters would be deficient if it did not include an awareness that health care interactions have a political context: between white and white or black and black they are indeed rarely a meeting of equals (although this depends on whether the health worker concerned is a doctor or a nurse, for example); between white health worker and black patient the interaction is bound to reflect the power relations of the wider society, and its context is the racist nature of many medical institutions. Due to the fact that my framework includes an understanding of health care encounters as interactive, the analysis is compatible with an

inclusion of this dimension.

In practice, the women's accounts of health care encounters were remarkable in their concentration on personal rather than political factors. This emphasis coincides with my own; a fact that causes me to hesitate in stressing it. This is because I see research, like health care, as an interactive process, inevitably reflecting to some extent the value assumptions of the researcher (see Ingleby 1981 concerning whether research can be value free). Indeed, the study itself showed up a number of cultural assumptions underlying the methodology. Clashes between assumptions and the progress of the research are painful but instructive; areas of agreement may be more dangerous: they may reflect an uncritical application of the researcher's values to the data. Was this the case here? There is no definitive answer to such a question - I can only draw attention to my own value position (see Appendix A) and to what I see as having emerged from the women's accounts. There are a number of explanations for the women's emphasis on personal rather than political factors in medical encounters, and it is clear that they were not unaware of their community's powerlessness within British society. For themselves, however, as women in purdah, their lives were closely circumscribed; personal considerations and the micro-politics of the family and women's networks were their main concern.

This study and the doing of it during these years when awareness of political influences on behaviour has come to the fore has forced changes in my own thinking particularly in respect of race. Although my emphases in this study are not primarily political, I do see it as important that my framework is one in which political factors are included. I have tried to show how the basis for this framework predated the study although the work

itself and my changed theoretical understandings have filled this out.

I have described my theoretical perspective in relation to the three main areas of my initial purpose. In so doing, I have drawn out those elements which represented starting points and those which have been changed by the study. It is clear that I started from a position of wanting to find out, with poorly defined theoretical preconceptions. The study has defined my perspective more clearly, in some cases altering it.

The theoretical perspective which emerges from the study is embodied in the framework which I have used to analyse and present the data. I outline this next, therefore. The rest of this thesis will show this framework in use and I invite the reader to reflect with me in the concluding chapter both on its adequacy for the task of presenting this work and on the question of the theoretical understandings to which it leads us on.

4. Analytic Framework

In the descriptions which follow, the respondents' behaviour in respect of health and illness is seen as resulting from the interaction of three key factors. These are:

- a) CONCEPTS: the women's understandings of health and illness and of themselves in relation to it.
- b) OPTIONS: what it is possible for the women to do about illness or to enhance health, both in terms of what is available to them and of what is acceptable.
- c) INTERESTS: the bases on which women choose to do as they do, reflecting their ideals and the pressures upon

them.

These factors are best understood through the use of them in the presentation of the women's accounts. I have already identified the issue of the way in which concepts are understood as critical, discussing both my initial assumptions in respect of this and some additional elements which have been added by the study. Both culture and structure are important influences on concepts. (Below I discuss the definition of these key terms.) The other two factors perhaps require a little more explanation insofar as they have not already been discussed as such although the foregoing has led up to them.

From the respondents' point of view, Options are the resources that are perceived by a person to ^{be} open to them in any situation. They include some of the official health services available as well as alternative health care from traditional practitioners or from family and friends, and self-help. Other factors will however determine which of these resources are included for any particular person and at any point in time. Thus visits to a G.P. were an Option for some women but not for all; some had friends who might help, others did not. Material resources might delimit Options; ownership of a car would render a place accessible or not; financial means or lack of them would mean private health care was an Option or not. Previous experiences would influence an individual's or the group's view of a resource as acceptable or otherwise. Concepts and Interests also determine Options: possibilities will be included only if, in broad terms, they appear relevant: this depends on how illness is conceptualised, and choices where more than one Option is open will be made on the basis of other Interests. Health care Options are therefore defined on the basis of cultural and structural

aspects of the person's life. The Options are themselves 'other', however - they have an existence apart from the person concerned. They may embody other concepts of health than those of the actor. In engaging in a health care encounter with one of the chosen health care Options, a person is interacting with other people. Although the interactive nature of health care encounters influences all three of the key factors identified (experiences of past interactions modifying Concepts and altering the person's perception of their own Interests) it is in a consideration of the Options that we look in most detail at the ideology and structure of the 'other side' of these interactions.

The category of Interests arose from the study. It was clear from the women's accounts that choices were made concerning behaviour; also that some behaviours were adopted despite being unlikely while others which seemed feasible were not. For example, women would modify purdah observance to have a hospital rather than a home delivery, but not to see their General Practitioner; they would 'go out' to visit some people but not others; they might take a child to see a doctor but not go themselves. Such actions could not be wholly accounted for on the basis of Concepts and Options; another consideration influenced behaviour. It is often assumed that Interests are individual and selfish. This is not so: collective Interests were apparent, as were instances of the women furthering the Interests of those for whom they were responsible (most often children) often at the expense of their own apparent Interests, at least in the short term. Indeed, to separate their own and others' Interests was not a meaningful reflection of their world-view.

The category of Interests is perhaps best understood by means

of an illustration. Interests can be seen as working at two levels,

- (a) informing choices concerning which type of health care, and
- (b) concerning whether to receive care at all.

When they relate to the former, they are very closely related to Concepts and the definitions of Options. Thus, it became clear that the collective Interest in a physically healthy outcome for mother and baby at the time of delivery overrode the women's Interests in purdah observance to result in all having hospital deliveries. Other potential Options (e.g. requesting home delivery) were not considered. Once in hospital, personal Interests in rest after birth (shared by all the women but sometimes contrary to their husbands' Interests) meant that women sought longer, rather than shorter, stays in hospital, aware of the hard work awaiting them. Later, however, women's Interests in health, although still present, were less overriding: many would not personally visit their G.P. despite acknowledging that their treatment would be better if they did. Purdah observance was not, in this case, overridden. These choices can be seen as made on the basis of conflicting Interests. These Interests are clearly related to, and derive from, Conceptual differences and the different way in which the service Options are perceived, however. Thus birth is seen as a critical, life threatening event; children are God's gift. Medicalised delivery is highly regarded. Ongoing health and illness are, on the other hand, to be accepted as inevitable: routine health care is not always effective.

In relation to the issue of determining health care overall, Interests can be seen as more separate since they may override receipt of health care, even when this is highly regarded. Interests in maintaining social relations are an example. One

family, with an epileptic child, were advised by a doctor not to take the child to Pakistan as his health would suffer. They believed this to be true, but went nevertheless: the woman's father had died and being with the family in the mourning period was an overriding Interest. Later the same family did not visit Pakistan, despite wanting to go, because they did not want to interrupt the same child's medication.

In what follows, I shall be looking at the interaction of these factors in the women's accounts of their behaviour and experience in relation to having a baby, rearing young children, general health and illness and mental well - and ill-being. The reason for the choice of these as areas of experience on which to focus was that I saw concepts of health and illness, particularly of mental well-and ill-being as likely to be rooted in women's everyday experiences, of which mothering formed a large part. Further, these were areas in respect of which the respondents could be expected to be in routine contact with health services.

In addition to my use of this framework to present the data relating to these areas of experience, I shall use it to describe the women's observance of purdah. This approach to the description of the respondents' social situation is unusual and perhaps requires justification. I came to feel during analysis, that purdah observance was behaviour like illness behaviour, in which Concepts, external factors which might be seen as analogous to health care Options, and Interests played a part. In exploring differences between the women's patterns of social interaction, I have found this strategy of analysis useful. Thus the three key factors and their relation to each other will be used in relation to all the data which is to be presented.

5. Definitions.

Although the account presented here does, I hope, 'speak for itself' in respect of offering an understanding of the Pathan women's own perspectives, careful attention to the use of key terms is essential if the account is to offer any contribution to theoretical understandings. The following discussions of key terms used in analysis are therefore important, both in locating this contribution and in determining its precise nature.

A. Concepts.

'An idea of a class of objects, a general notion'. 'The object of a conception is universal, of a perception, individual' (Shorter O.E.D. 1965 p. 360). There can, however, be a collective perception of an event and concepts can be the 'property' of individuals.

As this is a key factor in my analysis, I have spent some time investigating its usage, to be somewhat reassured in my growing confusion to read E. Gellner's remark that

The nature of concepts, and their relation to the things of which they are the concepts, and to the minds which use or contemplate them, are among the most hotly disputed subjects in philosophy. (Gellner 1964).

This being so, I could hardly expect to resolve the matter in an introductory chapter!

The distinction between concepts as, on the one hand, general tools of enquiry and, on the other as the content or object of some specific enquires (such as this one) is also made by Gellner and is useful. I shall use a capital letter to refer to Concepts when I am using the term to denote that which I am exploring, the subject of my study.

Even as a key term, the word is variously used: for example, one definition of culture defines cultures as comprising 'systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that humans live' (Keesing 1981, quoted in Helman 1984: 2, my emphasis). Another definition of ideology sees this as the 'themes, concepts and representations through which people "live" in an imaginary relation, their relation to their real conditions of existence'. (Althusser 1971, quoted in Hall 1981: 28-29 my emphasis).

Concepts have been studied by many leading sociologists: Claudine Herzlich's work (1973) uses the Durkheimian notion of representations and G.H. Mead is described by Stephen Mennell as contributing 'an account of how concepts, symbols or representations have their origin in social communication and interaction'. (Mennell 1974: 22). These examples from the Durkheimian and social psychological traditions are but two of many (see Mennell 1974).

We can conclude, then, that Concepts as an object of study are of central importance within sociology, but also that they are variously defined and used within the different theoretical traditions. I have already stated my view that the way in which they are defined is critical in an understanding of theoretical perspective and as a reflection of it, and indicated that I intend to draw out both cultural and structural determinants in the accounts of the women interviewed. This study concerns the nature of Concepts; my understanding of this term will therefore be illustrated by the analysis.

B. Culture, Ideology, Social Structure.

I do not propose to offer a review of the many ways in

which these key terms have been used. As the quotations from Althusser and Keesing in the last section show, both culture and ideology can be defined in relation to concepts in ways that appear to be very similar. Stuart Hall notes that culture may be so widely used as to include most facets of behaviour (Hall 1981: 26); Tony Bennett that culture and ideology are used within different traditions operating a 'related but not entirely symmetrical range of meanings' (Bennett et al 1981: 11) and Clyde Kluckhohn that 'since roughly 1935, many British Social Anthropologists have tended to use social structure rather than culture as a core concept' (Kluckhohn 1964: 167 my emphasis). Moreover, Kroeber and Kluckhohn are referred to as having analysed 160 definitions in English of culture by anthropologists, sociologists, psychologists, psychiatrists and others (Kluckhohn 1964: 166).

Since I wish to use these terms in what follows and to convey different meanings by them, it is important to discuss my intended use of them. Firstly, in view of the obvious overlap of these terms in various theoretical traditions, let me justify my differentiation of them. This arises from the way in which they are currently often used in the description and understanding of the behaviour of members of minority ethnic groups.

A number of studies and accounts concentrate on 'cultural' explanations of different patterns of behaviour. That is, they offer explanations of different patterns of beliefs which are seen as distinctive of the group and their place of origin. Examples of this are articles in medical journals concerning 'cultural' beliefs and practices related to childbearing, health etc. (e.g. Beard 1982). Careful writers delimit the groups adhering to such practices: earlier tendencies to speak of 'Asian culture' have

been criticised. The result of such 'cultural explanations' is to see practices as exotic and related to particular distinctive communities. They imply a sense of stasis: a feeling that culture informs behaviour in uniform ways amongst all members of that group, over time. In seeking to emphasise distinctive practices (an important endeavour) such accounts often deliberately (for the task in hand) lack a sense of process and change: those practitioners aware enough and concerned enough to read them come to see those groups of people as 'other' and rather locked into approaches to life which owe much to their origins and little to their current situation.

Such studies have been criticised on a number of counts.

Firstly, they seem to assume that 'culture' is something that ^{foreigners} have and fail to analyse dominant indigenous beliefs and practices within the same framework. Secondly, they pay little attention to structure and process. Thus they do not offer a means by which a political analysis is possible, for 'culture' tends to be treated as exclusive to the community concerned and commonalities between groups where there may be striking similarities of structure and position tend to be ignored.

Both when the focus is on patterns within the family and when it is wider, a structural analysis can offer the practitioner alternative methods of intervention which are relevant but not static. Cultural understandings, on the other hand, tend to leave the practitioner not knowing where or how to intervene in customs that are so 'different' (see Ballard 1982 for an account of S. Asian family structure and Ballard 1979 for suggestions as to how such understandings can help practitioners).

In this study, I want to speak on the one hand of the

distinctiveness of Pathan culture and on the other of the similarities with other (culturally very distinct) communities on the basis of a similar position in relation to the dominant society (for example the Samoan people described by Joan Ablon (1973)) - an issue of structure. Concerning Concepts, one of the contributions of this work is to illustrate the way in which these are both culturally and structurally determined. By this I mean that they can be seen to be related to patterns of belief and practice which are distinctive of the cultural group (in this instance Pathans) but at the same time related to aspects both of internal Pathan social structure and of the position of Pathan immigrants within the wider society.

The following definitions are taken from A Dictionary of the Social Sciences (1964) edited by Gould and Kolb. I include them to show that my usage is not idiosyncratic but can be seen to coincide with certain traditions, at least, in the literature.

i) Culture 'A culture is a set of patterns, of and for behaviour, prevalent among a group of human beings at a specified time period and which, from the point of view of the research at hand and of the scale on which it is being carried out, presents, in relation to other such sets, observable and sharp discontinuities' (Kluckhohn 1964: 165).

I shall refer to Pathan culture in what follows. I see this as characterised by the speaking of Pukhtu. However, I identified two subcultural groups within those interviewed on the basis that the women themselves draw attention to 'observable and sharp discontinuities' between the behaviour of the members of the two groups; differences which I shall describe and which coincided with different areas of origin, despite the speaking of a common language. Groups were defined by those concerned on the

basis of common ancestry.

ii) Ideology is defined by J. Gould as:

a pattern of beliefs and concepts (both factual and normative) which purport to explain complex social phenomena with a view to directing and simplifying socio-political choices facing individuals and groups. (Gould 1964: 316)

Ideology may be thought of as the 'distortion of thought by interests' (quoted by Gould 1964: 316) but I do not use it in this sense. Rather, I find it a necessary and useful term to refer to the Pathan system of beliefs which are seen as underpinning Pathan culture. These are not the same as Pathan religious belief (faith in Islam) although they are seen to derive from it. My usage of ideology is to refer to the system of beliefs that are essential to Pathan culture.

iii) Social Structure may be defined as those aspects of a society which permeate it and define relationships between groups of people. A definition quoted by Eister is as follows:

The structure or organisation of a society consists of statuses such as occupations, offices, classes, age and sex distributions and other circumstance - occasioned reciprocities and rules of conduct (Hiller 1947: 330 quoted in Eister 1964: 668).

It is clear that a certain social structure arises from Pathan culture and is characteristic of it. I am aware of limiting the sense of 'culture' by distinguishing it from the structures which characterise it. In so doing I am deliberately using the term in the limited sense in which it is often used in the field of medical anthropology. Arthur Kleinman points out that

Medical systems are both social and cultural systems. That is, they are not simply systems of meaning and behavioural norms, but those meanings and norms are attached to particular social relationships and institutional settings. To divorce the cultural system from the social system aspects of health care in society is clearly untenable (Kleinman 1978).

His dichotomy between social and cultural systems is close to my usage of social structure and culture, in which culture refers to 'systems of meanings and behavioural norms' and social structure to the relationship of statuses and institutional settings. Arthur Kleinman sets the dichotomy in order to emphasise one dimension (the cultural). Ronald Frankenberg's criticisms of Arthur Kleinman's paper include the argument that

Medical anthropology should show ~~that~~^e nature and importance of the structural oppositions in the practices which generate the different explanatory models of clinicians and patients elaborated by Kleinman. (Report by Thomas, 1978)

My purpose in distinguishing the cultural and structural dimensions on the lines outlined is the opposite of Arthur Kleinman's: I wish to demonstrate and illustrate in this case study the way in which concepts relate to both culture and structure.

I use culture therefore to refer mainly to beliefs and practices characteristic of Pathans. That there is a set of beliefs and practices that is characteristic is a firmly held view amongst Pathans themselves. I use ideology when my focus is the beliefs (rather than the practices). I use social structure to refer to the institutions and status relationships which characterise Pathan society or British society, depending on

context. These locate respondents in time and place and may also be similar to structures deriving from other cultural systems.

C. Ethnicity.

I shall be describing Pathans as a minority ethnic group on the basis that this is commonly accepted terminology. The term 'ethnic' is however, used fairly uncritically and without attention to theoretical understandings - most see this merely as an acceptable alternative to 'immigrant'. Roger Ballard draws attention to ethnicity as:

'a) the articulation of cultural distinctiveness in
b) situations of political conflict or competition' (Ballard 1976, quoting D. Parkin, 1974)

Description of Pathans as an ethnic group is, I would argue, justified and justifiable on theoretical grounds as well as those of popular useage.

D. Mental Illness.

I have already referred to my intention to restrict usage of 'mental illness' and 'depression' to occasions when I wish to speak of these conditions in the way in which they are defined within psychiatry. Although this begs a number of questions because of the numerous different theoretical understandings within that discipline (see Chapter Nineteen), it is useful to retain different terms when referring to respondents' and biomedical concepts in this area, at least while the issue concerns precisely the difference or otherwise of these concepts.

6. Layout.

I will introduce and define other key concepts as necessary

in what follows. Theoretical discussions, although necessary, are somewhat dry and heavy. This work is essentially about illustration not argument, and it is my hope that the discussions of this chapter will be illuminated by what follows. Part I concerns methodology; Part II the social situation of respondents; Part III the respondents as mothers and their experiences of health services that derive from this status, and Part IV their experiences of health and illness and of treatment, and their concepts of well - and ill-being, both physical and mental. Each Part (except the first) uses the framework as a means of presenting and understanding the data. Each (including the first) makes a substantive point as well as contributing to the whole. Thus the work is cumulative; each Part being essential to the overall presentation of these Pathan women's concepts of mental well-and ill-being and to the discussion of these.

PART I. RESEARCH AND SOCIAL PROCESS: ISSUES OF METHODOLOGY.

دُ يُو لاس نه بَرق نه خيزي

It takes two hands to clap (literally, a clap does not come from one hand).

Pathan Proverb. (Ahmed 1973: 41, and respondents.)

This Part focusses on Research and Social Process at two levels. Firstly there is the research as itself a social process changed by the interaction of researcher and those researched. A recent book describes the way in which methodology is changing, and the consequent need to monitor:

Accounts by researchers have revealed that social research is not just a question of neat procedures but a social process whereby interaction between researcher and researched will directly influence the course which a research programme takes... Accordingly the project, and the methodology, is continually defined and redefined by the researcher and in some cases by those researched. In these terms, researchers have constantly to monitor the activities in which they are engaged.

Nowhere is this more essential than in the conduct of field research, which is characterised by flexibility.

(Burgess 1984: 31)

The present study illustrates this well, and Chapters Two to Five offer a detailed account of the social process of this research. So striking were some of the changes in methodology that they lead on in Chapter Six to a discussion of some key issues of General Methodology. Also in that Chapter, I discuss

these issues in relation to the study of concepts and go on to consider the question of relativity and whether it is possible to speak of shared concepts or to provide an understanding of them through research, and the nature of that understanding.

Secondly, there is the sense in which any piece of research is a product of its context - both of the historical and geographical circumstances in which it was conducted, and of its context within the process of the development of academic knowledge and understanding. It is a creature of time and place in theoretical terms as well as circumstantial ones and I therefore preface this Part with a consideration of these contextual issues.

External factors influence a research project just as do the group studied and the problem to be investigated. The time at which it takes place and the place where research is conducted both influence the work and the data. Like health care provision, research projects are historically and geographically specific. For researchers and those interviewed there are personal landmarks which locate 1980-1981 in their minds. There are also regional and national ones. Nationally, this was the year of the Royal Wedding (of Prince Charles and Lady Diana Spencer). This was apparently more noted by the relatives of respondents in Pakistan than by the Pathan community in Bradford. In Pakistan, it was in every news bulletin and followed with interest - in Bradford many women with whom I spoke knew very little of it.

In Bradford, the end of 1980 was the time of the 'Yorkshire Ripper' and his arrest. There had been a series of women murdered in the region and a national murder hunt was launched to seek the killer. The last of the murders committed by the Yorkshire Ripper was in Leeds - some three streets from where I was staying and at

a time when I was there. It gave the weekly fieldtrips an aura of apprehension and danger, as of course, it did to every woman normally resident in the area. Research respondents were women not used to going out alone at night. However, the general fear amongst all women in Bradford was something of which respondents were aware from news reports and the radio.

Most importantly, from the point of view the respondents, this was the time of the arrest and subsequent trial of 'the Bradford 12' - twelve Asian youths found making incendiary devices with which to protect their community. Several respondents were related to those arrested - all identified with their cause, and with their certainty that the police would not protect them and therefore the justification of the young men's attempts to protect themselves and their community. This view was upheld legally and at their trial the youths released. However, the findings of the court and their implications have been largely ignored (Pierce, 1982). The women continue to live in fear, as this study confirms. It was also the year of the Toxteth and Brixton riots and the Scarman enquiry (Scarman 1981) and general fears that similar situations could arise in Bradford. Ironically it was this fear that made it a time of renewed interest in provision for ethnic minorities (even in a period of recession).

The law and order issue impinged most directly on the project through the husband of the Research Assistant. As a policeman himself and also a member of the community involved, he was viewed in various ways, sometimes as a potential bridge, at others as having abandoned his own people. His arrest of a member of the Pathan community on suspicion of a murder that had taken place within the community, was to have some implications for our

reception by respondents.

In addition, the research period was a time of increasing unemployment. As we shall see in the next Part, many of the respondents' husbands were unemployed. There is overwhelming evidence both that unemployment is higher amongst black people in Britain than amongst whites, and that this is partly, at least, due to racial discrimination against black people (Ballard and Holden 1975a and 1975b). In addition, the significance of unemployment is not the same for the immigrant as for the indigenous white person. There is a tendency to blame outsiders for the lack of work - the popular press often amplifies this view. Whereas the white man who is unemployed is a victim of a national situation, the Asian may be seen by others to be a cause of it. Moreover, personally, it is to work that he has come, and he often feels embarrassment and shame receiving social security benefits. Many Pathan men had only recently called their wives and children over to join them, having waited until they built up some security in Britain before reconstituting their families here.

This latter point relates to the geographic specificity of the group studied. Each city has its own history both of employment and of immigrant settlement which is distinctive. The research was done in Bradford because it was known to be a place where large numbers of Pathans had settled. Data from the census taken in 1981 relates to the city at the time of this project, showing that 1 in every 10 Bradfordians were born outside the UK; 6.7% in Pakistan and the New Commonwealth - over half of these in Pakistan (nearly 4% of the total). In terms of housing, we learn that 'insofar as the census measured housing conditions, it shows that Bradford's black population have far worse conditions than

the rest of the population' (City of Bradford Metropolitan Council, 1982). Rates of car ownership are lower than for white people. Unemployment is at a higher rate in Bradford (11.1%) than in any other of the Districts in West Yorkshire, with high concentrations (more than 25% unemployment) in those wards in which there are the highest concentrations of people from Pakistan. These are the areas in which my respondents were living.

To put the study in its true context, however, current data is not sufficient. It is the patterns of migration and settlement which are more revealing and their interpretation from the perspective of members of the various groups. The works of Badr Dahya (1974) and C. Richardson (1976) are useful in providing background concerning this aspect.

A piece of social research can be seen also as a part of the process of the creation of sociological understanding. Ronald Frankenberg draws attention to this, saying that 'sociology is always produced collectively... it is written within a context of a general ideology' (Frankenberg 1979).

One aspect of the context of this piece of work is the growing awareness of the political dimension in studies of minority/ethnic groups. I have already referred in Chapter One to changes that have occurred within transcultural psychiatry in Britain during the period of this research and to my involvement in these changes and the impact this has had on my analytic framework and theoretical understandings. It is indeed within the context of an awareness of both feminist writings and the demands of black people that I have struggled to comprehend what respondents were telling me. It is a fundamental aspect of my own

world-view that involvement with (and in) social processes are critical to the development of worthwhile understandings - the point of view so well expressed by Ronald Frankenberg (1979), although I am well aware that his commitments and mine differ.

The other aspect of the cultural context of this work to which I would draw attention is linguistic. Irwin Deutscher (1968) draws attention to the distinction between 'knowing' and 'knowing about' that is to be found in many languages (including French, German and Spanish) but not in English. Referring to sociologists who have drawn attention to this, he says: 'The inability of English speakers to easily make this distinction may have had serious consequences for methodological thought in the social sciences' (Deutscher 1968: 326). Ronald Frankenberg (1979) refers to this point too, seeing it as fundamental to the individualistic tendencies in social science methodology; tendencies which I will discuss below since they became apparent during this work. This link between this particular linguistic distinction and individualism in social science arises because 'knowing about' rather than 'knowing' is seen to have dominated English and American approaches to social science: indeed, has come to seem to be the only sort of learning about others that is possible. The lack of a separate word for 'knowing' means that the more subjective kind of learning that arises from involvement has not been apparent even as a possibility. 'Knowing about' objectifies those studied - this goes with a tendency to individualism rather than collectivity.

Language is a basic reflection of culture: it has been viewed as the basic unit of it. It is hardly surprising therefore that linguistic considerations were of crucial importance within the research process in this project which was overtly cross-

cultural: nor that they can be seen as significant of and reflecting cultural assumptions underlying methodology in social research, showing how this is itself a culturally specific way of 'finding out'.

I turn now, however, from the social processes which form the context of this work, to issues of social process within it. The account of the research process in the following Chapters has two purposes. Firstly, it offers a description of the methods by which the data has been collected in order that the reader may assess the conclusions of the study. Secondly, it raises issues, discussed in the last Chapter (Six) of the Part, which are in themselves of theoretical importance. These issues arise directly from the changes in methodology and are a consequence of the perception of research as social process (rather than as a set of standard techniques) since this entails a view that changes in methods reflect issues of theory.

Chapter Two. Drawing up the Research Project.

A piece of research falls into a number of stages: the first can be seen as that in which the research problems are identified and a strategy and techniques are selected (see Bulmer 1977 Introduction for use of terms).

1. Identifying the Research Problems.

As mentioned in Chapter One, the present work started from an initial interest in women and mental illness and in dependent women as migrants. Preliminary reading showed that the issue of depression/mental illness amongst Asian immigrant women in Britain was itself problematic. A review of research published by the (then) Commission for Racial Equality comments 'there has in fact been relatively little research done in this area'(C.R.E. 1976), i.e. concerning mental health among ethnic minority groups. Statistics of mental hospital admissions published prior to this study showed Asian women, as a group, to be underrepresented (Cochrane 1977) although some later work conflicts (Carpenter and Brockington 1980). On the other hand, a growing body of literature from within Asian communities suggested that Asian women, particularly the most secluded, were subject to stress and depression which was going unnoticed. (Saifullah Khan 1974; Knight 1978; Wilson 1978). The first problem then concerned the extent to which Asian women are clinically depressed. A second arose from it: why was it that this was not being treated within the NHS psychiatric services? Two sorts of explanations might be put forward. Firstly that the lay conceptualisation of depression is different from the biomedical conception in the case of this

group who are from an overtly different culture. This might include the idea that distress is presented in a way that is not recognised by health practitioners (see Kiev 1972 for support for this view) or that it is understood completely differently. Secondly, concepts might be equivalent and presentation potentially understandable but deliberately disguised, or contact with psychiatric services deliberately avoided, because such contacts are deemed by this group unacceptable and/or inappropriate avenues of treatment either generally or for this sort of disorder.

Aetiological questions were also of interest; particularly migration as a factor and the women's dependency (which might entail lack of involvement in the decision to migrate) and also their role of child-rearer (a role which is at the heart of the socialisation process and which therefore is closely bound up with, and defined by, cultural norms). Here, too, the literature was not directly relevant to the particular group to be studied. In respect of migration, a review by Diana Hull (1979) states that 'as a social phenomenon, migration is not well understood, and its influence on health is ambiguous'. Issues of whether migrants are preselected on the basis of abnormal mental stability or of abnormal instability arise, as do factors such as the size of the group at the point of destination. Thus 'where there is a large group of persons at the destination from the same group or area Lemert (1958) found mental hospital rates low, suggesting that support from compatriots mitigates the stress of the move' (Hull 1979: 34). Peter Hitch's work (1975) is also relevant.

In respect of childrearing and of women as mothers, various indications from studies of English-born women suggest a link with

the development of depression, but these need treating with caution when we are looking at a different cultural group. Thus Hannah Gavron (1966) describes the isolation of mothers with young children, and George Brown and Tirril Harris (1978) suggest that the presence of three or more children under fourteen years and lack of employment outside the home are both 'vulnerability factors' in the development of depressive illness in the women they studied. In respect of Asian women, even those who are not migrants, there is little data, due largely to the unreliability of epidemiological studies in the Asian subcontinent, although J. Ananth (1978) reviews a few of those that are available and comes to the interesting conclusion that 'Indian women manifest depression less frequently in spite of social pressures ... This low prevalence of depression in women may be related to their acceptance of the situation as unalterable. They do not aspire to change unfortunate circumstances.' (Ananth 1978). I will return to this paper because this suggestion did in fact foreshadow one of my own conclusions.

My interest was not however, in either mothering or migration per se, but the effect of the latter on the former. The only data I had concerning this was somewhat more circumstantial and negative and again, did not relate to Asian groups in Britain. Thus I knew that British and American Aid agencies lay considerable importance on the 'adjustment' of the wives of their employees in overseas situations and that they see this as problematic, aiming to facilitate positive adjustments by various strategies. No such strategies could be expected in respect of the Asian wife coming to Britain - rather the opposite. Was her position a similarly vulnerable and problematic one? The workers already referred to suggested that this was so.

2. Towards a Research Strategy.

A number of research problems can be seen as having emerged from this preliminary period of review. Both the aims of the research and the research strategy were dictated by the attempt to investigate these problems in combination with each other, by certain resource limitations and opportunities and by the interests of the funding body (by no means oppressive, but present, nevertheless). Thus

a) a large scale epidemiological study, which might have been most appropriate to the first problem - the extent of clinical depression amongst this group - was ruled out by overall resource issues and by the wish to explore lay concepts and aetiological factors. A more in-depth study was necessary for this.

b) a study of women diagnosed as clinically depressed (i.e. those who were already patients) might have been most appropriate had the problems been merely ones of aetiology. Such a study would not however, answer questions of prevalence of mental disorder in the community, nor would it have enabled an exploration of lay concepts.

c) my own knowledge of one Asian language (Pukhtu) was a positive resource of considerable importance in determining the group to be studied; as this group was a small one, a study of 'patients' within it would probably not be feasible.

d) the focus on young children was partly for reasons of the mother's increased contact with health services at this time, partly due to this being seen as a time of increased potential stress for mothers but also due to a wish to link with an ongoing

series of research projects led by Professor Meg Stacey at Warwick University - these were collectively entitled the Child Health Project. In addition to two 'core' pieces of research concerning the history and present work of the Child Health Services, researchers such as myself with projects that were related to this topic came together regularly to discuss issues of mutual concern. The existence of this group therefore constituted an extra 'resource' opportunity which determined the focus of the work to some degree.

e) it will be apparent that concepts of depression and mental illness were central. The terms are loosely used by many non-medical writers to cover a whole range of emotional conditions without showing whether these do or do not coincide with psychiatric usage. I intended to operate with two models - the psychiatric/biomedical concepts on the one hand, and lay Pathan respondents' ones on the other, exploring the latter and not assuming the two to be coincident. The study therefore had to be one in which the issue of 'what is mental illness?' was kept open - it could not in its very terms of reference and strategy prejudice this. Thus neither a predominantly epidemiological study nor one of a patient group would do.

It was decided therefore that the work would be a case study, involving a limited number of individual women (I envisaged a possible thirty from contacting perhaps fifty in total) who were Pukhtu speakers with young children (all under 5 years at the time of study) living in the community in a city in which there was known to be a sizeable population of Pathans. A Pathan Research Assistant would be recruited to help, especially with interviewing. Although my own spoken Pukhtu was a factor of

importance and meant that an interpreter was not necessary, it was felt important that a Pathan-born person be involved both to facilitate actual interviewing and understanding and to help with interpretation. My own Pukhtu is adequate to ask questions and 'get the gist' of replies; it is not fluent. This might have been sufficient for survey interviewing; for the type of in-depth work envisaged it would not be. The presence of two interviewers was seen as a safeguard in respect of interpretation also; the combination of cultural expectations that would thereby be brought to the work could be expected to enrich it. Together, the Research Assistant and I would get to know these women over a period of time in order to build up relationships of sufficient trust to elicit fairly detailed information in respect of two overall areas. The first concerned the women's health needs and use of services, both in respect of themselves and of their children. Attitudes to general health services and patterns of service usage were expected to be determining factors in the women's perception of health workers generally and of psychiatric treatment should this be/become necessary. Routine situations would be focussed on - having a baby and infant health care were likely to be recent and relevant areas. Secondly, the aim was to explore the women's concepts of health and illness, particularly stress and mental illhealth. As much information as possible would be drawn from discussions of general everyday health situations, in addition to specific discussions of this topic.

3. Research Techniques and Instruments.

The main technique used was to be the individual interview. These were to be semi-structured and their aim was to obtain data

from individual women concerning use of services and views of them on the one hand, and concepts of health and illness and mental well - and ill-being on the other. Interview guidelines were drawn up, focussing on specific areas. These were:

- a) Childbirth in England
- b) Rearing young children in England
- c) The women's own world- being a Pathan woman in Bradford
- d) Health and Illness
- e) Experience of stress

The guidelines were detailed; ^{they took the form of a} series of questions which I expected to use in the interview situation, although not rigidly. To this end they were to be translated into Pukhtu. The areas were chosen because they were ones which involved interaction with health services and potential mobilisation of the women's own support systems. They were also felt to be closely concerned with normal everyday life and thus topics to be fairly naturally discussed with us. Within each, the focus was on specific recent events.

I also set out to obtain three other sorts of data. One was 'factual' and socio-economic, and for this a checklist was drawn up of basic information relating to each respondent's social situation.

A technique of an altogether different kind, reflecting other theoretical perspectives, was incorporated in the use of the two Psychological Rating Scales. The Langner 22 item scale (Langner 1962) and the General Health Questionnaire (GHQ) 12 item scale (as referred to in Cochrane et al 1977 but, see Goldberg et al 1970 in respect of the full General Health Questionnaire) were originally selected. The basis for this selection was that they had been

used in a previous study comparing Asian-born and English-born rates of psychiatric disturbance (Cochrane, Hashmi and Stopes-Roe 1977). Authors of the study had concluded:

Both scales in their modified versions proved easy to use and acceptable to respondents. It was also possible to demonstrate high test-retest reliability for both scales. Using the criterion groups method, both scales appeared to be valid measures of psychological disturbance for Asian immigrants. (Cochrane et al. 1977: 162)

Although the context of the study in which the scales were subsequently used by Raymond Cochrane and his colleagues was different to that which I envisaged, it was important, especially when 'borrowing' instruments from another discipline (which reflected a different theoretical perspective on the social world) to use those which were claimed, within their own tradition, to be valid, at least in respect of the cultural group for which I was planning to use them. The scales were to be translated into Pukhtu with the help of the Research Assistant when recruited. The final type of data was not one for which a particular reserach instrument was devised. This was an assessment of the mental state of informants. In practice, this would appear as part of my field notes. It is important to note it, however, as a separate type of data because one of the aims of the study was to use a tripartite assessment of mental state: the women's own view would be drawn from interview data concerning stress; a biomedical assessment of the group interviewed, if not of the individuals, was the aim of using the test scales, and our own assessment, combining professional and lay, English and Pathan perspectives, was the third.

We also prepared a sheet introducing ourselves and the aims

of the research and seeking permission to interview. This referred to expected long term benefits in health provision arising from a better understanding of the needs of the Pathan community. It was the intention that interviews would be tape-recorded.

4. The Ordering of the Work.

An important factor influencing the work overall, and this thesis in particular, was the fact that funding for the work was provided by the Department of Health and Social Security rather more quickly than had been envisaged. There was therefore considerable pressure to begin fieldwork. My task was to work close to the practical problems and to produce reports which related to these rather than to the academic literature. Thus, the reading and comparative work which might have informed my approach could not be done prior to fieldwork or even prior to completion of reports for the funding body. This work has therefore been done subsequently.

Much of the material presented in this thesis was presented in earlier reports (Curren 1983a and 1983b). My emphases and points of interest were however, very different at the time when these were written, and this thesis takes those reports of the research project beyond a description of the lives and views of those interviewed to a consideration of this data in the light of the various bodies of literature to which it relates.

It is as important to note work which was not done at this stage as it is to describe that work which was done. This study would undoubtedly have been altered in some ways had a fuller

review of literature been possible prior to starting fieldwork. However, what may have been lost in this way was gained in another: the fact that the work was funded by a body interested in issues of practical rather than of academic relevance reduced the time for initial study but it opened up to me facilities in Bradford as a result of official Government interest in the work. This interest fitted well with my own concern with practical issues. The facilities are described in the next chapter.

Chapter Three. Entering the Field.

Having drawn up the research project, chosen a research strategy and procured funding for the work, I left Warwick University for the City of Bradford to start fieldwork. The 'field' that I entered was at this stage not the Pathan community, however, but the more abstract area of interactions between health workers and Asians and the places in which these were reflected on and discussed. My base in Bradford was Lynfield Mount Psychiatric Hospital which had developed as a centre for discussions of transcultural psychiatry and the health needs of ethnic minorities. There I was welcomed and offered a number of practical facilities, such as a room, telephone etc. as well as the opportunity to make contact with practitioners interested in the issues with which *my research was concerned*. The Transcultural Psychiatry Unit, in which I was given honorary status as a linked Research Worker, is described in more detail in a number of publications (see Knight 1978 and Rack 1982 pp. 266-9).

At the time I did not question this 'way in' to the research through a practitioner base. In retrospect, it can be seen to represent a departure from an ethnographic approach which might have been made directly to members of the Pathan community, and is perhaps a reflection of my general purpose and orientation which was not that of the ethnographer, although I was influenced by anthropological approaches. My purpose was to study concepts of health and illness as they affected behaviour. A large part of my focus was on health care interactions. I did not see the perspectives and concepts of practitioners as irrelevant in an understanding of the Pathan women's behaviour. Rather, I saw this

behaviour as arising out of interactions and potential interactions with health workers. My view of concepts included the notion that they might be influenced by such interactions. The views of practitioners were therefore relevant to my enquiry. In addition, it was my intention to communicate the data concerning Pathans to practitioners. An awareness of their concerns was therefore of importance to me for this reason also.

It is difficult, in retrospect, to disentangle motives and assumptions. At the time I did not question my own acceptance of a practitioner base. Nor did I see it as reflecting an identification on my part with world view of practitioners.

My explicit aims in this initial period (1st November 1980-31st January 1981) were twofold - to gain more information concerning the Pathan community in Bradford and to publicise my search for a Research Assistant. A third purpose emerged: I was discussing with people my research proposals, getting their views of the Pathans with whom they were in contact and of what they saw as problem areas. I shall consider these in reverse order. Once the Research Assistant was recruited, there was an additional preliminary task: the translation of research guidelines and instruments.

1. Discussions with Health Care Practitioners and Research Colleagues.

During the three month period, contact was made with some 30 professionals. Through the monthly workshops of the Transcultural Psychiatry Unit, I was able to meet many in the city, black and white, interested in ethnic minority issues from a wide variety of professional backgrounds. These comments all fed into the

research process.

Overall, there was a consensus of opinion amongst those with whom it was discussed that the proposed study would be interesting and valuable. There were numerous suggestions that the more secluded women were subject to depression, although several questioned whether the time with young children (that on which I was to focus) was the most stressful - suggesting that the rise in status of a new mother, the constant well defined activity that a new baby or young children entails and the probable lack of contact with wider society at this time might all result in fewer conflicts for these women than for those with school age and growing children.

There were suggestions that the difficulties thrown up by working with women so culturally different were causing problems for health visitors and that there were tensions between those who were adapting to accommodate and complement different practices and those who saw no need for this. The question of whether Pathan women would benefit from my research was raised. However, the overall and quite strong feeling seemed to be that the writing of an account of the world as seen by Pathan women themselves, could not but be a help to professionals in their ongoing work, particularly in relation to matters of pregnancy and motherhood, health, ill health and stress, and the view of health and other services. Most assumed that what helped them to understand the client would necessarily help the client.

In discussions of the work with some colleagues, there was concern about lack of a British control group. It was suggested that this would render us unaware of factors such as the class position of respondents and that features of the Pathan group

under study could not therefore be classified as due to this or that factor in the respondents' situation. This is a valid point and would be an important criticism had the aim of the present study been to make such classifications and statements. Even within the present concerns, it is a salutary warning and one that must be borne in mind in what follows. For the Pathan women under study are not merely Pathans - they are also living in a certain area, their husbands are in certain jobs (or not) and their children go to certain schools. Their behaviour is determined by a multiplicity of factors of which their cultural beliefs and background are merely a part.

Comparative studies have both strengths and weaknesses. One of the problems is in determining which factors should form the basis for matching of the groups because this assumes that one knows which factors are significant, and that they will be equally important for each of the groups involved. Even if one assumes that certain factors can be taken as significant (e.g. class position) a problem arises in the form of the basis on which such a classification is made. There is growing concern that commonly accepted indices of class position such as housing, employment or spending patterns do not have the same meaning for minority ethnic groups as for the general population (Illsley 1982, Dahya 1974, Rex and Moore 1967). Such concern unites those who see different cultural values as predominant in leading to different choices regarding housing, for example, and those who see racism as a major factor forcing a lack of choice for minority ethnic groups. Either way, inner city black and white neighbours may not be readily seen as equivalent in terms of social status.

Because of its exploratory nature, this study did not incorporate a comparative dimension. Its purpose was to ascertain

just which factors were of major significance for the group concerned. A following study might take one of the factors that emerges from it and explore this further, using a control group method. This was not appropriate, however, in this work. The study does however avoid concentrating solely on cultural determinants of either concepts or behaviour. Factors relating to social position emerge as of importance even though the particular group is studied in isolation and in its own terms.

Comparisons with published data relating to other groups will be made where this is appropriate and where such data is available. The bases for these comparisons will however, vary with topic in hand. Overall my purpose was to learn from the women themselves which were the important variables.

Various suggestions were also made by those I met concerning how I should go about introducing the work to respondents and seeking cooperation. Although none of the issues could be completely resolved before starting interviewing, the overall message was that to be successful in obtaining information such as I wanted, I had to demonstrate by manner and conduct a knowledge of and respect for Pathan norms of behaviour, otherwise my chances of obtaining cooperation would be very limited. My conduct and method of approach was clearly going to be as important as, if not more important than, the objective and scientific rationale for the research.

2. The Recruitment of a Research Assistant.

This period was also much taken up with search for a Research Assistant. The dilemmas involved in this search were set out in a memo written in October 1980 (Appendix B.). There were inherent

and important contradictions in the role - discussed in this memo - such as the question of how closely identified with the community it was desirable for the person to be. Nevertheless, the overall fact that it is not considered proper for a Pathan woman to be employed outside the home came to be the overriding factor as it was clear that there was a real likelihood that no Pukhtu speaking woman prepared to work in this way would be found at all. Fatima Khan was in fact located through the friend of a research contact. Even in retrospect (following considerable time spent with Pathan people in Bradford), I know of no other person who would have been prepared to take the job on. Fortunately, Fatima Khan was in all essentials the perfect choice. Of upper-class Pathan origin, she was the mother of three children under five. Her husband's family were well known and respected early settlers in Bradford. Personally, however, she and her husband preferred to maintain some distance, and were thus not known to most respondents. Her husband was in the police. This had drawbacks but meant that both Fatima Khan and her husband understood the meaning and importance of confidentiality. While she married before completing college education, Fatima Khan was bright and very capable. Her spoken English was good - unfortunately she was not literate in English. This latter factor did reduce her usefulness considerably since it meant that she could not be expected to read material connected with the work. Nor would she be able to help in the latter stage of the work - analysis of the data at Warwick University. She was in fact unable to travel for this purpose.

My definition of the role of the Research Assistant can be seen as reflecting a basic assumption similar to that already seen in my acceptance of a field base outside the Pathan community -

namely that we would be outsiders. An alternative would have been to have worked with a series of 'key informants' in each of the groups of Pathan women. At one time it seemed that my inability to recruit a Research Assistant would force me to work in this way instead. In the event it did not. Fatima herself, once recruited, preferred to remain an outsider. She was careful throughout not to reveal her identity. This was a precarious (and, at times, amusing) business. It is difficult to assess whether early identification would have facilitated or hindered the research process. Her relationship to her husband's mother (known to many respondents) was eventually revealed and elicited great interest but it seemed to result in little more than a lecture on how to show proper respect to her mother-in-law, and several requests for help from her husband in police matters. Her own reputation was safeguarded within the situation by the fact that our interviews took place among women, in their homes. Knowledge of our field work base at a place in the public domain (at Lynfield Mount Hospital) where Fatima was in daily contact with men was kept from respondents both in order to minimise our link with health (especially psychiatric) services and to safeguard Fatima's reputation in respect of her own purdah observance.

My relationship with Fatima has also to be mentioned as a factor influencing the research process. For practical reasons, mainly concerning transport, I moved my own base in Bradford to stay with her and her family after her appointment. There I was made extremely welcome and we have become friends. However, the fact that I was simultaneously studying Pathans and that many of the research subject areas were relevant also to Fatima's

situation meant that I was also in something of a participant observer role in her house. Fatima was herself within the criteria for a focus respondent and completed the schedules as part of the exercise of translation and familiarisation. Ideas of including her responses were, however, abandoned if ever seriously entertained. There were many occasions on which my developing understanding of Fatima (and of her family, many of whom I met) informed my understanding of other respondents, and these went beyond those explanations of behaviour and concepts asked for and given by her. Both of us were, like respondents, mothers of young children. Both of us had lived (she was still living) as migrants. Our understandings of ourselves and of each other informed the work and are impossible to disentangle from it. In addition, however, I was receiving an introduction to Pathan culture in her home which was different to that I had previously undergone in Peshawar and which, because of its timing, concurrent with interviewing, informed the work directly.

3. The Population under Study.

The initial period of work in Bradford was valuable in terms of specific information sought about the Pathan population in the city. I needed to know who the Pathans were, whether they formed a distinctive group of people, what the basis was for distinction and what was known about Pathans in Bradford. Some of the answers to such questions were drawn from published work during this period.

In respect first of the broader issue of Pathan identity I knew that Pathans do regard themselves as being a distinctive group (although work in their homelands of Pakistan and

Afghanistan shows that customs may vary widely between regional groups (Barth 1969)). They regard certain attributes as connected with Pathan identity (Barth 1969) - these are patrilineal descent (from a common ancestor who was known to the Prophet Mohammed); Islam (a Pathan's religion is not a matter for individual conscience - the handful of Christians of Pathan background are no longer considered Pathans by their families - to be a Pathan is to be a Muslim); and Pathan custom (in which is included the language of Pukhtu and the observance of pardah. Like the faith, the language is not an optional extra - on the other hand it is not a sufficient mark of a Pathan alone, one must not only speak Pukhtu but do Pukhtu also).

Turning, however, to consider the Pathans in Bradford, we find that there are two groups identified in early work (Dahya 1974) - those from Attock district (previously Campbellpur, actually just over the Provincial border) - an area known as Chhachh; and the Pathan tribesmen from Mardan, Peshawar, Swat and other parts of the North-West Frontier. Badr Dahya estimated that there were in 1964 some 3,000 of the former and some 300 of the latter in Bradford, out of a total of 10,500 from Pakistan (then West Pakistan) i.e. 29% and 2.9% respectively. There are no current estimates of the number of Pathans in Bradford, since district of origin is not recorded on any official record. Neither is mother tongue, although there is growing interest in this, and some recording of the information by workers for their own benefit, including an attempt while I was in Bradford by liaison teachers to record this information systematically. Furthermore there has been a recent project specifically collecting data relating to mother tongue of children in schools -

this is known as the Schools Language Survey. In March 1981, 79,758 pupils in 292 schools in Bradford were surveyed. Of these, 3% (415 children) spoke Pukhtu. (Schools Language Survey 1983) An estimate based on these figures and the 1981 census has been made for me by Nigel Grizzard of the Policy Coordinators' Department, City of Bradford Metropolitan Council. This puts the Pathan community at 1475. The present project was in contact with Pathans (of all ages) but it is not possible to say what proportion of the total this represents. While the former group (from Chhachh district) are not identified with the Pathans in Fredrik Barth's work, it is to this group that many refer when they speak of Pathans in Bradford, for many of these people speak Pukhtu, claim to be Pathans, observe purdah as closely if not more so than the other Pathans and also form a much larger (and therefore significant) proportion of the Bradford Pakistani population than do the Pathans from North-West Frontier.

It is therefore not possible to give a definitive statement concerning overall numbers beyond observing that Badr Dahya's work suggests that Mr. Grizzard's number is an underestimate. Pathan men with whom I discussed this put the numbers at nearer to an updating based on Mr. Dahya's percentages (which would give 5 or 6,000).

We can, in any case, say that Pathans do form a distinctive group: a group of which they are aware and of which the distinctive feature is a common mother-tongue. However, there are, within this, two subgroups - those (a majority) from the Chhachh area of Attock District in the Punjab province of Pakistan, and those (a minority) from a variety of villages and districts in the North-West Frontier Province. The Pathans living in Chhachh (many from the village of Waisa) claim to be descended

from a group of Pathan tribesmen forced to migrate from Afghanistan during the last century who settled in an area which is now over the Provincial border from their Pathan kinsmen. They thus claim to be true Pathans although of different tribal origin but are somewhat looked down on by those from the Frontier areas. Not all speak Pukhtu as their mother-tongue.

Discussions with workers and Pathans in Bradford increased my information about Pathans in the city. They were seen by most to be a distinctive group, characterised by manner, observance of pardah by the women, something of an air of separatism and aloofness. Early Pathan respondents saw the only distinctions within the Pathan community as that of observance or non-observance of pardah, not any regional differences, and it seemed as though the question of particular area of origin was often relatively unimportant in the question of identity, Pathans uniting with Chhachhi Pathans in the face of the various other majorities.

4. Translation.

Still from the field base at Lynfield Mount Hospital and before starting interviewing, there was one critical task to be undertaken: translation of the interview guidelines and test scales into Pukhtu. This work was done by Fatima Khan and myself and our Pukhtu was then retranslated back into English by an independent Pukhtu speaker, Dilshad Khan - a social worker of Pathan background working in Bradford. Difficult items were then discussed with Dr. John Bavington, himself a Pukhtu speaker. This technique of 'back translation' is a widely accepted one. Thus,

Irwin Deutscher quotes Mitchell:

There is general agreement on how the actual translation of the question should be made. First, the original instrument is translated into the local language, and then another translator independently translates this translated version back into the original. The original and retranslated versions are compared and the discrepancies are clarified.

(Mitchell 1965: 678, quoted in Deutscher 1968: 320)

This work served several purposes in addition to its primary aim of providing us with a Pukhtu version of the various schedules. Firstly, it familiarised Fatima Khan with the questions and topics to be covered and enabled the two of us to build up a relationship with each other before interviewing. Secondly, it raised issues concerned with the method of interviewing, since both Fatima and Dilshad Khan queried whether such a direct and detailed questioning approach as envisaged would be acceptable to respondents. Thirdly, it raised issues concerning the material itself, concerning the norms surrounding discussion of various topics; the way in which people think generally. Lastly, certain specific concepts were particularly difficult to translate.

To illustrate these latter two points, we were repeatedly forced to be less abstract since Pukhtu is a very concrete and contextual language. An example of this is 'Have you been taking things hard?' (GHQ Question 18). We had to render this much more specific, as can be seen from Appendix C. Concepts that were difficult to translate are of particular interest and included 'nerves', 'nervousness' and 'pregnancy'. Generally such concepts pointed us to important normative issues. For example, in the matter of pregnancy, the various social positions of the

translators were highlighted. Dilshad Khan (Pathan male) could not translate this; Fatima Khan (Pathan female) found it embarrassing and difficult but recognised two terms suggested by John Bavington and myself although she had doubts about using them. John Bavington (white male doctor) used the term he was familiar with and had used repeatedly in medical work in Pakistan - an Urdu word. He saw no embarrassment about this. I (white female non-medic) used a Pukhtu euphemistic expression (meaning literally 'hopeful, expectant') which I had been taught and had used personally in Pakistan. Clearly the translation of this term raised issues concerning norms relating to the discussion of pregnancy. These will be looked at in Part III.

Translation of the psychological test scales illustrates well the general issues raised by this exercise. Scales such as we used (the Langner 22 item and General Health Questionnaire 30 item scales) are collections of items which in combination, are seen by many to be indicative of the presence of mental disturbance in a certain proportion of the individuals in a group. These items have been devised and validated in a specific cultural setting. Translation into another presents problems. Firstly, there are the problems of translating the words. Parallel terms do not always exist. Phrases may have to be turned round. Secondly, once an acceptable equivalent term has been found, there is still the problem of knowing whether or not it conveys the same sense and meaning. That this is so even when the same language is involved is evidenced by David Goldberg's comments concerning the use of the General Health Questionnaire in the United States, and Raymond Cochrane's (1977) concerning its use in a different class context.

The version of the GHQ-30 that is used in the United States is not exactly the same as that used in the United Kingdom. Items 30 and 33 from the original 60-item questionnaire were withdrawn on the advice of American colleagues and were being replaced by items 15 and 16, since the former items were not easily understood by some respondents. Three further items had minor alterations to the wording to make them more comprehensible in the vernacular.

(Goldberg 1978 p.19 my italics)

And:

it became clear in the pilot study that the GHQ item... was unintelligible to many less well - educated individuals, so was replaced by an another from Goldberg's list of 20 'best items'.

(Cochrane et al 1977: 158)

If this was found to be the case when only one language was involved, how much more is it the case when one is trying to find the nearest equivalent words in another language? We certainly found that the translation process is a complex one, involving all levels of meaning, in which the translator has to recognise that the translation itself is not merely a tool but a critical part of the process of communication. The translator often has to choose to change the original meaning in order to make sense or to leave it knowing that it makes no sense in a different cultural system. This forces him/her to go behind the words to try to convey an equivalent idea even if its terms are different. Inevitably his/her own perceptions of meaning are involved.

In respect of the scales, this issue was further illuminated by the use of the items and discussion of them with respondents. The implications of this for the notion that they may be used

cross culturally will be discussed in Chapter Twenty-Two following the presentation of these results. However, the scales are a specific form of research technique - an example of the standardised questionnaire method of obtaining data. The issue of 'Asking Questions Cross-Culturally' (Deutscher 1968) is a fundamental methodological one which will be further discussed in that chapter. Certainly, the translation of the interview guidelines and tests was not merely a mechanical and somehow objective exercise. The process generated data and illustrates well the way in which research techniques, research strategy and general methodology are interrelated. Appendix C contains the testscales (original English), the Pukhtu versions, and a literal English retranslation of them showing the ways in which meanings were altered by translations. Although translation of the guidelines were made they were not eventually used in this form as will become clear. They are therefore not attached.

A note is necessary here to explain why although reference was originally made to the GHQ 12 item scale, in discussion of translation I have referred to the 30 item scale and used numbers which refer to items in that version. This I shall do throughout and it is the 30 item scale that is included in Appendix C with translations. At the time of translation, this decision to change had not been made, although we had become unsure which version to use for reasons to be discussed in the next chapter. In fact, we translated the full (60 item) scale to ensure that whatever our final decision, it would be covered by our work. Revision of the instruments followed early experiences in the field and will therefore be discussed in historical sequence.

Chapter Four. Issues and Revisions.

1. Some Unresolved Issues.

Interview guidelines ready and translated, we were now ready to start interviewing. There were still, as I have shown, unanswered questions relating to approach. For example, there were still doubts about whether or not interviews could be taped, about whether there would be sufficient women all of whose children were under 5 years, and about the Pathan community itself and the Pathan/Chhachhi distinction. Although opinions were expressed - often differing widely - these issues could not be resolved outside the situation, neither could the whole question of how it would all work in practice. During the translation process there were suggestions that the detailed sets of questions would be unacceptable. Overall, everyone had warned that respect must be shown for the women and their ways and that the imposition of an unacceptable approach would just lead to non-cooperation.

2. Sampling.

Given the lack of any information regarding the number and location of Pathan households in Bradford, a sample had to be drawn without the use of any sampling frame. Introductions to Pathan households were to be made by a series of personal contacts, and it was hoped that sufficient respondents would thus be contacted by a snowball effect. Some safeguards were however built in to ensure that I did not merely get in touch with one subgroup within the Pathan community. Thus I had listed Pathan

families referred to by workers in the city and in this way built up a map of the areas where Pathan families were concentrated. Introductions were then to be sought in the various areas identified, four workers from different departments acting as contact people introducing me to families known to them.

3. The Concept of 'Piloting'.

Many of the difficulties of this work, which have led to its most fruitful discoveries, arise from the way in which it 'stood astride' a number of methodologies, fighting a continual battle with notions of social survey research on the one hand yet never becoming fully ethnographic on the other. Many notions drawn from more 'objective' research traditions were tried and did not fit. One such notion was that of a pilot study.

Since there was no sampling frame there could be no independent pilot study. Moreover, no group could be defined as distinct; thus mistakes made in piloting, or approaches that didn't work, would be relayed to the group I wanted to study and prejudice their attitude to the work. I had, therefore, to see the initial interviews as a pilot phase, for inclusion in the main study but after which there would be a review of research methods. In many ways the first interviews would be the most important, not least, in determining future cooperation. Rather than reporting a clearcut test situation, therefore, in which one method was tried and proved unacceptable and another adopted, we have, in this account, to follow the trail left by the approach as it adapted to what it found.

4. Initial Contacts.

The issues will perhaps seem more real if some of the initial contacts are described. On one visit (which took place before Fatima Khan's employment), the women were welcoming but only one fitted my research criteria (having children all under 5 years). Yet the discussion was all relevant to my themes, covering such topics as breast feeding, arranging for the marriage of a daughter, and a neighbour kept in purdah that was to them excessively strict. None of these women felt her husband's permission to be necessary before she talked to me, but each declared herself unable to understand fully my explanation of purpose. My research criteria (mothers whose children were all under 5 and Pathans from the North-West Frontier proper) were not meaningful to them, although the fact that I wanted to focus on mothers with at least one child currently under 5 years was, as was my concern to deal only with Pukhtu speakers. I was given permission to return ('we always like visitors') but I was unsure whether I had gained permission to conduct the research.

The next visit was to a woman who had expected us but was out. Why? Fatima Khan and I therefore went to be introduced to her father-in-law who gave blanket permission for us to visit all his relatives who lived in that street. He took us personally and introduced us, despite the rain. The procession that went from house to house came to resemble a soggy piper as women and children in brightly coloured satins and thin cottons came with us. Although calling themselves Pathans, only two women of his family spoke Pukhtu. However, neighbours to whom he took us did and this later proved a good contact. In this household the woman

clearly said she did not understand our purpose and did not see it as her place to do so; would we explain to her husband? This we did and he gave permission for his wife to be included in the study, while she gave us permission to come and see her again. She did however have children over 5 years as well as under.

5. Issues That Emerged and Their Effects.

Two overall issues were emerging concerning general methodology: first the fact that the research was a process in which relationships with those interviewed were a determining factor in respect of methods, and second that the original approach that had been proposed was based on individualistic presuppositions which were not relevant in this context. Lest this sounds a sweeping statement, let me show how I became aware of it through the interviews.

A. The Consequences of Relationships.

From the examples given it is clear that a relationship began to be established the moment we entered a house. Once we had expressed an interest in their lives and once they gave us their willingness to talk to us, we could not, on impersonal research grounds, just say we would not come again. Even in respect of our research purpose alone, news of such bad behaviour would soon spread and our reputation be spoiled. This was apart from human considerations. Thus research criteria needed to be trimmed to the basics which would make sense to our respondents as reasons for non-continuation of the relationship. These criteria came to be the presence of at least one child under 5 and that the women spoke Pukhtu (rather than that she was a 'proper' Pathan from the Frontier, not Chhachh district). Even then we were introduced to

non-Pukhtu speaking friends and expected to spend time with them. 'If I let you become interested in me, you must show interest in my world and friends' seemed to be message. If this was indeed the case, these 'extra' contacts and visits would not be wasted but would be a way of learning about respondents in their total situation. They seemed to be insisting that we could not isolate them from it.

This led to the drawing up of group discussion guidelines and inclusion of additional respondents - a major modification of both strategy and techniques which I will discuss below.

B. The Issue of Permission.

Another issue was that of permission. Whose permission was necessary? Our approach was that we sought introduction to the wife by a female worker known to her (although in some cases these workers first sought permission from the husband). We then explained ourselves to the woman and left a card for her to show to her husband, suggesting that we could explain it to him if he would like this. We fixed a date for return when she would tell us whether she was willing to cooperate and what her husband's reaction was, or when we could discuss it with him direct. The 'community leader' was another dimension. In the second visit described, the elderly gentlemen had given us blanket permission to visit without reference to the wishes of the women themselves or their husbands. (It became apparent over time that this was not sufficient.)

We found on several occasions that the women did not feel themselves able to give permission for the research, only for us to visit them (as if these were separate). We came to understand that for the women they were separate. We referred to the

benefits for the future developments in the health service of information such as this, on the basis of which their needs could be taken into account in planning. But all this research rationale belongs to ^{the} public domain. These women's lives were restricted to the domestic domain. Thus the only permission that was in their power to give was permission for us to enter their homes and talk with them. The division of labour between husband and wife in which he controls all dealings with the world outside the home was often made explicit and I was referred to the husband. This was exemplified on the occasion on which I was called into another room to discuss the research purpose with him while the ladies sat with Fatima exchanging pleasantries and chatting in a wary fashion until his wife and I returned to announce that the work has his blessing and I could meet with them for this purpose. All the women then relaxed and I did not have to meet all the husbands as this man was clearly something of a leader. In fact, his wife had no child under 5 years, but we had to maintain a relationship with her as it would have been discourteous not to have done so.

Yet some women did not wish their husbands to be asked and stressed their independence to meet with other women without permission. In such cases, I was never sure whether permission to visit was the same as permission to use material for research purposes, although I had made it very plain that this was the intention.

The situation was complicated by cultural norms which make it very hard for any Pathan to say 'No'. Permission could not, therefore, be overtly denied. One woman whom I pressed for a response on the issue of permission to return just persistently changed the subject and behaved towards us in a way which Fatima

Khan found offensive; she seemed to be saying 'No' in all ways she could. We, therefore, accepted this as refusal. However, we visited later when she had given birth to a child, just a courtesy since we were in the area. It also meant we could test out how we would be received. We were welcomed and encouraged to return, whereupon the research schedule was completed with her cooperation. This woman was one of those in respect of whom 'blanket permission' had been given by the elderly gentleman in the example cited. He was the older brother of her father-in-law. In face of his permission, she could not deny us hers overtly. In fact she quite clearly did deny us permission to visit her until she decided we were acceptable on her terms.

It seems to be the case that the relationship between respondents and interviewer is as important, if not more so, than the purpose of the visit. This attitude seemed true of the Pathan women's relationships with other officials too (such as Health Visitors). If the relationship (and thus the personal characteristics of the interviewer) has to be assessed as well as the purpose, then to press for immediate permission is not appropriate. While a purpose can be assessed quickly (as by those husbands who did this, including one who refused access on the basis of it) a person and a relationship cannot. The proper response is the standard one: 'You are always welcome'. This is the traditional response to any outsider who becomes a guest the moment she passes your threshold and honours you by her presence. We then, were 'always welcome'. Our acceptability and how much would be discussed in front of us would become clearer later.

This explanation, however, is one that was not in our minds as we were piloting. Then there was only some confusion and

numerous questions at the way in which access was sometimes apparently neither denied nor granted, and at the way in which other women were continually involved in the research process and our criteria seemingly not understood.

C. The Tape Recording of Material.

The tape recorder was taken to a couple of houses, but one refusal by a husband and another woman's horror at the thought led to our decision not to persist with it. It is impossible to say what the overall reaction would have been had we persisted. Attitudes to interviews did indeed vary, and it may be that the tape recorder would have been acceptable to a certain number of respondents. But it seemed as if it might convey an undesirable impression of our intentions. For the observance of purdah means for many, that not only the bodies of Pathan women should be concealed but their voices and views as well. We were wary therefore of any suggestion that by using the tape recorder we were infringing the purdah observance of women involved. Indeed, towards the end of the project, a rumour did start to the effect that a woman was going round seeking Pathan women's views and that this would violate the purdah of those women who cooperated. Most women did not see it this way and dismissed such views but they are mentioned as an indication of sensitivity about the issue and to justify the care which we, as researchers, felt it necessary to take both to protect respondents and if the research was to continue.

6. Revision of Research Strategy and Instruments.

A. The Issues of Group Discussions: Focus and Additional Respondents.

In the first two months of fieldwork, the idea of group discussions arose. This followed the first of the visits described where the outstanding impression was of women who met frequently in each others' homes and who shared views and exchanged opinions on most matters of daily concern and who were in fact more at ease meeting outsiders in the company of their friends.

In discussion with colleagues both in Bradford and at Warwick University, it was felt that group sessions were forced on us by the women's joint living situations which could not inoffensively be changed for the research purpose and also, more positively, that a different and less artificial type of data would emerge from such discussions. The intention was to make use of the natural and apparently daily meetings of friends and the normal discussion of issues of common interest that occur spontaneously. The researcher's task would be to introduce topics for discussion and to lead it into the areas of interest to the project. This would probably not prove difficult as birth, childrearing and health are all matters of everyday interest.

Individual interviews would still be conducted to obtain information of a more specific and/or confidential nature. Guidelines were drawn up for the group discussions, following roughly the same topics as the individual guidelines. The decision to make a virtue of necessity and include group discussions as part of the interview process was an attempt to correct the individualistic bias which seemed to underlie the

initial approach and to let the data obtained reflect the women's real living situations. However, the individual focus was retained insofar as it was with individuals that the schedule was to be completed. Thus two categories of informants emerged - focus and additional respondents, the latter being those women present at group discussions who were not themselves focus respondents.

B. Revised Research Instruments and Recording Systems.

In May 1981 the interview guidelines, group and individual, were revised in the light of further experience in the field. Overall they were shortened and the subject matter was somewhat altered. In the first section on childbirth there was less concentration on detailed accounts of labour and of antenatal visits and more emphasis on encouraging the woman to describe the event as she saw it. In the third category, that concerned with the woman's own world, sections on pardah, on use of English and on religious observance were included. This followed discussion with colleagues and experience in the field of the topics that were of the most interest and concern to the women.

Group and individual interview schedules were more or less similar (the latter being more specific) in order that one or other could be used depending on the number of people present when the researchers arrived. The psychological tests became the first part of the last section which was entitled 'Experience of Stress' on the individual guidelines and the intention was that an attempt would be made to cover this material when the respondent was alone. Record sheets were devised as a way of keeping track of the interview process, so that researchers could cover topics as they arose naturally but at the same time keep a check list of

topics so that areas not covered in an informal manner could be deliberately introduced towards the end of interviewing. It was decided that the 30 item General Health Questionnaire should be used. This was to include the maximum number of items in order to explore their applicability to a group so culturally different but also to keep the number of items small enough to be managed in the interview situation. I knew of other studies using this version of the GHQ, particularly Joan Hughes working with deprived mothers in Coventry. I subsequently learned of Elizabeth Watson's work in Tower Hamlets, for which she and her colleagues have translated the 30 item GHQ into Bengali. Use of the same instrument would enable us to compare results. Attached (Appendix D) are the revised interview guidelines, and the recording sheets. The factual checklist originally devised was incorporated as part of this recording system.

Chapter Five. The Interviews.

1. The Women Included.

During the year's interviewing we were in touch with 50 women. Of these 21 had been eligible for inclusion and directly approached - four were subsequently not included. One of these was Fatima herself: she had been contacted on such a different basis that it seemed misleading to include her responses although these represented a point of view of great interest (being from a different class background amongst other things). However, they could not be 'slipped in' and considered in the same way as other interview data. Another was a woman whom we were asked to visit by a Health Visitor. We did not attempt to revisit because we felt that completion of the schedule was potentially damaging to her due to her personal problems. The deliberate exclusion of socially vulnerable individuals clearly had implications for the subject of this research and was not a policy adopted in any but this one instance. The introduction had in any case, been made in a biased manner on the basis of her difficulties. We were seeking for a community sample selected on a basis as random as possible but certainly not presented on the basis of personal stability or otherwise. Thus there seemed good methodological criteria for her exclusion as a focus respondent as well as the humanitarian ones mentioned. The two other women refused to be included. In the case of one, she was willing but her husband was not. We formed a good relationship with her, she was grateful as was her husband that we had sought his permission in addition to hers, and we parted with regret on both sides. No reason was given for their refusal although we asked for one. In the other

case, we were viewed with more suspicion, and it seemed that the mother-in-law (in this one case present in the home) was the one who said that the woman should not be included. Permission was never overtly refused: on subsequent visits the door was not answered despite evidence that someone was home, and on one occasion a young girl was sent to tell us not to come again. Fatima found this process very embarrassing: the refusal had to her been apparent on our first visit; not to 'take the hint' was rude on our part.

This then left seventeen respondents who fulfilled the research criteria, being Pukhtu speakers with at least one child under 5 years. Contact was maintained with these respondents until the interview schedule was completed. The focus respondents included two pairs of sisters, who could not but be visited jointly as they lived in the same house. With most of the women, other members of the network were present at times during interviewing. These are the twenty nine additional respondents. Some of these women we came to know very well, others we met only once or twice. Some were clearly leaders or key figures within a network in which we were interviewing other members. We visited some independently if the occasion arose e.g. if there was a birth or death. In some cases the individual focus was retained clearly, either with no additional respondents present, or with some occasionally met when our visits coincided. In other cases we were definitely met by the group rather than any individual. These women were those who lived in areas where they could reach each others' houses without penetrating public space. It reflected the circumstances that they were often in each others' company - thus it was for them the most natural way to receive

outsiders. It possibly also reflected a check on our activities: a protective/screening factor at least in the early stages of interviewing. On some occasions, other women would be deliberately 'called' to come when we visited.

2. Length of Contacts.

One hundred and five visits were made over the one year interview period. Of these, contact was made on ninety-one. Table (i) shows the time spans covered with each focus respondent. The average number of contact visits per household was five and the average time span of interviewing four months. However, the picture is better conveyed by the detail than in the averages, since the averages conceal wide variation which was itself significant.

As stated, the criteria for the duration of contact was the completion of the interview schedule with each focus respondent (or premature closure by the respondent). There seemed to be three factors of relevance determining this.

(a) The acceptance or otherwise by respondents of the researchers and the work. Where respondents were wary, they either terminated the process prematurely or allowed the interviewing to continue but responded briefly and without elaboration. Where the work and workers were well accepted, topics were discussed and some detail gone into.

(b) The degree to which the occasion was regarded by respondents as a social rather than work one. This would sometimes follow from (a) but not always. Thus, there were some respondents who accepted the work and the research~~er~~ team well and were forthcoming but nevertheless kept the purpose of the contact in

Table (i) Number of Visits and Duration of Contacts.

Respondents Number		Number of Visits Figures in brackets are those visits on which contact was not made at all	Duration of Contact (in months)
1.	*	12 (+ 4)	12
2.	}	12	7
3.			
4.		5 (+ 7)	6
5.		7 (+ 2)	6
6.	}	8	5
7.			
8.	*	9	8
9.		6	6
10.		3 (+ 1)	1
11.		6	2
12.	*	5	4
13.		4	3
14.		3	1
15.		3	2
16.		4	2
17.		4	1
		Total 91 (+ 14)	Average 4.4 months.

Notes: * including contacts with other group numbers when the focus respondent was not present

+ one household

mind, allowing and expecting us, as interviewers, to be directive. These interviews corresponded most closely to the pattern originally envisaged. Respondents in this category were those with some formal education. These interviews were full but purposive, with contact spanning usually 4 interviews over a shortish period of a month or six weeks. Other respondents either seemed to view the contact as social, leaving the interviewers less free to direct proceedings, or fell into the group mentioned above in (a) who tried to keep the contact brief and relatively superficial due to lack of confidence in the whole affair.

(c) The number of people present affected the length of contact - it being longer when more people were involved. Where the interviewers were well accepted and interviews regarded as social rather than purposive, there were more likely to be others present although the presence or absence of others was also independently determined by the nature of the woman's network and the degree to which she was or was not in a joint living situation.

All interviews were conducted in Pukhtu, except in those instances where additional respondents spoke Hindi or Urdu. In these cases Fatima Khan took the major role. In the majority, however, particularly the more directive ones, I took the leading part, with Fatima Khan joining in to explain some point or facilitate discussion. On some occasions, where a group of people were involved and particularly in the more 'social' interviews, we would both become involved separately in conversations. Notes were sometimes taken - this depended on the style of the session, it being easier to take notes when the purpose was overt than when respondents preferred a less formal style. In all cases Fatima Khan

and I returned immediately after the session to record in detail what had occurred. This was done by recounting the conversation and other points of interest onto tape. This was usually done in English, not Pukhtu, as this was the language used (predominantly) between us and its use proved most efficient. However, concepts of note were recorded in Pukhtu. The presence of two workers ensured a detailed and fairly accurate record.

3. Ongoing Issues of Relationships and Permission.

The impact of the nature of our relationships was therefore reflected in the duration of contact in each case. Within the context of each there were, however, fluctuations in how much at ease we were with each other. The issue of permissions is not a 'once-for-all' one - at certain times respondents would, in covert ways, 'refuse' to see us. At one stage we angered one pair of sisters whom we knew very well. Our request to complete the psychiatric test scales with them clearly offended them; it reemphasised our formal reason for visiting. This breach was healed when we visited again following a birth, with a gift for the baby. No reference was made to their previous anger.

The women's difficulty in refusing overtly was reflected in the variety of ways in which they would put us off: issues concerning the negotiation of boundaries were ever present. In two cases we colluded by visiting when the husband was absent although when one of these husbands was present he welcomed us warmly. His wife's response to us in his presence was completely different to her response when alone, however, and she made fun of the questioning as if to distance herself from her former frank cooperation and emotional involvement with us. Many of these

factors concerning the process and the relationship itself taught me as much about the women and their views as did their verbal responses in the interview situation. These factors are difficult to analyse separately although the discussion of relationship and of the translation of meanings (see below) clearly draws on this sort of data. It has also informed my analysis in other chapters.

4. Termination.

The termination of contact with each respondent was decided on the basis of completion of the schedules. However since the target sample of thirty focus respondents was not reached (although a total of 46 respondents were included) new introductions continued to be sought until such time as the interview period had to be brought to a close. There were two reasons for the decision to stop of which the most important was the overall research schedule. Sufficient time had to be left for the stages of analysis and of writing, particularly in view of the fact that Fatima Khan would be unable to help with this. The original interviewing period was extended from September to November because of the extra time taken making records after each interview rather than during the interviewing by tape recording. Interviewing was allowed to continue for as long as possible to enable the maximum possible number of respondents to be included.

The second factor concerned our reception in the community. Following the arrest by Mr. Khan of a Pathan man for the murder of another, there was considerable hostility towards Mr. Khan on the part of certain sections of the community. Fatima Khan was known as her husband's wife and there was concern lest this situation

would affect our reception by respondents. This factor alone would not have been sufficient to bring interviewing to a close, but coinciding as it did with a time when, for other reasons, this was felt necessary, it confirmed the advisability of not seeking for more respondents.

Many respondents asked us to return - courtesy visits were made during the latter period to some where interviewing had finished in the earlier phase of the year and visits were subsequently made to others on occasions when I came to Bradford for other reasons (such as feedback of results). The research process had indeed become a series of relationships which do not end merely because sufficient data has been collected.

Chapter Six. The Methodological Issues Reviewed.

One of the exciting and creative features of this study has been the way in which changes in the methods themselves have led to a revision of theoretical understandings. It could be argued that a thoroughly ethnographic approach would have been better suited to the work from the start. There are however drawbacks in the participant observer approach as Ursula Sharma discusses (1979) one of which is the problem of comparability. Another is that of communicating with those used to a more quantitative approach (medical doctors tend to fall into this category). Although I was not initially aware of the extent to which the situation under investigation would change the methods used, I did wish to use some methods accredited within traditional psychiatry.

The research process has taught me about both 'sides' in the research relationship: about those I set out to investigate and about the assumptions which underlie many research methods. The foregoing account of the research process has been included in some detail in order to draw attention to the issues raised. Here I discuss three aspects of the encounter between researcher(s) and those researched which can be seen as having lain behind these:

- 1) variations in the overall definition of the encounter;
- 2) the means of communication - variations in assumptions and concepts evidenced in the use of language.
- 3) the meaning of the encounter for those involved.

Finally I shall look at the issue of individualism in research - an issue which arises from a consideration of the research process overall.

1. The overall Definition of the Encounter.

Sociology has become the science of the interview, ... the interview, as itself a form of social rhetoric, is not merely a tool of sociology but a part of its very subject - matter.

* * *

All this amounts to a definition of the interview as a relationship between two people where both parties behave as though they are of equal status for its duration whether or not this is actually so; and where also both behave as though their encounter had meaning only in relation to a good many other such encounters.

* * *

A relation governed by the conventions just discussed can occur, it is clear, only in a particular cultural climate; and such a climate is a fairly new thing in the history of the human race. Anthropologists have long realised - if not always clearly - that the transitory interview held with respondents who do not share their view of the encounter is an unreliable source of information in itself. (Benney & Hughes 1956, reprinted in Bulmer 1977: 233,234,241).

The respondents I interviewed did not share my initial view of the encounter. Our meeting had, therefore, to be redefined in terms which they dictated. To some extent, we had to discover these terms, and the boundaries, as the work went on. As interviewers, knowledge of the culture gave us some sensitivity to the sorts of rules involved - in Fatima's case they were rules she shared - however these rules were not quite the same as ordinary social ones; we were sometimes offered more latitude, sometimes

less. Her reactions showed when this was so: she would sometimes be surprised at how much had been said, at others embarrassed when I sought to go beyond what she saw as the limits. This was at times necessary in order to be sure that the boundary existed. At other times we were 'used' and Fatima was personally embarrassed when respondents asked us things beyond the boundaries of social courtesy e.g. to shop for them, or when one continued to clean the floor as we talked. I was often not aware of, and consequently not offended by, this. (Even had I been, it seemed for me not unreasonable that respondents should 'use' us, we were 'using' them.)

The women found it difficult to comprehend my purpose because it related to the public domain. Within the domestic domain, which I wished to enter, relationships are usually reciprocal and multistranded. My single purpose (one which was not directly to serve them or at their instigation) and non-reciprocity seemed to have no clear analogies: the closest was that of a guest.

My non-reciprocity was clearly a problem. There are strong cultural norms concerning the reciprocity of visiting. The case of one woman who was isolated due to strict purdah illustrated this well, for although her husband did not forbid her to receive female visitors, she was not allowed to return the visits. This was the reason given by her next door neighbour for the fact that she did not visit although she knew the woman was lonely and pitied her. To some extent the fact that I lived outside the area explained my inability to entertain women in return. Fatima, however, did not. With Fatima, her own family's stay with mine one weekend was a milestone in our mutual relationship. In terms of views, I was also not giving as much as I got, although I did

give enough information concerning myself and my family to enable the relationships to continue. Had I brought my baby with me, I am sure this would have facilitated interviewing; I decided against this for personal reasons, however. It was clear to me that some giving of gifts when a baby was born would be essential. The nature of the gift was important but Fatima and I had differing views concerning what was appropriate. In turn, we were offered, and had to accept, meals and other refreshment. This was no hardship but increased our sense of being guests and entertained. Emily Jones has described this as 'The Courtesy Bias' (Jones 1963) and sees it as a potential distortion of data where respondents feel unable to offend the interviewer and expect that she will not offend them. I found in a number of my interviews that reminding the respondents of my purpose was offensive. (My motive was usually to reassure them concerning why I wanted to know something.) It was as if I was reminding them of the instrumental and unequal nature of a relationship which they were defining in social terms.

2. Language and Concepts.

The issue of equivalence of terminology is closely bound up with that of the interview as a means of data collection. I came to see the difficulties we had in translating not just words, but meanings also, as valuable sources of data in themselves. The words, like the relationship, were not just a tool that I wanted to get as right as possible but part of the data that I sought to understand. Difficulties pointed to discoveries. Consider for example an unequivocal word such as 'mother'. I was a mother interviewing mothers. Our biological right to the role was

equivalent. The word had the same meaning in this sense in Pukhtu and English. The social meaning of motherhood was for each of us different, however, as exemplified by my having left a 2-month old baby to be interviewing them. Words are cultural and social constructs; their meanings are not easily equivalent across cultures.

Some of my discoveries that certain items in the questionnaires were untranslatable are echoed by other writers, for example:

This last item later proved to be untranslatable. After much discussion, the translators decided that although it was conceivable that an American might enjoy a quarrel for its cathartic effects, the notion would be incomprehensible to a Thai. (Phillips 1959-60: 190 quoted by Deutscher 1968: 321).

In much the same way, I found notions of 'being able to keep busy' (General Health Questionnaire 30 item scale, Question 4) were not translatable into Pukhtu embodying as they do a sense that being unoccupied is wrong. Irwin Deutscher goes on from discussing problems of lexical equivalence to discuss the related problem of variability in the kinds of distinctions a language may facilitate or retard and shows how these influence responses. After looking at some solutions to these problems in cross-cultural research, he comes to a conclusion with which I would entirely agree:

Another step, then, toward the solution of problems of comparability in cross-lingual research is to interpret the discrepancies uncovered by the back-translation technique in creative ways. For example, such discrepancies can suggest

that a concept is more salient in one culture than another or even that it is absent in one. Or they might enable us to discover the way different cultures lead people to perceive differently what we assume to be the same phenomena.

(Deutscher 1968: 339)

This is precisely what I will be attempting to show in the data that follows especially concerning mental illness. By taking a list of items seen as indicative of mental disorder, translating them, backtranslating them and then using them with respondents I have learned, I think, of some ways in which Pathan culture leads Pathan people not only to perceive but also to conceive of these states differently. The issue of cultural variations in the differentiation of emotional states is one frequently referred to within Transcultural Psychiatry (see Littlewood and Lipsedge's review 1982: 76), and is one which I shall take up in a later chapter.

Methodological issues are both raised by this process and central to it. In another paper (Deutscher 1969-70 in Bulmer 1977: 243-258), Irwin Deutscher points out the extent to which such factors are present in all work, not only that which is overtly cross cultural.

3. The Meaning of the Encounter: the 'game which we play' or Meaningful Relationships?

But the interview is still more than the tool and object of study. It is the art of sociological sociability, the game which we play for the pleasure of savouring its subtleties.

(Benney & Hughes, 1956 in Bulmer 1977: 234-5)

Personal involvement is more than a dangerous bias - it is

the condition under which people come to know each other and to admit others into their lives.

(Oakley 1981: 58)

A number of authors discuss the way in which involvement with those they interview can be a positive factor - for example, Ann Oakley describes how it influenced the high rates of cooperation in various aspects of her research programme (Oakley 1981) and Robert Burgess summarises a discussion of various authors' work, including his own, by saying 'In short, researchers who conduct interviews in field research need to consider the extent to which their personal characteristics will influence the practice of interviewing.' (Burgess 1984: 106) This I have done at various points. Thus while my status as a mother and as a person who had lived in Pakistan and spoke Pukhtu created bonds, the fact that I was/am white and work in the public domain were points of difference. These factors had an undoubted but complicated effect. I want however, to go beyond a consideration of effects to a more important issue: that of one's own involvement in the work and with those interviewed. For as a person, one's own life is being created by those one interviews as by other relationships. There seems to me to be a difference between the interview as 'the game which we play' and personal involvement which is not just feigned.

Clearly some of the distancing techniques suggested by some methodological texts and quoted by Ann Oakley (1981) do not create very good rapport. They ignore the needs of the person being interviewed for some reciprocity. However, it would be possible to create illusions of reciprocity and equality which satisfied those interviewed without the researcher/interviewer becoming personally involved. This is a central issue for social work too.

To some extent anthropological accounts of participant observer work do this; to a certain degree the researcher is always 'shamming' because s/he can always get out - back to the West from the typical 'native' setting described in classic works. To the extent that one's emotions are involved at any one point however, this is transcended. What then does it mean to become involved as a person? What does this say about the work produced?

The women I interviewed insisted that we related at a personal level, despite inequalities in our mutual situation. It was personal qualities which they assessed and which determined their permission given or withheld, and the boundaries of the relationship. In many ways I did not in fact become as personally involved with them as for example, Ann Oakley did with her respondents. It may be that the differences in our social situations and race, combined with geographical distance, determined this. (See also Jocelyn Cornwell's discussion of Ann Oakley's arguments, 1984: 13.) At the time of interviewing, however, relationships were personal ones and they had meaning for me in their own right.

4. Individualism in Research.

I came to see this insistence on the personal partly as a feature of a more collective culture. Certain research methodologies, particularly the use of the interview and structured instruments seemed to me to be very individualistic.

The initial approach was, in retrospect, individualistic, insofar as the initial plan was to interview a collection of individuals who were seen as representatives of the larger group

norms. We thus assumed that they would be able to tell us something of the shared concepts of mental health and illness, stress and support. They would also be themselves potentially disturbed or not in either of the two senses, ie. by Western standards (as ascertained by the psychological tests) or by their own - and we were interested to know what these were. While the existence or lack of social networks and support systems was acknowledged, I saw these very much as attributes of each individual, the presence or absence of which would protect her or make her vulnerable to stress and breakdown (cf Brown and Harris 1978).

A woman's social groups were in fact prior conditions for her existence. Her description of herself was not in individual terms, and individual freedom and autonomy were not goals sought - rather women wanted to be good wives, daughters, mothers and friends. One did not learn more about the women's lives by excluding the other women and interviewing in confidence but by paying attention to them, for she defined herself in relation to them. Thus I came to feel, not only that attempts to interview individuals in confidence were not possible but that assessments of individuals in isolation from a consideration of their social groups were invalid. This may be truer for other social groups than we realise or acknowledge, but that it is true for Pathans became apparent and seems to be of great importance. (For a discussion of the relationship of the individual to his group and its effect on consciousness in Asian cultures, see Parekh 1974).

Ronald Frankenberg has also described much of sociology as individualistic in a paper (Frankenberg 1979) in which he sees most sociologists as 'caught in the trap imposed by limited methodology and theory'; 'beguiled into abandoning the search for

analysis of social phenomena and into turning to attempts to understand, explain or classify individual acts and attributes'(p. 11). He says, further, that

until we recognise that intellectual work, in sociology as elsewhere, cannot be reduced like sexist sex to a subject/object relationship, we are unlikely to devise methods of work which transcend confusing the social with the mere aggregation of individual characteristics (p.12), and sees the sociologist as 'inevitably participant' (Frankenberg 1979: 13).

Ronald Frankenberg sees the research process and sociological thinking as very much the product of the culture (including the social structures in this case) in which it is conceived, pointing to the English language in which the distinction between 'knowing' and 'knowing about' is not easily made. In this analysis I have chosen to split the issue of process and relationship within the research from the issue of the context - historic, geographic, academic and cultural - of the work which I considered at the start of this Part. They are of course closely related. Staying with the issue of individualism within the research process, however, Ronald Frankenberg concludes that objectivity in research 'comes from living through and then transcending the subjective' and that 'the most generalisable, objective conclusions can only be obtained from the most detailed subjective immersion of the researcher into the particular' in which the researcher is 'born out of struggle to comprehend social process within theoretical understanding'. This is best done in 'detailed processual studies which are usually small-scale in nature' (Frankenberg 1979: 14, 19, 15).

My experience in this work confirms this. It was in meeting with respondents with markedly different assumptions concerning social relationships that I was forced to adapt my methods and question some assumptions which I saw as underlying them.

5. What is Learned from this Study?

Key themes in this Part have been those of process and interaction in research. I have drawn out the social process of the work and stressed its specificity as a product both of the particular nature of my relationships with those interviewed and of its context in a number of ways.

Moreover, process and interaction are key themes in respect of understanding Concepts also. I will show how Concepts can be seen to be dynamic, and I have already stated my view that they are essentially interactive. Claudine Herzlich states this in a passage which echoes much of what has been said in this chapter concerning the research relationships:

If a social representation is a 'preparation for action', it is so because of this process of reconstruction and reconstitution of the elements in the environment ... The points of view of individuals and groups are then seen as much from the point of view of communication as from that of expression. ... A subject who answers a question in the course of an enquiry is not simply selecting a response category, he is giving us a message. He is aware that faced with another investigator, or in different circumstances, the message would be coded differently (Serge Moscovici in Foreword to Herzlich 1973: xii).

This leads us to ask what can be learned from a study of

Concepts that is not specific to that particular investigation.

In respect of Concepts of health and illness, Jocelyn Cornwell's contribution is helpful in that she identifies two categories of response: 'public' and 'private' accounts of health and illness (Cornwell 1984). Thus she accepts that accounts differ with the interaction involved but draws attention to a key variable in the way in which they do so. My data was collected and analysed before her work was available and I have not therefore been able to use this distinction. It is probably fair to say that this study contains a mixture of 'public' and 'private' accounts: I have mentioned occasions when we, as researchers, seemed to 'cross over' a line, often when we reminded respondents of our research purpose. Many sessions were group sessions, however, and I think it likely that the accounts were usually 'public' ones, although we cannot assume that the distinction can be uncritically applied to this different cultural group where 'public' and 'private' are differently viewed. The value of this should not be underestimated on this account, however, since no accounts of any sort have hitherto been available in respect of those studied. If the data accurately reflects the women's views, of whatever sort, that is a starting point. I have to acknowledge, however, that it is no doubt in many respects a 'best face' account overall. This means, particularly, that the women may have, if anything, underplayed their distress and personal suffering. If so, they did so because they chose (possibly unconsciously) to protect what they saw as more important: their community's self respect and way of life. Overall, although it is important in understanding the data to acknowledge the specifics of the way in which it was collected, by

whom, and on the basis of which assumptions, I would claim that the view which emerges is a valid reflection of how the women thought, if (inevitably) a partial one. By showing the research process clearly I have hopefully indicated what sort of partiality can be expected.

Although I have stressed in this Part the ways in which this work was changed during the research process, the importance and uniqueness of the research relationship and the ways in which methodology itself reflects a particular culture and point in the overall social process, I do not therefore see what emerges from the study as dispensible and valueless for these reasons. Indeed, one of the contributions it offers is, in my view, a striking illustration of these processes at work. The theoretical understandings to which it gives rise transcend the specifics of the research process itself.

A number of these understandings concern, not Pathan women or health and illness, but research methodology itself. The way in which these understandings have emerged is by careful attention to and description of the social processes involved: understanding does not, in my opinion, come from failing to acknowledge the specifics of the process but from attending to them with a view to seeing what we can thereby learn about those processes. That has been the aim of this Part of the thesis.

PART II. SOCIAL SITUATION AND INTERACTION.

بیتے لہ یا کوردے با کوردے

For the woman, either the house or the grave.

(Pukhtu proverb, Ahmed 1973: 44).

In this Part, I have two main aims, following the overall aims of this thesis. The first is specific. It relates to the issue of seclusion as a factor leading to depression amongst Asian women in Britain. I have already referred to writers who have suggested such a link; in order to explore it in more depth it is now necessary to look at seclusion (a structural factor of the women's lives) and at whether this appeared to lead to isolation (a psychological state) and of what kind, and further; what meaning this had for the women concerned. In a later chapter, I will then be able to look at the relationship between isolation and mental state.

My second aim in this Part relates to the more general overall purpose concerning the women's concepts of health and illness. As already discussed, other authors have drawn attention to the way in which 'ideological', 'cultural', 'structural' and 'social' factors are of importance in understanding the concepts of health and illness held by various groups. As already stated, these terms are variously used and reflect different theoretical positions both in respect of each term and in relation to each other, and I shall restrict my own use of them to that stated at the outset. It is clear, however that the respondents' position in the social structure will be relevant to an understanding of their Concepts of health and illness. To understand these Concepts therefore, this position needs to be described, and this

in turn entails a description of the social structure at a micro-level. Further, I have stated interest in the role played by material and other social circumstances in health and illness behaviours. Through the description in this Part of the social situation of respondents, these circumstances should be made clear. In addition, the material and other Interests of respondents (the other factor which I have suggested is important) are likely to be Interests which are common to behaviours other than health and illness behaviours. We can learn about these from looking at the women's lives in general terms, therefore, to add to the understanding gained through studying their accounts of health and illness behaviours. Thus the matters described in the Part have a place in my analysis of health and illness behaviours, being some of the factors which determine both Concepts and behaviour.

As well as being important insofar as they are factors in the overall analysis, this description of the lives of respondents has contextual significance. Like Jocelyn Cornwell (1984), I do not believe that health and illness can be considered in isolation, but that 'we have to consider its place in the context of their lives as a whole'. (Cornwell 1984: 1) By describing general aspects of their social situation here, I will provide this context.

In describing the women's lives, a central place has to be given to pardah observance. Purdah observance is central for a number of reasons. It was this aspect of their lives that led to questions concerning mental ill health. As we shall see, pardah observance does affect both the women's Concepts of health and illness and their receipt of treatment. Purdah observance is important both to the women themselves and to outsiders. It is an

overriding aspect of the social structure as illustrated in the Pukhtu proverb at the head of this Part. I found, however, that purdah observance was different when viewed from 'inside' and when viewed from 'outside'. Moreover, it worked out in different ways for different women, and had differing implications. I found that the women's Concepts of purdah and of how to behave properly had ideological and structural aspects. Moreover, purdah observance was further determined not only by the women's ideals and views of what ought to be but by material and other circumstances such as the size and location of houses. The influence of these factors is discussed in Chapter Ten.

The women's Interests also modified behaviour, excluding potential courses of action and allowing others which seemed precluded. For example, many women did not learn English, despite the possibility of doing so in the home, but did go out to attend antenatal appointments, despite the presence of men from whom they were secluded. Chapter Eleven considers the role of Interests.

In short, then, I found the same set of factors to be of importance in describing purdah observance and patterns of Social Interaction as I had proposed to describe health and illness behaviours. Furthermore, although purdah observance will be seen to be a factor determining both Concepts of illness and the seeking of treatment, this observance was itself modified on occasions by the women's Interests in receiving health care. Not all women modified their purdah observance for this reason, of those who did, some forms constituted such a reason, other forms did not. Such differences will be explored both here and in following chapters.

I shall therefore describe the women's social situation within the same overall framework which I shall use for the

presentation of their accounts of health and illness. It will be clear that the first aim (that of understanding seclusion and whether this leads to isolation and what this might mean) will be achieved in the course of the more general exploration of Concepts and of behaviour. So too will be the aim of 'introducing' the respondents to the reader.

My starting point is the women as Pathans. I therefore look first (in Chapter Seven) at three aspects of Pathan ideology which can be seen as influencing women's social situation in overall terms. In respect of this study, the aspect of most importance is that which results in a sharp division between the public and the domestic domain, excluding women from direct participation in the former. The next chapters, therefore, look in more detail at the women in these two domains. In the former, the public domain, they have no place in their own right. This is, however, the context of their lives and determines many of the conditions under which they live. These are the subject of Chapter Eight. The following chapters concern the domestic domain within which women's lives are lived. Here I look at and analyse the women's pardah observance and their social relationships, using the framework already discussed. I argue that it is strong notions of community and of the importance of social relations which determine women's patterns of interaction rather than pardah observance which determines, more accurately, their non-interactions. However, these cannot be separated; pardah as understood by respondents is understood within the context of other social values. It is the context that makes pardah observance a positive facet of life when viewed from the inside, in contrast to an outsider's view. These issues are brought

together in the last chapter of this part in which I discuss the question of the meaning of seclusion for these women and their view of their own 'work'.

Chapter Seven. Pathan Culture, Ideology and Overall Social Structure.

The women interviewed all saw themselves as Pathans. All spoke Pukhtu. In Pathan ideology, a key concept determining both identity and life in public and domestic domains is that of honour (izzat or ghairat). This concept also influences a Pathan's perception of social status. Whatever the person's position in life, unless honour is maintained, wealth and occupational status are empty and meaningless. Honour is primarily a male prerogative and a man can achieve prestige and respect both within his peer group and even beyond it if he is seen to behave honourably.

A parallel concept, that of sharm (modesty, shame, embarrassment depending on context), is discussed by Catherine Thompson (1981) in relation to Hindu villagers and by Patricia Jeffrey (1979) in relation to the women of a Muslim community in North India. Although sharm relates primarily to women, it applies also to men in a way that appears to be parallel to the way in which izzat, although applicable to both sexes, is predominantly a male ideal, particularly for Pathans. Catherine Thompson's discussion usefully relates the notion of sharm both to the maintenance of social distinctions (between what is public and what is private) and to individual identity. In the case of the Pathans I interviewed, male and female worlds were clearly structurally demarcated. Although concepts of sharm were still of importance, certainly in respect of identity and self respect, it is probable that they were less crucial in the maintenance of the social structure, than for Catherine Thompson's respondents who

did not observe pardah.

This social structure is one in which women are viewed as the possession of and identified with their male kin. It is their duty, therefore (and in their interests) to contribute to male honour by their behaviour. Hanna Papanek (1973) follows Honigmann (1957) in quoting a Pathan proverb: 'A man is known from the qualities of his wife'. Honourable status is then conferred on the man's dependents by extension as well as partly deriving from them. The maintenance of honourable behaviour is not perse a religious matter, although the customs that define it are seen by Pathans to be derived from Islam. However, being a Muslim and being a Pathan are not synonymous. Pathan ideology goes beyond and in some senses is different from Islamic ideology, although it is a vital part of being Pathan that one is also Muslim. Language is very explicitly a part of both the culture and the ideology. A phrase 'doing Pukhtu' sums up the Pathan's sense of the way in which belief is integral to both speech and action. An outsider who speaks Pukhtu, as I do, is therefore instantly a family member and assumed to share some basic attitudes. This is partly due, I think, to the sense of wonder and respect that members of a distinctive minority culture have when any outsider learns their language (especially if they have not learned the dominant regional tongue; in this case Urdu). I have often speculated on a probable similarity that may exist amongst Welsh people in respect of Welsh speakers. However, the explicit way in which Pathans identify language and behaviour seems to add an extra dimension which is peculiar to this culture, distinguishing it both from general characteristics of minority groups and from general features of Muslim and Indian societies in which honour is important.

These claims may sound extravagant. In defense of them I would refer the reader to Fredrik Barth (1969) following Sir Olaf Caroe (1958) who both see the maintenance of honour as basic to Pathan identity. More tellingly, Pathan proverbs 'Mataloona' (Ahmed 1973) resound with the theme as do Pukhtu films. Examples of the latter are not hard to find, from the famous historical tale of Pathan who killed his brother for dishonouring a female British captive (the young Alice Starr kidnapped in Bannu in the last century) to the more extravagant story I saw during the fieldwork period. Entitled 'Ghairat Zama Iman Day' (Honour is my religion, faith) this told the story of a son who consented to be hanged to preserve the honour of his mother, which was threatened by the fact that a rich enemy possessed her dupatta (symbol of female modesty); a dupatta she had herself given as the price of saving another son from ruin at the enemy's hands. Clearly all Pathans do not behave honourably (both films have their 'baddies', Pathans themselves). However, the ideal informs behaviour in everyday situations as I discovered in the course of the research. Fredrik Barth (1969) identifies three areas of social life in which honour must be maintained: in public affairs; in the use of material goods and hospitality; and in domestic life. All three of these spheres are of relevance in the present study.

1. The Honourable Pursuit of Public Affairs.

At first glance this may be felt to be irrelevant in the British context, as its main traditional expression is the tribal council (jirga) through which public affairs are decided. It may be argued that in a society such as the British one, seen as

dissolute, there is less obligation to maintain honour in public affairs. Since this is the husband's concern, and this study was concerned with the women, this was not studied. However, comments made by two of the husbands suggest that it is not so and that they were attempting to maintain standards of honourable behaviour in a system which didn't help them and in which it wasn't even acknowledged as praiseworthy. One man was losing social security benefits because he had been honest enough to declare that he owned two houses. In fact there were court proceedings in process to evict tenants who were not paying rent or maintaining his property and because of whose presence the house could not be sold. His indignation was mainly at the fact that he knew people with other houses who did not declare them. His honesty had landed him in a financial 'no-win' situation, yet (and this is the distinctive factor) he was proud of his honourable behaviour which he saw as definitive of himself as a Pathan. Another man in receipt of social security benefits refused to put in an additional claim for travelling expenses to visit a child in hospital (the distance was considerable) as he saw this as dishonourable. However it would have been impolite to disagree with advice and he therefore further confused the situation by assuring concerned social workers that he would claim the money.

2. The Honourable Use of Material Goods and Hospitality.

For a Pathan, even an enemy once in your house is under your protection. In Pakistan I was frequently told 'You are our guest in this country'. This makes the attitude of the British public to immigrants inexplicable to many Pathans. I was often involved in discussion of this and people (usually the men) quite rightly

pointed to the way that outsiders were treated in their country. Of course there are differences - I pointed out that not all Pakistanis were polite to foreigners and that not all the English resent their presence - there are also differences in the nature of the migrations as well as structural differences in the power relations in the country of settlement which may be seen by some as affecting the argument, but this is a matter not of logic but of ideology. It applied in the private as much as the public domain. Tea and often meals were offered, particularly when I was known to have travelled a distance. I was inevitably not just a researcher but their guest. One woman took trouble to explain to me that offering hospitality was in no way a bribe to officials, it was her duty and her pleasure. All health and other workers who visit Pakistani homes will be familiar with such notions of hospitality - it is important to note their meaning.

Fredrik Barth's (1969) analysis is again interesting - he says that 'In the host-guest relationship, any single encounter is temporary and the statuses thereby reversible and reciprocal, and hospitality is easily an idiom of equality and alliance between parties'. Yet professional visits like research ones are not intended to be reciprocal - these relationships are defined as one way. (Oakley, 1981). Fredrik Barth (1969) continues 'a consistently unilateral host-guest relationship, on the other hand, entails dependence and political submission by the guest'. What does this do to the health workers who are in fact politically more powerful than their hosts, and may need to exercise this power? Is there any way of avoiding the host-guest relationship when visiting the home? This seems difficult, and both in Pakistan and in Britain it is my experience that Pathans

are uncomfortable with home visits (although they will be honoured by truly social visits) and much surer of their position (which they define as dependent but in which they have the power to leave) when they visit a worker in a hospital clinic or office. Yet, due to the seclusion of Pathan women, home visiting is very important as a means of contact; as we shall see below, it may be the only one.

This problem does not merely arise from a conflict between 'their culture' and ours, however. There are conflicts within the roles of workers whose job it is to establish a 'good relationship' as the basis for work with individuals and families. Volumes have been written defining these ~~roles~~^{ethics} for health visitors, social workers and researchers (Oakley 1981 reviews some of the material on the researcher's role). Yet they remain artificial constructs. They are relationships which many have become used to and able to work with. However, there is evidence that not all sections of English society find them meaningful. Most workers using these ideas are aware of instances where the notions break down. The ethnics of such relationships and indeed their viability have been questioned (Oakley 1981). In Part I, I discussed this as an aspect of methodology. Cultural factors related to overall ideology made these difficulties more apparent in the present study - pointing us more clearly to underlying assumptions. In practical terms, the way through these difficulties seemed to be to realise the conflicts, to realise that patients/clients/respondents were also confused as to what to expect of both parties, and to try to make headway on the basis of as much honesty and sensitivity as possible, rather than attempting to understand or create a 'right way' through the difficulties. Workers who were respected were those who were

most human, who laughed, cried and somehow conveyed real concern. Such factors were commented on, not whether people 'broke the rules' - their own or Pathan ones. In such a situation, the rules are indeed hard to find for either side, and the evidence seems to be the rules themselves are in process of creation. In other words, I am suggesting that where both parties recognise that familiar social and cultural rules of behaviour may not apply, the interpersonal level becomes more important, and assessments are made on the criteria of perceived concern. Even within this, however, it is dangerous if we thereby assume that such criteria of perceived concern are somehow universal. Although the feminist call for treatment of respondents as persons and for recognition of the importance of relationship seems close to the Pathan women's tendency to assess personal rather than professional skills, each are surely culturally determined as much as the more formal norms of behaviour. Warmth is conveyed in one way within one culture, in another way in another. I would personally maintain that communication of concern is possible despite such factors of difference, but awareness of them and of the power relations in the situation is important nevertheless.

3. The Honourable Organisation of Domestic life: the Seclusion of Women.

This brings us to the heart of the matter, as far as this study is concerned. It is right that a discussion of purdah should be set in the context of its place as one of the central facets of Pathan ideology. The observance of purdah will be seen to fundamentally affect the health care received by these women - it

may be seen by some (possibly even the women concerned) as undesirable in the context of life in Britain. But is not just an arbitrary fact of life, that can be retained or dispensed with easily in a new context. While anthropological readers will not be surprised at this last statement, which is almost too obvious to state, it is important to state it because a number of observers, including practitioners, seem to assume that purdah observance can be pursued or not as matter of individual or family choice. This is to see purdah as ideology only, neglecting the fact that it is a structural aspect of Pathan life. The concept of honour so central to Pathans is underlined by Hanna Papanek (1973) reporting on studies of Pathan women in Pakistan. She ties it firmly to the social structure, however, saying that 'a valued quality like izzat, and its corollaries of control and obedience, are integral parts of the system of symbolic shelter in a Muslim society where men control the behaviour of women'. (Papanek 1973: 319). Pathan culture embraces not only the ideology of which honour is an integral part, but the social institutions in which it is preserved.

Purdah is one such institution, It is 'a complex of norms... structuring relations in the local community' (Sharma 1980); a 'system of sex segregation' (Papanek 1973) and 'an ideal system' regulating behaviour (Saifullah Khan 1976). Verity Saifullah Khan notes that this 'ideal purdah system' is varied as a result of three basic variables: cultural, ideological and socio-economic, and she goes on to look at the way socio-economic factors in particular affect purdah observance of Mirpuri immigrants in Bradford. Her study is particularly relevant because her respondents were, like mine, Pakistani immigrants in the City of Bradford.

I will be distinguishing Concepts of purdah from purdah

observance. My distinction is not the same as Verity Saifullah Khan's 'ideal system' which she acknowledges to be of her own construction rather than consciously verbalised by respondents (who were Pakistani but not Pathans). The Concepts of pardah I describe are derived from the accounts of a group of Pathan women in Britain. While I found basic similarities in the Concepts of all the women due to the overall Pathan ideology and an overall agreement concerning the ideal structure of life within the home (especially the sexual division of labour), variations in the Concepts of groups of women emerge clearly. One of the bases for this is a sub-cultural one due to the fact that, although all the women were Pathans, there were within this two distinct cultural subgroups. The grouping was reflected in Concepts of pardah i.e. of proper behaviour. In common with Verity Saifullah Khan, therefore, I found cultural differences in pardah observance, but these were discernable, not only in behaviour but in the Concepts of the subgroups.

Socio-economic factors are important in my analysis as in hers. Although these did operate at the level of Concepts, insofar as position within the social structure did affect the concepts of all respondents, the group was relatively homogeneous in respect of overall socio-economic level and therefore Concepts of pardah did not seem to be differentiated on this basis within the group. Pardah observance, on the other hand, was clearly affected by material and other circumstances such as the size, layout and location of houses; considerations which Verity Saifullah Khan includes as socio-economic factors and which I shall be seeing as factors determining Options. The category of Interests is not one that she explicitly refers to although it is

implicit in her analysis of changes likely to occur in the British situation. Both functional and structural explanations are used in Verity Saifullah Khan's article, which shows purdah to be a system of social control and a symbolic system as well as offering 'the beginnings of a structural explanation'.

(Saifullah Khan 1976: 238)

Fredrik Barth's discussion of seclusion among Pathan women, is also particularly relevant, this time due to its focus on Pathans. He describes the seclusion of women and encapsulation of domestic life as a behavioural solution to the contradictions in Pathan value orientations. These contradictions he sees as being the emphasis on masculinity and virility, the high evaluation of males yet the emphasis on consummation through females. There is a denial of attachment to and importance of things, yet female kin are seen as things but cannot thereby be shared in the way that material goods must be (through hospitality). A male is dependent on and vulnerable through his women. This discussion has parallels with that of Veena Das (1976, quoted by Catherine Thompson 1981) who suggests that women are gateways to caste and family membership, and that of Hanna Papanek (1973) in her discussion of purdah as 'symbolic shelter'.

Where most of these writers, including myself, would part company from Barth's analysis is where he says that the adequacy of this solution (i.e. the seclusion of women and the encapsulation of domestic life) to the resolution of ideological conflict, is suggested by the relative absence of divorce and of murder following adultery (although see Ahmed 1980 concerning this aspect of Pathan life); by the trust placed in women by absent husbands and in the traditional views of women as upholders of honour. Here he is taking ideological accounts as the whole picture, as

well as demonstrating a considerable male bias. These factors seem to demonstrate little more than that the ideology is strong, well sanctioned and that people on the whole conform to it - publicly at least. To make any statement concerning the adequacy of the solution for individuals (as opposed to its function in respect of social order) we need surely to look at what purdah means in a defined situation, taking account of, if not focussing on, its meaning for those whose life it most closely defines; the women.

There are a number of sensitive descriptions of the lives of women in purdah which do this. Out of case studies mainly conducted in Pakistan and India, they offer an analysis of the institution of purdah in relation to the division of labour by sex and social class (Papanek 1973); to the satisfactions offered within the role for one who observe purdah (Jacobson 1977 reported by Sharma 1980); to the issue of change due to the political and economic pressures (Mehta 1976 reported by Sharma 1980); and to its structuring of social relations at the level of local community (Sharma 1980). Patricia Jeffrey (1979) also explains purdah in economic as well as ideological terms. The value of these works lies in their argument from particular situations to analysis and (for my purpose) in their concentration on the women's own view. This is a tradition to which my work is intended to contribute.

In this chapter, then, I have outlined aspects of Pathan ideology and the overall social structure associated with these. The ideology informs behaviour and assumptions in day to day life, however partial and far removed the ideal. The basic social structure by which life divided into 'separate worlds' for men and

women is, in the process of migration, transported into different circumstances which mean that the structure has different implications for individuals in the changed locality. Ideological pressures of the wider society may be added to the constraints on women observing pardah in this new situation where societal ideology is critical of rather than supportive of pardah observance.

In turning now to a consideration of the respondents' accounts of their lives, I will consider first the public domain. Although this is not the area in which women move, it is the context within which their lives are set.

Chapter Eight. The Social Context of Respondents' Lives: the Women in Public Domain Terms.

In the public sphere, the typical Pathan woman has no status in her own right. Like some of her 24 carat golden jewelry made in Pakistan without a hallmark and therefore priceless or worthless in world markets, she has no status in an arena where she has no claim to a place. None of the respondents had ever had a job outside the home or expected to. Only five had any formal education, only two of secondary level.

1. The women themselves.

The times at which she herself is officially recognised are when she is born (if the birth is registered), attends school, marries and migrates. The languages which she speaks and/or understands may determine her ability to communicate outside the private domain. These are therefore shown in Table (ii). The first column represents the answer to a question concerning a respondent's village. The answer was always immediate, this was an important social fact, relevant for her. The only hesitation was often in weighing up the amount of detail that would make sense to interviewers. Responses given are recorded, their location in terms of administrative district and Province are also noted. The majority of respondents were from the area known as Chhachh, many from one village. The question of Pathans and Chhachhis has been discussed. Opinion in Bradford is that the distribution of respondents arrived at, although not intended as representative, is not a bad reflection of the total Pathan

Table (ii) Public Domain Social Facts - the Women

As at October 1981. According to area of origin. It should be noted that the order in which respondents appear in this Table does not correspond to that in other Tables.

* Indicates an estimated age (see text). Mother Tongue is underlined.

Village	Age	Mother Tongue and Other Asian Languages	Level of Schooling	Years Married	Years in England	Spoken English
Those from North-West Frontier Province						
Near Peshawar	38 yrs.*	<u>Pukhtu</u> only	None	at least 21 yrs.	3 yrs.	v. little
Near Peshawar	24 yrs.*	<u>Pukhtu</u> , Urdu (literate) Arabic	None	7 yrs.	4 yrs.	some
Chakdarra, Swat	30 yrs. (H.V. records)	<u>Pukhtu</u> only	None	10 yrs.	6 yrs.	v. little
Chakdarra, Swat	26 yrs. (H.V. records)	<u>Pukhtu</u> only	None	probably 6 or 7 yrs.	6 yrs.	v. little
Naway Kali, Mardan	31 yrs. (known)	<u>Pukhtu</u> only	? Primary Education in England	7 yrs.	4 yrs.	seemingly v. little

Table continued

Table (ii) continued

Village	Age	Mother Tongue and Other Asian Languages	Level of Schooling	Years Married	Years in England	Spoken English
Those from Campbellpur District (now Altock), known as 'Chhachh'						
Waisa	24 yrs.*	<u>Pukhtu</u> , Urdu (some), Hincó	None	7 yrs.	6 yrs.	v. little
Waisa	19 yrs.*	<u>Pukhtu</u> , Urdu (literate), Hincó	5th Class	2 yrs.	1½ yrs.	v. little
Waisa	27 yrs.*	<u>Pukhtu</u> , Urdu (literate), Hincó	12th Class	10 yrs.	10 yrs.	some
Waisa	38 yrs.*	<u>Pukhtu</u> , Urdu, Hincó	None	21 yrs.	13/14 yrs.	v. little
Waisa	23 yrs. (H.V. records)	<u>Pukhtu</u> , Urdu, Hincó	None	4 yrs.	4 yrs.	v. little
Waisa	23 yrs.	<u>Pukhtu</u> , Urdu (literate) <u>Punjabi</u>	4th Class (failed)	7 yrs.	1 yr.	v. little
Waisa	24 yrs. (known)	<u>Pukhtu</u> , Urdu (literate) <u>Punjabi</u>	5th Class	8 yrs.	8 yrs.	some
Near Waisa	20-25 yrs.*	<u>Pukhtu</u> , Urdu (some), Hincó	None	3 yrs.	3 yrs.	v. little
Nartopa	29 yrs. (known)	<u>Pukhtu</u> , Urdu (literate)	Matriculation	12 yrs.	11 yrs.	some
Barazai and Topa	22 yrs.*	<u>Pukhtu</u> , Urdu, Hincó	None	5 yrs.	5 yrs.	v. little
Pabodei	29 yrs.*	<u>Pukhtu</u> , Urdu	None	12 yrs.	10 yrs.	v. little
only district given	39 yrs.*	<u>Hincó</u> , some <u>Pukhtu</u>	None	13 yrs.	12 yrs.	v. little

community in Bradford. This can only be impressionistic however.

The lack of general awareness of age and dates of birth contrasts with the ease with which respondents named their village. Even in respect of their own children, the women were often not immediately aware of dates of birth. Birthdays were clearly not celebrated as a rule. Many of the women will themselves have been born at a time when births were not systematically recorded. Moreover, they were often unwilling even to hazard a guess or discuss the matter. In such cases, which are shown on the table, an estimate has been made by adding the number of years the woman had been married (or age of oldest child plus one year if date of marriage was itself not known) to a suggested average age at marriage of 17 years. Some will have married and had a child earlier than this - in fact a number claimed to have married 'young' by which they mean shortly after or around puberty. Others have clearly married later.

Mother tongue is that with which they were most familiar as a child. One woman was brought up by a grandmother in a village where Pushtu was spoken, but her sister (with whom she now lives) was raised by their parents and spoke Hinco at home, as does the woman's present husband. Pukhtu is therefore not the current language of the household, although it is the woman's mother tongue. Only two other cases raised similar difficulties - usually this was a clear issue.

Level of formal education is noted. The most frequently given reason for discontinuation of education after primary level (fifth class) was that primary education is located in the village whereas secondary level is in the town, necessitating a journey that was not seen by her father as appropriate for a girl approaching puberty. We are of course thinking of values that

were current some 10-25 years ago. Some of the women however, continued with their religious studies and can read Arabic (and thus the Qu'ran) even where they cannot read Urdu. Pukhtu is not taught in schools and therefore if a woman could read at all it would be Urdu (the national language) or Arabic.

Women would be more likely to know how long they had been married and in Britain than the date of marriage or migration. This is therefore recorded in this form. The length of stay in Britain was usually well known to the women and often she would tell us at the same time how many trips she had made home in this time, if any.

Spoken English is a subjective estimate on the part of the researchers. None of the women claimed to speak English and few to understand it, although some did purport to understand quite a bit although too shy to reply. At the time of their schooling, many set books would have been in English but the few who sat for matriculation exams pointed out the difference between English as learned and spoken in Pakistan and English used daily in England.

2. Their Family of Origin.

Within the Pakistani situation status is accorded to men and by extension to their families mainly on the basis of ownership of land (in a rural society, the main determinant of wealth) and of piety. More recently, occupations not related to land ownership have arisen - these are achieved rather than ascribed - doctors and lawyers and (to a lesser extent) schoolteachers are respected. Certain families, moreover, are Sayyid or holy, being related to the prophet himself. Members of these families are often

religious teachers or leaders (Caroe 1958, Jeffery 1979). I did not, unfortunately, include questions concerning family of origin in my research schedule, so have no data concerning this in respect of my respondents. The migrant is also viewed, however, as having social status, particularly if he shows evidence of his newly acquired wealth by sending money home, building a house in the village, bringing expensive presents etc. As long, that is, as he maintains honourable standards of behaviour, while living in a society in which this is assumed to be difficult. The status given to the migrant is, of course, not important between Pathans in Britain, all of whom are migrants.

3. The Families' Status in Britain.

In Britain, my respondents were members of a minority ethnic group. They are moreover, instantly identifiable by the colour of their skin as well as clothing and other differences. Their status is therefore an inferior one since British society is undeniably racist. The effects of racism will be referred to throughout this thesis insofar as it affected the women's lives in various specific ways. In addition, the chapters concerning experiences of maternity and child health services will draw on data concerning the experiences of other minority ethnic groups. Despite differences of culture, their similar status as minority ethnic group members demands examination of the similarity or otherwise of their experiences. Although this factor is an overriding one in respect of status, other issues affect the way in which status is demonstrated by those concerned, on the one hand, and assessed by an outsider or researcher, on the other.

In this country, the status of a family is commonly

determined by the husband's place in the public domain - primarily by his earning power (educational level and the status of his occupation) and by his spending power (as usually reflected by type of housing and standard of living). However, we run into difficulties when trying to place the social and economic status of immigrant families in these terms. There are two reasons for this. Firstly, as we have already indicated, the migrant has two contexts in which status must be achieved - the Pakistani one and the British one. The former tends to be more important than the latter. Various works (e.g. Jeffery, 1976, Saifullah Khan 1974) note the amount of money regularly sent back to be spent in Pakistan - either to support relatives or to build and maintain a family home in the village there. Several respondents referred to such arrangements. Ursula Sharma (1977) discusses the mutual dependence between migrant and non-migrant in the village. The 'myth of return' (Anwar 1979) is ever present, and for a Pathan is realised in death if not in life - the aim being that all Pathan adults return to Pakistan for burial, groups of men having set up insurance saving schemes to finance this when the time comes. Only small children are exempt. For some the return home is seen as a goal they are working towards - others see it as something that may never actually happen. Either way, status must be maintained at home for the sake of their children and their chances of a good match if no other reason. To see the sending of money home as an exercise in status maintenance is not to deny that other motivations exist or to undermine the fact that families may want to fulfil their obligations to kin at home because they care about them.

Patricia Jeffery (1976) argues strongly that the lives of the

Pakistani families she interviewed in Bristol cannot be understood by consideration only of the situation in this country. My data bears this out. This has implications in all areas of life - particularly striking in this study is the influence that family events in Pakistan have on social interactions in Bradford (see below. In the present context, however, the practical consequences of maintaining status on two fronts is that the resources earned are not all spent in this country.

The second point is a related one. In British society, social and economic status is usually seen as accruing to the nuclear family unit. Thus the classic pattern is for a family to have consumption patterns that reflect their earning power. While gifts may be given within the family, different members of a typical English family may end up in quite different statuses. Status tends to be achieved on an individual basis and accrues to the individual and family who achieve it. But Pakistani families do not tend to fit this pattern. Status is seen not only in nuclear family terms, but in the context of the wider family. Prestige and indeed economic assets may be and often are considered to accrue to the wider unit. Similarly, matters such as housing and employment may be decided in a framework that takes account of many social factors and thus does not merely reflect the social and economic status of the nuclear unit. Because marriages are usually arranged within the family, sometimes between cousins, there is a real sense in which the wider family unit is closely identified as 'one's own'. Beyond this, a fellow member of the tribe denotes a person with whom a blood relationship could be traced back in time, and a fellow villager is also closer than one who is totally unrelated.

It is because of the obligations and responsibilities which

bind these various categories of 'relations' that social and economic indicators such as housing, level of education and employment cannot be used to allocate these people in a classification of class position such as that usually used in social research. This can give rise to problems as evidenced by the Medical Research Council's difficulties in classifying Asian women in studies concerned with rates of perinatal mortality. (Dr. Raymond Illsley, personal communication, 1982). Social scientists' preoccupations reflect an individualist focus of attention in this as in other matters (see also Ch.6).

A. Employment.

It is well recognised that an immigrant's employment may not reflect his range of skills. Migration is often accompanied by a drop in employment status when qualifications are not recognised, skills not seen as relevant and racism deters employers from giving a job to someone of a different skin colour (see Ballard and Holden 1975a and 1975b). Other factors are relevant however. The two contexts of the migrant's life mean that breaks in employment occur in order that visits may be made to Pakistan. Most respondents told of such breaks, often followed by a period of unemployment on return.

The work that a man does will probably be chosen in the light of other social factors - respondents were amazed that my husband's career prospects alone had determined where we settled as a family rather than considerations such as living close to parents. Moreover, jobs may be taken because they enable a person to help others get work, or even on behalf of others. In Pakistan it is not unusual for one son to be in high status employment to support other brothers at home. Individual

potential is not the sole or even major determinant of employment status.

B. Housing.

In respect of housing, Badr Dahya (1974) has criticised John Rex and Robert Moore's work (1967) for its assumption that immigrants would prefer 'better class' housing (usually detached and suburban) to inner city so - called 'overcrowding'. The suggestion is often made that it is only discriminatory practises and racist attitudes among the white population that confine immigrant groups to inner city neighbourhoods. Racism is undoubtedly a factor limiting choice of housing. However, other factors operate. Values are different and choices if they do exist made on different bases. One's own garden may be less important than a shared and private play area; ideal house size is determined by the requirements of providing separate living space for men and women - preferably including separate entrances - there is great surprise at the predominant English ideal of a room of their own for each child. Moreover, family members may be expected to stay for long periods. Racism does indeed often ensure that non-whites have few or no options. But standards or location of housing cannot be assumed to reflect this factor alone.

C. Standard of Living.

As already noted, the standard of living of the family, as reflected in what they spend money on, is determined by the amount of money to be spent on living in this country and by different values influencing choices. For example, co-ordinated colour schemes are not valued but video recorders were common amongst respondents at a time when they were still considered luxury goods by most indigenous families. They enable Urdu films to be shown in

the home and thus watched by all the family. Thus an analysis even of their own patterns of spending may not help in a social classification of Asian families if it is based on English assumptions, although there are undoubtedly internally recognised indicators of standard of living. Exploration of these would be very interesting, although it is not the objective of this study.

With these warnings concerning their meaning, however, Table (iii) shows the husband's present employment and the type of housing of respondents. None lived in rented accommodation. Although these factors may not be interpreted in familiar ways as indicative of class position, they do inevitably determine some of the basic conditions of existence for the women. Financial anxieties were very real for many, and, where work was available, husbands sought to increase the family income by working overtime whenever possible. I was told that Pathan men were considered good employees but also that their long hours of overtime could mean that women were left alone for long periods and were hence more subject to depression. I saw less of this than of its opposite - the strains on a woman when her husband is home more and thus intrudes more into the private domain which is traditionally hers.

Table (iii) Public Domain Social Facts - Husbands' Employment, Housing

As at October 1981. According to Employment Status. It should be noted that the order in which respondents and their husbands appear in this Table does not correspond to that in other Tables.

All houses were owner-occupied and terraced.

Those Husbands currently in Paid Employment				
Years in Britain	Place of Work	Size of House	Car Ownership	
19 yrs.	Foundry	Large	Yes	
18 or 19 yrs.	Bakery, (previously Mill)	Small	No	
18 yrs.	Mill	Large, shared	No	
16 yrs.	Mill	Large	?	
12 yrs.+	Foundry (3 day week)	Small	No	
11 yrs.	?	Large	No	
10 yrs (from childhood)	Foundry	Small	No	
4½ yrs.	Mill	Small	No	
?	Taxi Driver	Small	Yes	
Those Husbands currently not in Paid Employment				
Years in Britain	Previous Work	How Long Unemployed	Size of House	Car Ownership
21 yrs.	In Pakistan, in Police. ? Britain.	?	Large	No
20 yrs.	Mill	8 months	Large, shared	Yes (shared)
20 yrs.	?	Retired ? when	Large	No
18 yrs.	Mill	'Recently'	Large, shared	No
18 yrs.	Engineering Works	1 yr.	Small	No
16 yrs.	Bakery, British Leyland, Mill,	?	Large	No
'Many years' 10 yrs.	'Box Mender'	4 yrs., following industrial accident	Small	Yes
'Many years'	Mill	8 months	Large, shared	Yes (shared)

Chapter Nine. Patterns of Social Interaction within the Home and Outside.

Purdah observance affects the majority of aspects of the womens' lives within the domestic domain. However, it was clear that observance was not uniform within the group of women studied. It seemed likely that an exploration of common aspects and of differences would reveal some of the critical factors determining purdah observance. In addition, however, it became apparent that patterns of interaction amongst women (and hence the extent to which they were secluded or isolated) reflected ideals other than the ideal of purdah, which sometimes conflicted with it. Patterns of interaction and quality of interaction also had to be distinguished because of the importance of the latter for issues of mental health.

Variations in the purdah observance of the women interviewed can be best illustrated by describing their patterns of interaction both within the home and, more importantly, their networks and social relationships outside. This I will therefore do in this Chapter before drawing out the role of Concepts, Options and Interests in the ones following.

1. The Division of Labour within Households.

Most households were single ones consisting of husband, wife and their own children. The three exceptions (involving five focus respondents) were instances where two sisters were married to two brothers and the four and their children shared a household. In two of the three households, the father-in-law shared the home also. One mother-in-law was normally present but

visiting her grown children in Pakistan during the period of fieldwork. The other mother-in-law was dead. In one other household the parents-in-law were not normally resident (having their own home elsewhere although they had previously shared the home) but the father-in-law was on an extended stay in the household while his wife also visited Pakistan.

None of the focus respondents were currently living with their mother-in-law. On the whole, the older generation was notable by its absence 'We are our own elders (masharan)', I was told, and the women felt that this gave them greater freedom to determine their own behaviour. However, one woman who normally lived with her mother-in-law put the opposite point of view saying that it was the presence not the absence of elders that removed responsibility for social matters, leaving younger women freer. It seems to depend whether it is desirable to be free to determine ones life or free from certain social obligations. Clearly both responsibility and a lack of it can be onerous in excess. One household in which the mother-in-law was normally present was one in which we were refused permission to interview. It was thus not possible to make any assessment of the effect of the mother-in-law's presence on the woman.

Husbands varied in the degree to which they were prepared to work in the home. Some wives described their husbands as 'strict' or 'lazy' and unwilling to lend a hand at all. If women were ill, they were expected to continue - if very ill or absent, a female relative or kin would be involved if possible. Others said their husbands would sometimes care for the children to enable them to receive visitors in peace, although they soon gave them back if they cried or had a wet nappy. Still others said their husbands

'did everything' in their absence and even where a female kin member was available, would care for the children, most often they boys, if they preferred to stay at home. Two husbands prepared tea for us when we visited. Both did it as if it was not unusual for them (although it would have been in other households) and without having been asked to do so by their wives.

It was clear that the women did not feel they had strong cause for complaint when their husbands did not share the care of home and children (so long as they fulfilled their external responsibilities fully) yet since some husbands did do so they might feel relatively deprived by comparison with other women. The presence and proximity of a female network and closeness of relationships within it would have an effect on how much the husband was forced to do, particularly during a wife's confinement, for example. There were two examples of relationships which appeared (to an outsider) particularly mutually supportive within overall acceptance of a strict division of labour. These were the two where the husbands made tea for us. In one case there was a lack of female kin. This woman was also the only respondent who had passed her matriculation. In the other, the husband had been ill, and this had forced a different pattern in respect of the division of household tasks, including the wife's undertaking of some of the 'outside work' (mainly shopping) since they lacked close male kin to do this. She described how this had been looked down on and went to great lengths to justify her actions thus underlining their unacceptability. She had only deviated because of the force of circumstances. Her action seemed to have led to a reciprocal greater involvement of her husband with the children and home, and they declared that they had become closer as a result of this.

Where sisters lived together, household tasks seemed to be freely shared and I was told that this was not cause for dissent. However, in one case it did seem to be and there were clear boundaries to co-operation, particularly in respect of the children. The one sister in this case objected to the other asking her son to fetch things for her, and the other sister said she would rather remember her sister as she was in the days before they shared a house. There seemed in this case to be a distinction between the public and the private accounts of this situation (see Cornwell 1984). In another, the one sister was trying to encourage the other to entrust the care of her children to her whilst she went on Pilgrimage to Mecca (Haj). In the third case, however, co-operation seemed fairly comprehensive and although they admitted to quarrelling and making up from time to time, both fed the children when necessary (including the bottle fed but not the breast-fed babies) regardless of whose they were.

The nature of the household and the division of labour within it are shown in Table (iv).

2. The Women's Social Networks.

That most women interacted frequently with others was apparent to me from the start of the work. As mentioned already in Part I it forced a major modification of methodology. The numbers assigned to women in the majority of the tables reflect my original individualistic bias - they correspond to the order in which women, as individuals, agreed to be included in the study. Except where I have felt it necessary to alter the numbers and order of respondents in order to preserve confidentiality (Tables

Table (iv) Nature of Household and Division of Labour

Respondent Number	Nature of Household	Division of Labour
1.	Nuclear family	No male - female role-sharing
2.) 3.)	Joint household. 2 sisters married to 2 brothers (kin) and children of both. No elders.	Minimal male - female role-sharing Tasks shared between sisters to some extent.
4.	Nuclear family	Minimal male - female role-sharing.
5.	Joint household. 2 sisters married to 2 brothers (kin) and children of both. Father-in-law present.	Minimal male - female role-sharing. Task shared between sisters.
6.) 7.)	Joint household. 2 sisters married to 2 brothers (kin) and children of both. Parents-in-law but mother-in-law temporarily absent.	Minimal male - female role-sharing. Tasks completely shared between sisters.
8.	Nuclear family	Some male - female role-sharing if wife ill or absent.
9.	Nuclear family	No male - female role-sharing except in wife's ill or absence (very rare).
10.	Nuclear family	No male - female role-sharing.
11.	Nuclear family	No male - female role-sharing unless wife absent.
12.	Nuclear family	Some male - female role-sharing.
13.	Nuclear family	No male - female role-sharing.
14.	Nuclear family but brother-in-law and father-in-law on extended stay.	Minimal male - female role-sharing.
15.	Nuclear family	Some male - female role-sharing, quite marked.
16.	Nuclear family	Minimal male - female role-sharing.
17.	Nuclear family	Reciprocal male - female role-sharing, quite marked.

(ii) (iii) and (vi)), I have retained these numbers because this retains the comparability between this report of the data and other previous ones (Curren 1983a; Curren 1983b). However, this ordering obscures the women's social groupings. Table (v) therefore retains the numbers but sets them in a different order so that the groups become clearer. Although the majority of women belonged to networks, I became involved in only four of these to the extent that I regularly met with members of them who were not focus respondents. I shall start this description of the women's patterns of interaction from my own experience of them, and from a description of the physical arrangement of houses which was a critical factor.

I first became involved with a network of women (Network A) whose houses were in two adjacent and parallel streets, backing onto each other with a space between the backyards of each side. This space was quite large and constituted semi-public space. Husbands used front doors which did not lead onto it. Wives used the back rooms (in all cases a kitchen) the backyard and backgate. Not all the houses were owned by Pathans, but the use of the backs by non-Pathan men did not constitute a problem for the women who needed only to observe purdah in respect of fellow Pathans. Respondent 1 belonged to this group insofar as her elder sister was a key member. When she first came to England, this girl stayed with her sister. However, her husband then bought a house the other side of town where they had some kin, although those women were older. She continued to visit her sister often but needed her husband's help to do so; he was a taxi driver. In her new home, another terrace of houses, she visited some women from her village along the backs of the houses. She longed to go to the park which backed ^{on to} her house but this was a public place. She

Table (v) Women's patterns of Interaction & Purdah Observance.

Respondent Number	Women met her in her home during interviewing		Purdah Observance		Local Network: Presence of kin and fellow villagers		Own kin in Britain	
	Number of Women	Relationship, to Focus Respondent	Degree	Use of Burqa to go out	Existence	Interaction	Location	Interaction
1 before move 2 after move	8 2	sister, villagers aunt, villager	strict	no	yes	daily	sister in net-work, sister more distant.	daily Interaction, fairly frequent.
			Excessive	yes but unused	no but Pushto speakers.	less frequent	brother in Sheffield.	Infrequent visits.
2 3	0	-	not restrictive	no	no but Pushto speakers.	Some contact	distant kin in Britain.	Infrequent visits.
			not restrictive	no				
4	1	neighbour	strict outside locality	yes but not in street	yes	daily contact, little support	brother in Birmingham.	Infrequent visits.
5	1	sister (shared house)	very strict even in street	yes	yes	daily contact	none	-
6 7	1	friend	not restrictive proprieties observed but free visiting	yes	yes but not in street	Some contact not daily	none	-
			not restrictive due to proximity of network	yes				
8	6	immediate neighbours villagers	not restrictive due to proximity of network	yes	yes	daily contact well supported	sister in walking distance.	frequent contact.
13	1	unrelated woman asking for help	not restrictive due to proximity network	yes	yes	daily contact well supported	in Sheffield & Oldham	Infrequent contact

Table (v) Continued Women's Patterns of Interaction and Purdah Observance

Social Networks	Respondent Number	Women met her in her home during interviewing		Purdah Observance		Local Network: Presence of kin and fellow villagers		Own kin in Britain	
		Number of Women	Relationship to Focus Respondent	Degree	Use of Burqa to go out	Existence	Interaction	Location	Interaction
Network D	10	1	sister-in-law	not restrictive	yes	yes	probably daily contact	English M in Birmingham	none - had rejected her
	11	1	friend - now pathan	not restrictive	yes	yes	frequent contact but little support	none	-
	12	5	Co-villagers friend like a sister. (Pathan)	not restrictive	yes	yes	daily contact well supported high status	Watford & some others in Britain	Infrequent visits
Network A	14	0	-	not restrictive	yes	yes	frequent contact	sister and aunt in walking distance	frequent contact
	15	0	-	not restrictive	yes	no	some little contact with non-Pathan neighbour	none	-
	16	1	fellow villager	not restrictive	yes	yes	frequent contact	cousin and aunt in walking distance	frequent contact
	17	1	friend/ neighbour	minimal - moves outside a great deal due to force of circumstances husband's illness	yes	yes	frequent contact	cousin and aunt in walking distance Oxford	frequent contact

was more restricted in her new location than previously. Also in Network A was respondent 9. She was a woman whose husband dictated extremely strict purdah observance. Not even the proximity of the group who were Pathans (albeit from another village) nor the physical arrangement by which women could visit each other without going into public space affected her patterns of interaction. Her house was marked by boarding erected above the fencing in the back yard. Since she could not visit them, other women could not visit her.

The women of the next network with which I became involved (Network B) lived in a single street, mostly on one side of the road. There was rough track behind the back yards of the terrace and no houses backed onto it from the other side. Women used this back track freely. They also visited members of the network across the street to the front. As most were not only fellow villagers but also close kin, this use of public space appeared to be justifiable. Respondents 2, 3 4 and 5 belonged to this group. However, the first two shared a house and were somewhat apart, being 'true Pathans' from the North-West Frontier while the others were from Chhachh district. The first two women did not regularly visit anyone else in Bradford or seem to have news of them. They were included by the majority of Chhachhis in the street for all major celebrations but informal visiting between them appeared to be infrequent by mutual consent. These two sisters were freer in their external observance of purdah; the younger went to meet her child from school without a burqa. These women saw Campbellpuri Pathans as observing some of the outward appearances of purdah (such as wearing a burqa) rather than more subtle distinctions which relate to 'sharm'. They maintained

superficially cordial relations, however. The other two women belonged to a much larger group of kin of two generations who had settled in the one street. The first (respondent number 4) was a woman whose status position was ambiguous (see below Chapter Ten). As we shall see, she was one of the two focus respondents whom I felt to be depressed. She was however, a firm member of this network in structural terms. I shall discuss below (Chapter Twelve) issues of informal organisation within the networks and informal status, which were more important than overall seclusion in whether or not women were isolated in emotional as opposed to physical terms.

Respondents 6 and 7 were in another part of town, sharing a house. They seemed to have a much wider ranging network in which visits were made to people rather than daily life being lived in the company of others. There were no other Pathans in the street. The fact that they were 'proper Pathans' from the Frontier seemed to lead, again, to an observance of purdah which was freer in an external sense although no less strict in terms of norms of proper behaviour. They knew and had news of many of the leading Pathan families in Bradford.

The third network (Network C) in which I became involved was one which is a famous Pathan area of settlement (Richardson 1976). The houses face onto a square which is apart from the main road, entered through a narrow street. The houses are large - a present dispute continues over whether they should be preserved. The layout is ideal for purdah observance - men gather at the fronts of the houses (in the open square), and children play there. Women use the back entrances and can tap on the walls to call each other. Respondents 8 and 13 belonged to this group but I got to know a large number of others within it. Permission for me to

visit was given by a man who was the husband of neither. It was impossible to visit one person without becoming involved with the group. They were not close kin but fellow villagers. All were Chhachhis but seemed to have news from most sections of the Pathan and Chhachhi communities. Fatima was least easy visiting this group; perhaps because they knew her mother-in-law, possibly due to the key position held by members of this network in Bradford in respect of information control.

Respondent 10 was a member of a network in which I never became involved. Her husband was not keen on our visiting although her English-reared sister tried to persuade them both. My presence clearly exacerbated family tensions and we completed only half the schedule before she refused to see us. She and her sister lived next door to each other and were clearly in touch with other Chhachhi families in the streets around.

The fourth network (Network D) in which I became involved contained two more focus respondents (numbers 11 and 12) and other women whom I came to know. Visiting was frequent although the houses were not obviously conducive to this: set in two streets, access for the women had to be along public pavements wearing a burqa. Two women, although not related, were 'like sisters': one of the few important relationships that seemed to be built on personal preference, although both were Chhachhis and their husbands were friends. Respondent 11 was structurally a part of this network having married a man whose previous wife (who had died tragically young) had been a key member of it. This respondent also lived in the same street. On the basis of this and of distant links of kinship between the husbands, she had to be visited regularly and included in all major events. She was

however, not personally accepted or accorded informal status. She was clearly clinically depressed.

The four remaining focus respondents lived in households which were not obviously part of a communal set up. The first was part of a local network of her own kin - because of the close relationship involved she was able to walk the few streets (wearing a burqa). The second (number 15) seemed to have no contact locally with other Pathans or Chhachhis. There were no kin or fellow villagers in walking distance or in Britain. She had passed her matriculation and was (of those interviewed) the most at home with English people (e.g. health visitor) and appeared to be relatively independent, although she did wear a burqa to go out and rarely did so. The last two respondents were cousins and clearly part of a network of women in the locality whom they visited on foot, having to go 'out' to do so as houses were not linked.

I have summarised these details in Table (v). Additional respondents are also shown on this table since they were members of the women's networks with whom I met during the study whose comments have been included (see above Chapter Four). Their relationship to the focus respondent is noted. They do not necessarily reflect the woman's interactive pattern overall except where I met with a group of women as described. Even then, I might well not meet with a sister who lived a few streets away and was clearly an important part of the woman's circle of relationships, maybe providing more real support, emotionally and in terms of practical help, than those women I did meet.

3. Discussion: Uniformity from without; Differences within.

In this chapter I have described the women's patterns of interaction within the home and outside. Outsiders see only what the women do not do (e.g. they do not visit the childrens' schools, travel on public transport, visit local shops) as characteristic of women 'in pardah'. Despite this assumption of uniformity and its attribution to the factor of pardah observance on the part of these women, patterns of interaction appear to be much more complex and differentiated when viewed closer to. In the next chapters I explore some of the reasons for these differences, using the framework outlined in Chapter One. Firstly I shall look at the women's Concepts of pardah: did they all have the same ideals of behaviour? If not, what factors accounted for differences amongst those interviewed? Was there evidence of change in respect of the ideals held by one individual or group? Next, I shall consider the womens' Options for interaction: what role did different circumstances play in effecting interactive behaviours and pardah observance? Lastly, were other factors important? What effect did individual and group Interests have?

From the descriptions already given, it is also apparent that the implications of the womens' social situation differed for individuals within the groups. Formal structures and rules of behaviour were powerful and might influence what a woman was able to do or who she could and did meet. Within this, there seemed, however, to be differences in the degree of supportedness enjoyed by the members of networks. There were also differences in the meaning and psychological implications of seclusion which seemed to depend on the reasons for it. Overall, seclusion was viewed by the women concerned in a way quite different to the perception of

outsiders, who often condemn the system of pardah. It is important too to differentiate the views of these respondents from those of other Asian groups of women who are less committed to the ideal of pardah than are the Pathans. These issues form the subject of the next Chapters.

Chapter Ten. Factors Influencing Interaction and Purdah Observance.

In this chapter I will consider first the womens' ideals of purdah observance and the influences on these ideals before looking at circumstantial factors which effected their behaviours in this respect. Clearly the general ideal of purdah for all the women derived from the overall Pathan ideology and social structure which was described in Chapter Seven. However, the womens own concepts of womanly behaviour were more various, and after describing areas of consensus and difference in respect of their own ideals, I shall look at the influence of four factors on these: regional/sub-cultural variations; the effect of the women's actual religious observance and identification; the importance of their husbands' views and any influences due to the position of women within their micro-structure of social life within the domestic domain. Even when we have noted differences amongst those interviewed in respect of the ideals to which they each aspired and have explored the reasons for this and marked the evidence of change over time, we shall still be forced to consider next the role played by circumstantial factors in determining behaviour. As we shall see, the Options for social interaction were not equivalent for all those interviewed. Even within a group of relatively homogeneous material resources, the arrangement and location of houses; the prescence or absence of fellow kin and villagers in the locality all effected what was possible. For all women, their position within the wider society as members of a minority ethnic group further delimited their Options.

1. Concepts of Purdah or of Womanly Behaviour.

I shall consider concepts relating to three areas of life: the women's own conduct, dress and demeanour; the division of labour between the sexes and the woman's movement outside the home.

A. The Women's Own Dress and Demeanour.

All wore the traditional baggy trousers and long tunic (shalwar-cameez) with a long scarf (dupatta). Many saw this as a religious matter, but only one had ever worn trousers which would, they acknowledged, be religiously acceptable (as long as not too tight). One other said she would like to do so but wouldn't dare to invite criticism of fellow Pathans. Most mentioned the strong force of public opinion and their ^s husbands' views (often a reflection not of each man's personal preference but of his desire to see his wife behaving acceptably) but when pressed all admitted that the matter was in the end one of their personal identity - they would not feel right in themselves if they dressed otherwise. In this matter we can see the way in which religious rule becomes custom and then personal identity. Norms which are initially religiously (and impersonally) sanctioned, become sanctioned by public and community opinion and eventually internalised. Dress is an integral part of purdah observance; fashions effected the length and style of cameez and of shalwar, but not women's understanding of this form of dress as essential to their self concept as women in purdah.

All the women separated themselves from men, except husbands and close kin, both within their own houses and outside. The use of separate rooms, the avoidance of proximity and eye contact were

all mechanisms for this. Amongst themselves, however, they would observe their men folk and discuss them. I have a lasting picture in my mind of a group of women watching (from behind net curtains inside the house) their husbands buying ice creams for the children. None would have seen it as proper to join the group; all would have averted their eyes and hastened to distance themselves had they come into the same space and all would have seen such behaviours as correctly reflecting womanly demeanour. Separated by curtain and glass, however, they joined in laughter at the scene, and particularly at one man's rather short trousers (shalwar). The ideal of womanly behaviour amongst a group of related women was clearly in contrast to the ideal dictating their physical distance from their menfolk and their demeanor when together with them.

B. The Sexual Division of Labour.

The basic division of labour whereby the husband was responsible for the 'outside' work and the wife for that within the home, applied to all. All husbands did the shopping, paid the bills and most collected the family allowances and visited the doctor on behalf of all the family, as well as working outside the home to support the family financially. Similarly all wives regarded housework, cooking and childcare as their tasks.

Social obligations straddled the two worlds depending on whether the male or female network was involved. So in the case of a death, a husband would visit the husband to offer condolence and the wife would visit the wife. However, the wives did not expect to know the wives of all men known to their husbands. I am not sure how far this worked in reverse - it seemed to depend on the nature of the relationship involved. Since the women's relationships were mainly restricted to the kin and fellow

villager categories, their menfolk would probably also know each other. But men might form relationships in the public sphere in which the wife had no part - thus at Eid time (one of the two major religious festivals) the men might visit freely and their wives not at all. The idea of 'going with them' or of involving the whole family on the basis of the husband's relationship did not seem to occur. To some extent male and female networks seemed to operate separately. In one case the wives of two brothers quarrelled and although the two brothers continued to meet (albeit unknown to their wives) the women and their daughters-in-law and daughters could not (despite a close blood relationship between one daughter-in-law and her husband's uncle's wife). Towards the end of fieldwork Fatima Khan and I were welcomed to a home by women whose husbands would have closed the door in the face of Fatima's husband. Such behaviour seems to depend on the extent to which the quarrel involves the honour of the whole family.

All those interviewed saw this basic pattern of division of labour as natural and right. It applied in broad terms in all cases. As we have seen, there were, however, variations within this pattern. Only in one case was this a variation in the extent to which the wife penetrated the public space. In all others the variation was in the extent to which the husband involved himself in housework and childcare. These differences did not seem to reflect different ideals, however. They were differences in behaviour rather than differences in concepts. Concerning movement outside the home, however, we find differences, not only in the way these ideals worked out in practice for various women, but in the Concepts and ideals themselves.

C. Movement Outside the Home.

To many observers, the wearing of a burqa - the modern version of which is a sort of coat-like garment with veils for head and face - by women in the street is the mark of a woman in purdah. To many in Bradford it is the mark of a Pathan. Yet the woman in my sample who observed the strictest purdah never wore a burqa, for she never went out except by car and then only rarely. In fact it was pointed out by some that the sight of women walking about in veils was a sign of greater, not lesser freedom, as these women might not have previously been able to walk out at all (see also Saifullah Khan 1976: 226 and Papanek 1973: 295). Undoubtedly, concepts of what was appropriate in respect of this aspect of purdah were changing. The important thing for most was that they should not go out 'without a reason' and that their persons should not be seen by men - particularly by those men from their own village or fellow Pathans. Thus for most, short journeys on foot, wearing a burqa, to the house of a fellow villager for the purpose of offering congratulations or condolence, were consistent with their own Concepts of purdah.

In the last chapter, I described variations in the extent to which women interacted socially and moved outside the home. I shall look in a minute at circumstantial factors that seemed to influence this and, in the next chapter, at the role of Interests. Some differences were apparent however in the Concepts or ideals themselves. For example, in the case of the woman who could not visit even other women next door, using the back entrance as others did, both the woman herself and her neighbours saw this as excessively strict but it was the husband who determined the nature of the observance of purdah. Not even the woman's own brother could alter his views, though he had tried. It would be

on the husband's honour that the behaviour of his wife reflected. It was for him to decide the constraints within which she had to live. The women accepted this and neighbours saw a suggestion that they might 'do' anything to help the woman concerned (for whom they felt pity) as absurd - she had a husband, it was for him, not them. Another woman was allowed to visit women from her village in the same terrace, but not to cross the street or enter a public place, such as a school building (for a language class) or clinic. Her husband was seen as 'strict'. Yet another woman met her children from school, not because of force of circumstances but seeing this as consistent with her purdah observance. Amongst another group, it was seen as permissible for an older woman to cross the street, but not for younger women to do so. This leads us then to consider factors that might have influenced these different ideals or Concepts of purdah.

2. Factors Influencing Concepts.

Four factors seemed of importance in influencing concepts of purdah and ideals of womanly behaviour. Two of these were group factors, one of which related to culture and the other to structure. The other two were factors working at an individual level. Thus there were sub-cultural differences amongst respondents; differences relating to the status of women within the domestic domain (mainly age related); differences in the views of husbands concerning their wives' behaviour and possible differences resulting from the womens' own religious commitment and identification. I will look at these in order.

A. Sub-cultural Variations.

Some Pathans from the Frontier saw the ideals of seclusion as more strictly adhered to amongst Chhachhis (Pathans from Attock district), although they commented that other customs associated with modest behaviour were less rigidly followed; for example discussing taboo subjects in front of children. There was a feeling that they were seeking to be more Pathan than the 'true' Pathans, conforming to the external forms of purdah rather than to its spirit. Despite these internal differences, however, all united in viewing purdah as a vital element in their view of themselves as Pathans.

B. Differences of Formal Status.

Just as concepts of a group or class of people can be seen to reflect their position in the overall social structure of society, so too at the level of everyday interaction, individuals' concepts of purdah and of themselves as purdah-observing-women can be expected to reflect aspects of the micro-structure within the women's networks.

I have already mentioned those aspects of status which might derive from husbands' or fathers' position. Within the women's world, other factors seemed of potential importance, although the first - the woman's stage in the life cycle - was obscured by the fact that those interviewed were all young mothers.

The importance of a woman's age or, more specifically, of her stage in the life cycle, as a determinant of her views of herself and of proper behaviour (what I have termed Concepts of purdah) has been discussed by other writers (e.g. Lewando-¹⁹⁸⁴Hundt). For all the women interviewed, their status as mothers was important. One woman straddled a number of stages in the life cycle - by having married an old man with senior status, she saw herself as

senior to other women who were her step-daughters-in-law. She had a young child the age of her step-grandchildren, however, and she often complained of not receiving the respect due to her. It is possible that her ambiguous position in respect of stages in the normal life cycle contributed to her poor informal status, although other factors seemed more important. It is interesting to note however, that her expectations of others were based on a self-concept derived from her place as wife of a senior man.

Informal status in the group will emerged from the study overall as an important factor in women's mental well - and ill-being. Although it might seem logical to describe it together with aspects of formal status which undoubtedly were of importance in determining patterns of interaction amongst women, I am forced by my data to conclude, that informal status and respect within the group did not greatly affect patterns of interaction, although they did affect the quality of interactions (and frequency to some extent.) Neither personal preferences nor dislikes altered the overall patterns of interactions viewed as consistent with purdah observance. This is perhaps a telling point in respect of the womens' Concepts of purdah. Undoubtedly these reflected both aspects of ideology and micro-structure, but it was aspects of formal rather than of informal structure. The purdah ideal of the seclusion of women from the outside world was modified for most women by the Pathan ideal of community, but, as we shall see, this was a sense of formal bonds between individuals, not a reflection of informal ones. For this reason, I will not describe the various aspects of informal status within the group in this context but later (Chapter Twelve).

C. The Husband's Views.

It appeared to be the husbands' Concepts of purdah and ideals that were important, rather than the woman's own views. This reflects the pervasiveness of the overall purdah ideology and social structure which together determine life so absolutely that the Concepts of most relevance to behaviour are those of the men rather than of the women. It must be said, however, that this was an ideology and structure accepted by the women. All the women were proud of their observance of purdah and scorned those Mirpuris who do not keep purdah (see also Dahya 1981 concerning the effect of Pathan scorn on Mirpuri observance). There was also evidence that ideals held by some of the husbands were open to change due to various factors, including their wives' own perceptions of what was right.

D. Religious Identification.

For most respondents, their religion was fundamental both to their self concept and to their behaviour. Islam therefore structured life within the domestic domain for these Pathan women in ways that were a direct expression of individual and collective faith. We shall see that it directly influenced health Concepts also.

All respondents claimed to pray five times daily and to keep fast in Ramzan. Observations and other remarks made by women confirmed that most did so. It was not unusual to arrive when a woman was praying, had just finished or was washing preparatory to prayer. Many reckoned their times of rising and going to bed by their prayer times. These times vary with the times of sunrise and sunset, so the baby might be fed before or after first prayer, and then similarly at the end of the day. Others did not refer so readily to prayer times and their times of rising seemed

to preclude prayer which led us to question the regularity of this for them in practice. During Ramzan, however, all were fasting when visited. The religious calendar dominated social life, much as the Christian calendar might have in sixteenth century England. Several had been on pilgrimage to Mecca (haj) and many talked of wanting to go. All ate only meat that was killed in correct Islamic fashion (halal) and thus passed as vegetarians in most public places (such as hospital) as they rightly assumed meat and meat products would not be halal. The ingredients of biscuits were discussed and some men had written to a local factory to ascertain that certain types of biscuits were all right for them to eat. (See also publications of the Brighton Islamic Centre on this subject.) I was given a free sample of chicken soup that would otherwise have been thrown away. The care taken in this matter was notable even in those one or two who made no secret of the fact that their religious observance was otherwise kept to a minimum.

Although variations in religious identification were observable amongst those interviewed, these did not seem to relate in any clear way to Conceptual differences. In some instances, greater spiritual awareness seemed to go with less rigidity in ideals of purdah; in others it reinforced 'strict' views. There was little doubt, however, that ideals of purdah and of correct womanly behaviour were seen by all as religiously sanctioned and underpinned. There was also evidence of spiritual Interests as a factor modifying behaviour in other areas (e.g. fasting in pregnancy) and of the direct influence of religious ideology on concepts of health (see Chapter Twenty Three).

3. Options: Circumstantial factors influencing Social Behaviours.

We have seen, above, that Concepts differed amongst those interviewed, so too did the Options open to women in respect of social interaction and movement outside the home. My description of patterns of interaction in the last chapter took as its starting point the women's social networks. These were based on physical factors such as the arrangement and location of houses. This factor, and the absence or presence of kin and fellow villagers (a direct consequence of migration) determined the womens Options. All women were further constrained by racism within the wider society.

A. Arrangement and Location of Houses.

This factor was of such importance that I have arranged the description in the last section on the basis of it. The women who were most free within the constraints of purdah were those whose living conditions were easily adapted to separate living for man and women. Visiting was easy where a terrace of houses shared a back passage and where houses were arranged in a square so that the space in front or behind them was shared and relatively cut off. Fellow villagers moved into such housing areas because of the benefits for the womenfolk. Although the women themselves would not make decisions concerning housing, husbands could be expected to take their requirements into account if they wanted contented womenfolk and domestic peace.

B. Migration and Membership of a Minority Ethnic group.

For the women, their migration and consequent membership of a minority ethnic group were given circumstantial factors of their lives. My interest here is in the implications of these for their

lived lives within the domestic domain and in the ways they affected their observance of purdah in this country.

Migration meant that for many women, even those who were members of large networks within which they interacted frequently with others, many members of their network were absent. Frequently those who were absent were their own close kin. Some women did have a sister in Bradford (even in the same house) especially where both had married brothers. Many had not. None had their own mother living in visiting distance. Most were without the company of elder women relatives and while many did enjoy the freedom which resulted from this, the social functions of such women in the village situation were left unfilled. Thus, after the birth of a baby no-one had the time to make the special halwa traditionally given to the new mother to give her strength (as we shall see Chapter Seventeen). In terms of mental health, there was little fall-back for a woman who was unhappy. In Pakistan she would be able to visit her own kin at least on big occasions, to condole over a death and celebrate a marriage even if they were not close enough to see frequently. A number of these migrant mothers had, by contrast, not even been able to share their grief at the death of their own mothers. And if times are hard, it is to one's own kin that one can safely complain - they will keep purdah with you, i.e. share your sorrow in confidence, whereas outsiders cannot be used as confidants in this way. Thus some women, while not isolated were, because of the different nature of the migrant networks, not supported either.

Purdah does not necessarily lead to isolation but observance of purdah in Britain is different from its observance in the village. Networks exist but they differ in their membership and

these differences may be critical for individual women. Both female kin (particularly elders), and male kin were missed - the latter if a woman's own husband were ill and unable to perform 'public domain functions' on her behalf. In such an instance no male stand-in might be available in Bradford.

In many ways the fact that the women were members of a minority ethnic group effected their purdah observance and life within the domestic domain very little. The encapsulated nature of the Pathan woman's world was brought home to me most clearly by two examples. I asked one woman whether it was not harder to fast in a society where not everyone observes Ramzan. Her reply was a surprised 'But everyone does'. Everyone known to her certainly did. The other incident arose when I had bought some things for a lady from a chemist and she calculated the repayment in £ s d - a currency that has never been in circulation during the time of her residence here. This is apparently typical amongst the women, who never shop in person. Their world is enclosed and cut off.

However, even in the encapsulated world of women in purdah, where few of the values of English society reach, racism touches these mothers. Awareness of public hostility towards them ran deep and it was to them incomprehensible. Apart from the fact that their expectations were rooted in rules of hospitality in face of which such attitudes did not make sense, they could not see that they caused any trouble that would warrant such reaction. Most were very undemanding, full of praise for health and education services, and very wary of complaining as they didn't expect a fair hearing. The abuse these women experienced was all the more cruel for its pettiness: releasing dogs into the private area behind the houses that the children played in (Pakistani children

are on the whole frightened of dogs) - an area that was not public but backed onto the houses; pulling off the womens' burgas as they walked along the street, taunting the children and even hitting them. These attacks were generally not reported to the police but had the effect of further restricting the movements of women already very restricted. One woman could not let her children out to play at all due to the attacks on them - and seven children at home in the holidays confined to two living rooms was nearly driving her mad. (I use the term colloquially but literally too, if depression can be termed as 'madness'.)

Some men reported attacks but met with little encouragement from police and felt further rebuffed and belittled. When this was brought to the attention of higher ranking officers, efforts were successfully made to help, but the Pathans concerned felt this was only because of intervention on their behalf, not due to any worth accruing to them in police eyes. The trial of the Bradford 12 at this very time made the same point that was repeated to me: they will side with the whites, there is no justice for us. Most women were related to one of the 12 and saw their actions in preparing to defend themselves as completely justified as, indeed, did the jury (Pierce 1982, See also above Chapter One). Unfortunately, I was not interviewing at the time of the verdict so don't know how vindicated they may have felt. Probably not very - that month a joker had rung up saying they would put a petrol bomb in the house of an Asian family during the night. Police seemed unsympathetic and advised the man who reported the call to return when an incident had actually taken place!

Thus the women's experiences as members of a minority ethnic

group further defined their situation, collapsing this already encapsulated world in many instances.

4. Discussion. A Missing Factor?

Taken together, difference in Concepts of Purdah and differences in the Options for social interaction explain many of the differences observed in the way in which the women interviewed behaved. It became clear, however, that although observance of purdah (including the circumstances affecting it in this country) explained some patterns of non-interaction, it did not, alone, explain all patterns of interaction.

It was apparent that something led women to overcome their observance of purdah in some instances. Why was it that women interacted with others (even those seen as proper to visit) at all, in view of the emphasis on seclusion? Why did they risk meeting men to receive antenatal and obstetric care but not to attend language classes? Why did some, although not all, overcome their adherence to purdah observance to receive routine medical care though none would attend their children's school parents evenings? To answer these questions, we turn in the next Chapter to consider the role of Interests. As we shall see, some of the Interests which for some women overrode strict purdah observance reflected deep-rooted Pathan ideals as central to both Pathan ideology and social structure as is purdah observance itself.

Chapter Eleven. Interests.

It is usual to consider both the material and the non-material Interests of actors as factors which influence behaviour. While material Interests might be apparent to an outside observer, they are not treated in any detail here, for the reason that there was little reference to them in the women's accounts. In the main material Interests concerned the family overall and were not on the women's agenda within the domestic domain although material considerations did play a significant part in the maintenance of social relations in forms such as the assessment of the value of gifts or personal possessions. Some women surprised me by their awareness of the market value of their homes and would readily assess a person on the basis of their dress, jewelry or other possessions.

At the other extreme, spiritual Interests were clearly of importance, determining far more than the women's religious observance and acting, at times, as a factor conflicting with health advice - for example in respect of fasting in pregnancy (see below, Chapter Fourteen) - or with family demands and responsibilities - for example in going on Pilgrimage (see below Chapter Twenty-Three). Religious practices served as a comfort in times of stress, and women had a clear Interest in these ⁱspiritual benefits, which provided compensations in what was otherwise a hard routine.

There were, however, two collective Interests which emerged most strongly from the accounts as determinants of pardah observance and social interaction; these were the maintenance of social relations and the receipt of health care. Both are of central relevance to this thesis.

1. The Maintenance of Social Relations.

There was clearly a set range of people with whom contact was to be maintained, if at all possible. In respect of close kin, letters and/or tapes would be exchanged if they were in Pakistan, or telephone contact if in other parts of England. Within Bradford, one would expect to visit and be visited by, close kin. For women this involved the issue of whether or not a car was needed and how easy it was to get one. Pathan women never travel by bus. If in walking distance, the journey could usually be made on foot and not even the strictest observance of purdah would prevent mutual visiting between close kin.

More distant kin and fellow villagers would be visited frequently if to do so were easy, less frequently if not. But news would be sought through others of those one might have hoped to visit. Events of great significance such as births or deaths could be seen as testing times and relationships were broken off if someone who should have visited did not do so at such a time.

Parties or celebrations brought large numbers of people together and were much discussed. Two such - both to celebrate the circumcision of a son - took place and were discussed during the fieldwork period. Weddings were rare, as they usually took place in Pakistan and many women had missed the weddings and burials of close kin. But events in Pakistan were nonetheless marked although they had to be experienced at a distance. It was as important to condole over a death or congratulate for a birth of relatives in Pakistan as over such events in the community in Bradford. 'Ghum-shadi' (= sadness and happiness) was the business of the women's lives, wherever it took place, if it affected a

member of their network.

Thus each woman has responsibilities towards every other family member and often every other fellow villager. These mutual obligations to support each other in sorrow and gladness and the complementary duty of knowing about others' behaviour in order to be well informed within your community (as a basis for good decision making regarding the marriages of one's children) all demands that contact should be maintained, by personal visits if possible. For most of the women, such visits constitute a legitimate reason for moving out of the home through public space. They are thus socially sanctioned as well as personally satisfying.

I was repeatedly told that purdah meant that women did not go out 'without a reason'. This reason might be the receipt of health care; more often it was the maintenance of social relations within the group. These social relations had a meaning over and above that which they might have in an English group. Within English society, the importance of the maintenance of social relations is often, in my view, undervalued in an overt sense. It may be that an awareness of their importance in other groups will lead us to question the ease with which they are often dismissed within our own society as somehow more peripheral to life than, for example, career mobility or educational opportunity. For the Pathan women interviewed, the initial 'exchange of pleasantries' was often not a preliminary, but the main agenda. A visit to a friend might be more important than the clinic appointment thereby missed, even for the woman's long term health. Even 'gossip' which has, in our society, a negative connotation, has to be seen in context of the importance of knowing about other families' affairs in order to make sound

decisions about one's children's futures. Maintaining social relations is sufficiently important in Pathan society that there is laid down division of labour in respect of it. For example, younger family members always visit elders at festivals, but amongst women the older women do the visiting on behalf of their younger daughters-in-law. In addition to housework and childcare this was the women's work: the maintenance of social relations. As socially recognised and sanctioned 'work' it constituted, for most of those interviewed, the 'reason' necessary to enter the public domain if only briefly. It was in the interests of the whole community that women maintained these social relations with their kin and fellow villagers.

These relationships were formally rather ^{than} informally structured. They were given, rarely chosen. Friendships might spring up between women who were neighbours, but if one moved away, few obligations bound the two in a relationship which endured, even if the move was only across town. There are echoes here of Jeremy Seabrook's account of Northamptonshire bootworkers early this century: 'When we moved from the street we did not see Mrs. Hawkes for eight years. I thought that enough shared experience bound us to her - for she had been good to us - to allow the relationship to continue, to warrant the journey of no more than a mile at least occasionally.' (Seabrook, 1973:81). I was told of a parallel instance. Such 'extra' relationships might be made and broken off - some were clearly started in the maternity ward - but they were not the stuff of life. If purdah was strictly observed, it would not be deemed proper to visit them - this would not constitute the 'reason' necessary to go out. On its own, friendship or personal choice on the part of a woman did

not constitute such a reason, although a sympathetic husband might take such factors into account. The evidence suggests that women were not as passive in their acceptance of their husbands' rulings to his face as they were to others in their apparent acceptance of his standards. But this is speculation.

2. The Receipt of Health Care.

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'We do not tell our mothers that we see male doctors.'

Respondent.

The clearest example of the way in which group Interests modified purdah observance for the women was in the receipt of health care. This modification was not absolute as we shall see; most of the women were treated by proxy by their GPs. The others, however, compromised their observance of purdah by visits to the surgery. In the case of childbirth all, even those who observed purdah most strictly, chose to be delivered in hospital; thus uncompromisingly entering the public domain. None had even requested a home delivery. Asked why, the answer was always in terms of Interests: the Interests of the health of the mother and the unborn child. As we shall see, the benefits of medical care were valued: in this instance they were the most powerful determinant of behaviour. In the chapters which follow, where purdah observance is seen as a factor influencing the illness behaviour of these women, it is important to bear in mind this reciprocity. Purdah observance was also, in the final analysis, itself determined by the women's Interests in receiving health care. This was most apparent in respect of childbirth itself; the area in which a successful outcome was most highly valued and most directly seen as linked to medicalisation. Antenatal care

and receipt of routine health care were more ambiguous and thus led to modification of purdah observance for some women but not for others.

3. Learning English.

Another collective interest is of importance because of its absence. Many assume that women will have an interest in learning English (see for example, Bhatti 1976). There is nothing in the women's concepts of purdah nor their circumstances which would prevent their learning, provided home tutors were available. A number of women had had home tutors or currently had one. Their discussions of this issue illustrated the fact that this was not an issue which most saw as of importance, however.

Women wanted their tutors to be young, preferably with young children and not too serious. This was important, yet when they did like someone, they spoke of having such a good time they didn't learn anything. One told of a teacher who was recruited by her son to teach his mother, but who made little headway since they gave her plenty of food and her purpose was so frustrated that she stopped coming. The fact of the matter was that while they very much enjoyed having visitors, learning English was not for most a high priority. Some said this directly. 'I know how to cook, clean and care for my children. What more do I need to know?' There were numerous requests for home tutors, which I passed on but had apparently misjudged. One group of women for whom the tutor organiser kindly made special provision were then all out on more than one occasion when she was known to be calling. It may be that requests for home tutors were a sort of

test for me : how much was I prepared to do on their behalf? There was some evidence in retrospect that this was the case.

However, there was also evidence that pressure to learn English came from husbands and children and was not a major concern of the women themselves. Suggestions that television might be used as a means to learning were not met enthusiastically. The overwhelming impression was that in a busy day (and the women were undeniably very busy with household chores and childcare) learning English was rarely necessary. It was necessary for health situations and some bemoaned their lack of ability to communicate with friendly neighbours. Otherwise it was a public domain demand with little meaning in the encapsulated Pathan world. Some husbands talked of the early days of migration before their wives came when they had had to speak English. This was seen as good (since for the men knowledge of English actually was an advantage) but since their community had built up, it was less necessary. One husband was using his free time since becoming unemployed to attend English classes. His wife and family laughed at this. But this man spoke of their helplessness without sufficient knowledge of English in legal situations. With other authorities too they were always dependent on others. If abused they were unable to reply, unable even to know always what was subtle abuse and what not. The hope for the future lay in their children who would know English and thus be able to stand up for themselves. But the women did not see knowledge of English as their passport to anything that was of importance. And in the private domain it was not.

One might see the issue of their children's future as a matter of importance to the mothers such that they would cultivate an interest in the majority culture. Arrangements were made by

schools to facilitate such links. School centres were set up to ease the entry into the school system for children with little or no knowledge of English; liaison teachers have been appointed whose job it is to act as go-between between school and home. Unlike Health Visitors, who have a similar role as intermediaries between the public sphere and the private in respect of health care, liaison teachers have been appointed only to respond to the different needs of immigrant families. Education Welfare Officers do not have as comprehensive a role for the native white family in respect of education as do Health Visitors in respect of health. If anything, education had set up liaison between public and private in the other direction - parents are involved in schools as governors, on parent-teacher associations, and increasingly as volunteer helpers in schools. Yet in respect of non-English speaking families a need has been seen for the institution to reach out. Although knowledge of English on the part of the mother might be seen as in the long-term interests of the children, this was too far ahead to provide sufficient motivation for the women I interviewed. The demands of an average of four young children each are considerable, and many English women become cut off in the early years of motherhood. It is not surprising that these Pathan women, most of whom were illiterate in their own language (though not therefore unintelligent) did not make the considerable effort required to learn a language that was in fact unnecessary in much of their day-to-day living. Moreover their definition of mothering was one concerned more with nurturance of children than with stimulation; there was an expectation that fathers would know about and deal with matters relating to education - in the separate worlds of male and female

created by purdah, this is an aspect of the male world, not the female.

4. Purdah Observance In Context: A Positive View.

Purdah observance is negatively viewed by most outsiders. In my analysis I have had to conclude that while it explains aspects of the women's non-interaction, it cannot alone explain their patterns of interaction which often seemed to be maintained despite purdah observance because of other interests and ideas. Again, a somewhat negative view. The women interviewed did not, however, view purdah negatively. I have left out of the discussion of their concepts of purdah above their overall view of purdah as positive. Thus, I was told of having a baby in the village 'in purdah'; a positive notion of being amongst peers, other women known to you. Many women used the term to convey an idea of confidentiality and trust - one's children could be expected to keep purdah with you (e.g. not telling father that mother had lost her temper); a blood relation might be trusted to keep purdah but not necessarily a co-villager.

Moreover, there is a difference between a recognition of a system's limitations when you are basically committed to it and accept it, and an overall attack on its roots. The women saw the limitations that were imposed on them by living in purdah (mainly the inconveniences, such as being unable to get your husband to buy a backbrush or to consistently get those sort of disposable nappies that fit baby best). But these drawbacks, though acknowledged, were seen as acceptable because the overall system of purdah was so. It removed responsibility and anxiety ('my husband takes care of all that') and they could see few benefits

in so-called 'freedom', or a system where social obligations were poorly defined and often in their view unmet. Thus pardah was seen as protective, and women valued this. The 'shelter' provided was for them real (not just symbolic: Papanek 1973) and they can be seen to have had an interest in this protective aspect of pardah.

It is true that their isolation from society did present deeper problems occasionally, such as for the woman who wished for an abortion but had no access to one, or the unhappy woman with no way of seeking help except through her husband who would not be sympathetic. But in these instances it was not pardah observation that was blamed, but migration which had cut them off from other members of a network within a system of pardah through whom such help might have been sought.

D. Lerner (1964) makes the point that in order to kick against and overthrow the system you know, you have to have a vision of how it might be different. These women had no such vision. They did not know women with greater freedom, except from the films, in which freedom was frequently synonymous with what they saw as sexual licence. Thus their social situation was not one they resented. The only preferable situation known to them was that of their sisters remaining in Pakistan, but even the fact of their forced migration was not overtly resented but accepted as their fate.

The women had a sense of the collective. They were citizens of a community wider than the range of their daily activities, wider even than the overall society in which their own domestic domain happened to be. Family life was prized, yet individuals less missed. A grandfather argued against the nuclear family

system by saying that he would miss his grandchildren if he lived separately from them - yet his wife had been gone a year, visiting other children of theirs in Pakistan and he was quite happy about this separation from his wife. One of his grandchildren had been left with her maternal grandmother in the village as a baby - apart from its mother. The child's mother said she missed her but the fact that she was happy there in 'our place' made it all right. One has to understand the meaning of the family - the deep sense of the wider unit and conviction that Pakistan is 'our place' even if one is temporarily absent, to the extent that being there and with one's own made up for separation from closest relatives. However, most respondents were absent from both close individuals and their homeland and this often led to homesickness.

To separate purdah observance and the maintenance of social relations as distinct facets of overall Pathan culture is to do each, particularly purdah observance, something of an injustice. For the women interviewed, purdah observance was properly viewed within the context of this emphasis on the collective and on social life rather than individuals.

Chapter Twelve. Work, Seclusion and Isolation.

The notions of work, seclusion and isolation will be important in respect of the overall subject of this thesis: concepts of health, and illness behaviours. It is important therefore to consider these themes in a little more detail, both as they emerge from this data and together with other accounts in the literature.

1. The Women's Work.

Other authors draw attention to the need for a 'reason' for visiting and to the maintenance of social relations as legitimate 'work' for women in purdah. Thus Ursula Sharma (1980) quotes Jacobson's suggestion that restrictions on women's movements outside the home 'have the effect of limiting a woman's capacity to form relationships with women outside her own family and thus of isolating her' (Sharma 1980: 232). In respect of her own sample of women (Hindus living in North India) Ursula Sharma concludes, however:

Women are, strictly speaking, true to their own assertions that, they 'do not sit about in other people's houses' in the sense that they do not indulge in purposeless visiting. But there are so many legitimate purposes for visiting that women do in fact, lead a very active social life, in spite of the norms that restrict their appearance and movement in public. In fact it is worth noting that it is a specifically female duty to maintain good relations with neighbours, kin and old family friends through such visiting, and to represent the family at weddings, religious ceremonies and the like.

(Sharma 1980: 234).

In the British context, amongst Muslims, Verity Saifullah Khan (1976) notes that purdah for Mirpuri women means that 'they do not go out of the house more than is necessary' (p.231) and includes visiting friends living nearby as a reason for going out. Catherine Thompson says of those Hindu women she studied 'There is an ideal that women should not leave their houses unless they have some special reason, and visits just for informal chats are frowned on'. (Thompson 1981: 40).

The meetings amongst the Pathan women I interviewed were not seen as 'informal chats'. I did not find a concept of 'informal chats' or 'purposeless visiting'. Certainly any contacts that were viewed thus would not constitute the 'reason' necessary to 'go out'. Amongst my respondents it was the positive importance ascribed by both men and women to visiting between that made it apparent that this was viewed as legitimate 'work' which had value not only for the individual but for the whole community. Women's individual psychological well-being would not have been a sufficient validation even if it could have been proved that visiting was conducive to this, because the collectivity was valued rather than the individual in all matters. Hanna Papanek (1973) draws attention to the mutual dependency which accompanies the 'separate worlds' for men and women that characterises purdah and also says that 'the view of the life which is implied in the use of symbolic shelter is also one which sees individuals primarily in the context of their social units rather than as single individuals, architects of their own fate' (Papanek 1973: 293). Collectivity is also emphasised by Verity Saifullah Khan:

A man or woman must be conceptualised as existing in a

complex network of rights and duties which extend from the central core of his immediate family to a wide set of paternal and maternal kin relations. He or she is not an individual agent acting on his or her own behalf but exists only in relation to family and kin. (Saifullah Khan 1976:225)

It is Hanna Papanek, in another paper (1979) who makes a link which relates the visiting done by women to the concept of 'work'. Her paper is entitled, significantly 'Family Status Production: The "Work" and "Non-work" of Women'. She says that

particular kinds of work that I call family status production maintain and enhance the family's social standing, although they do not necessarily enhance the woman's status within that unit (Papanek 1979 p.775).

She gives three categories of such work- 'support work generated by the demands of income-earning activities by other family or household members' (p.776); the training of children (p.777); and what she calls the 'politics of status maintenance' (p.778) which includes the exchange of gifts and of information and the provision of hospitality. Ritual and religious observances are also noted. The Pathan women I interviewed were involved in each of these and I have noted the importance of religious observance as a source of self definition and informal status within the group. Only the third necessitates movement outside the home, however. That women in pardah continue to do this must therefore mean that it is work that is of great social importance. Hanna Papanek sees status production as a useful analytic construct because, unlike housework which although a recognised category of work, 'lacks analytic power because productivity is hard to define and so many tasks are included' (p.780), status production refers to the latent meaning of work

and clearly defines what is produced: status. I would want to suggest a parallel concept of 'health production work', for women were critical agents of health maintenance for their husbands and children and, moreover, their visiting had a further latent function in respect of mental health for the members of the network. In some cases interactions were of negative value in respect of mental health; in others, positive.

It is not only those whose primary concern is to elevate and understand the work of women who would see such activities as work. Cato Wadel, in an article entitled 'The Hidden Work of Everyday Life' (1979) states that 'the maintenance of neighbourhood and community requires effort on the part of the inhabitants' and notes that

a certain ambiguity is associated with such neighbourly activities as visiting, 'giving a helping hand', or simply listening to the worries of others. At the same time as they are trivialised through comparison with 'real' work activities - and even 'excused' in such phrases as 'Well, this won't do: I must go and do some work' - people get very upset when they believe they are being neglected by their neighbours. Indeed, doctors, psychiatrists, psychologists and other social workers have documented how it is especially individuals who are not involved (either as givers or receivers) in such neighbourliness that are likely to have a precarious medical/mental state of health'. (Wadel 1979: 374)

Cato Wadel goes on to consider why it is that activities associated with informal community relations have not been associated with work. His whole analysis is of interest, but it

is the aspect quoted which relates most directly to the Pathan women's situation. My argument is not only that their activities should be considered as 'work' by outsiders but also that they themselves define it as such. That this is so is demonstrated by the fact that it is sufficiently in the collective interest to constitute a reason for 'going out'.

2. Seclusion and Isolation.

It will be apparent from the description of the women's lives that community, seclusion and isolation are all complex. Simple causative links cannot be drawn. It seems best to distinguish the women's actual patterns of interaction from the supportedness of their situation. The fact was that I found two opposite instances which belied any simplistic link between seclusion and isolation/distress. At one extreme was the most secluded of the women - secluded from the public sphere and most secluded within the private. Although she admitted to feelings of loneliness and homesickness, she was supported within her physical isolation by a sense of community to which she belonged by virtue of the fact of her seclusion. There is a sense of belongingness and identification in conformity when this is believed to link one with a moral community. To the extent to which the overall pardah ideology defined her own self-concept, she could feel supported in her situation. By contrast, much of the concern regarding secluded women in Britain relates to women who do not have this strong sense of personal identification with the institution of pardah. Of course such a woman is vulnerable - an ideological community is less supportive in trouble than an actual interactive one. I cannot say to what extent the long term reality was in

fact supportive. As an ideal type, however, a number of women's situations demonstrated that such a position is not only possible but some seemed to approach it. Another vulnerability factor in a situation of extreme seclusion is the husband and wife's mutual dependence. Although this dependence is mutual, it is the woman who is the more vulnerable if interpersonal relations between them are not good. It is not in his insistence that she observe strict purdah that he is the oppressor (she may endorse this view), but in his treatment of her within the home. Amongst other women who were isolated (due to a lack of kin or fellow villagers in the neighbourhood combined with purdah observance which, although not strict, precluded casual contacts), a strong emotional link seemed to have built up between husband and wife such that these women were well supported within the home although isolated to some degree from other contacts.

At the other extreme are the women who are not isolated since they belong to strong networks and interact frequently with other women. However, two such women were not personally supported. The reasons for this lack of support seemed to be to do with informal status within the group; a factor not so far considered.

Homemaking and childcare were expected of a woman and taken for granted. Her obligations to husband and children would be met even on her death bed. They were not therefore factors on which informal status was based. Some degree of external responsibility could be referred to in respect of failure in connection with these basics - a husband might have little money and some children might be 'naturally' ungrateful or disobedient. On the other hand, such factors as skills in dressmaking and pride in her

family's appearance; her personal devotion; and her interpersonal skills were seen as all the more admirable because they were not taken for granted.

The women who were not accepted both had high status overtly being married to men of good standing in the group. They were second wives, however, replacing women who had died who had been close to the other women in the network. Their presence was resented; they were poor substitutes for their predecessors. Structurally a woman likely to be given in marriage to a man who had been widowed (and in one case was much older) might be expected to have defects that had precluded a more desirable match being arranged for her. Both had. One had herself been married before and been widowed; the other confessed to having a reputation as something of a simpleton.

Entry into an established group of women in a new country without the backing of one's own kin is not easy. Neither were given the chances to settle that might be given to a young bride entering such a situation. One could argue that Interests had little to do with their lack of acceptance; that the situation was against them from the start. It was the other women's Interests in excluding these women that perpetuated the situation, however. The contrast between the obligation to include these women and visit them and invite them, and the ridicule to which they were subject within the group was marked. One had curry 'accidentally' thrown at her at a party, the other found women 'out' when she called and was talked about in her own home while she prepared tea. Members of their networks were women who were in other contexts compassionate. In one case, they talked freely of their own struggles and unhappiness and the need to support each other. Suggestions that the unaccepted women were unhappy

and an attempt to explain their unacceptable behaviour on this basis were not met with agreement, however. It was the women themselves who were seen to be at fault and intrinsically unacceptable.

The group was sufficiently important that a lack of informal status led to a situation where members would be unlikely to become close to a member who was poorly regarded in the group as a whole. If a person was not acceptable by other group members, it would not, in the extreme, be in any woman's interests in terms of her own status to be sympathetic towards her.

These women were not isolated in a physical sense. They were, however, emotionally unsupported. The only sense in which they were isolated was from their own kin who might have offered emotional support.

Concerning seclusion, we need then to ask, 'from whom?'. All were secluded in a broad sense. What was their actual pardah observance - what did seclusion mean for each of them? True, for all it led to isolation from the public domain, from casual contacts. But most were not disturbed by this. For some it led to isolation in a daily sense where no visiting or mutual interaction was possible. This was often accepted. There might be support, either at an ideological level or in the knowledge that their lack of contacts was due to external factors, (e.g. no close kin or villagers) and could therefore be accepted as Fate and coped with in the way in which women coped with other adverse circumstances. There were also those, however, who were unsupported although in almost daily contact with other women. Only a few of the women spoke of wanting to make relationships beyond the circle of permitted kin and fellow villagers within

which interaction was sanctioned. The group within which interaction was possible (if one existed) was a strong one, offering a high level of support to those members well accepted within it, but from which a person with little status could not escape and to which she had no real alternative source of such support. This contrasts with the situation of many English mothers in which they have many superficial contacts but few close friends and in which there is the opportunity to interact as one chooses but no immediate access to any defined group. Again, it cannot be assumed that patterns of interaction or non-interaction and degrees of supportedness are related in a simple causative way.

3. Conclusions.

Purdah observance is a complex set of behaviours. In terms of life within the domestic domain it can be worked out in a variety of ways. The facet most apparent to an outsider is the way in which women are limited to the domestic domain. This facet in itself is only perceived as restrictive by the women when they would wish for access to the public sphere. This they might do if purdah observance was externally imposed, for example, in the case of Pathan girls brought up and educated in Britain, or of other groups of Asian women for whom self identification is less bound up with purdah observance. These factors did not apply to my respondents but this does not deny that they would apply to other groups and that it is representatives of such groups who would see purdah as inevitably restrictive and restricting. My respondents wished for access to the public sphere only if things 'went wrong', if husband or fellow villagers were not supportive.

This study did not lead me to the conclusion that simple links could be drawn between a social structure characterised by the seclusion of women and depression or even a sense of psychosocial isolation on the part of the women who were secluded. Questions had to be asked concerning both the way in which the overall ideology and social structure worked out in practice and its consequent implications in terms of daily life and also about the meaning of seclusion for those involved. This then brings in the issue of other key societal values and ideals, in the context of which seclusion was understood by those concerned.

PART III. THE WOMEN AS MOTHERS.

ثومرة لوع مال وي دومرة بر حال نشي

The greater your wealth (of children), the worse your health.

(Proverb quoted by Respondent.)

For the women interviewed, mothering was a central feature of their lives. The last Part discussed other aspects of their social situation and their work. Deliberately, however, I left out of that description and analysis the feature of their lives which contributes most to the women's own status amongst peers, and to their self definition and which has most implications for their daily lives. Child-bearing and rearing was, for all, the 'business of women'; children were described as their 'glory', their 'wealth'; yet also, (as evidenced by the proverb which heads this Part) a direct drain on the women's own health. Child-bearing and rearing are both normal and routine events and situations but also of major importance and, in the case of childbearing, life-threatening.

Consideration of the women as mothers has central importance and significance in this thesis overall for a number of reasons in addition to its importance for respondents.

a) Insofar as mothering was, for all interviewed, their major preoccupation, demanding more time and energy in their everyday lives than any other activity or concern, it constituted a predominant life experience for them. As such, we could expect it to be stress and satisfactions in this area of the women's lives that contributed largely to feelings of mental and emotional well - and ill-being. I have already expressed my belief that both experiences of distress and concepts of health and illness are rooted in everyday experiences. It was one of the starting points

of this work that migration might have made childrearing particularly stressful for the women involved in the study. This data will therefore relate both to mental state and to Concepts of health and illness.

b) The material relates directly to interactions with health workers. It is in respect of mothering that women have most routine contact with health services. Indeed, it is an area of considerable interest in terms of these interactions because it is one where there is movement, in both directions, between public and domestic domains. Thus women are drawn out of their homes to receive ante-natal and obstetric care and health workers come into the home to check and monitor the progress of children. These routine interactions with health services and workers may predispose women to seek treatment for other disorders (perhaps including mental ill-being) or not to do so. The data can be expected to show up differences and similarities in the Concepts of the women and health workers. Insofar as areas of conflict emerge in their interactions with each other, these may point to different conceptualisations or interests. The data also tells us something of the women's expectations of health services and vice versa.

c) The area is of importance both for practitioners and in relation to some key themes in the academic literature. For practitioners and policy makers in health and education services, mothering presents a critical paradox. Birth and the early years are recognised by all schools of thought as critical to later health and development in terms of individual achievement and mental health. They are, however, largely outside direct state control. There is therefore widespread criticism of, and interest

and investment in, the behaviour of those responsible for the bearing and rearing of children: usually mothers. To the extent that many of a woman's activities in respect of child care are increasingly seen as 'health work', some regard mothers as 'unpaid health workers' (Stacey 1984). Others view mothers as either co-operative or non-cooperative consumers of health care. Either way, the importance of the issue is not disputed.

For academics, mothering is a critical arena in the debates concerning medicine as an institution of social control; medicalisation and male dominance. The redefinition of traditional 'women's work' concerning the bearing and rearing of children as areas of life in which medical (usually male) expertise is necessary, and the consequent devaluation of women's own experiences is a topic of central interest for feminists (e.g. Ehrenreich and English 1979; Oakley 1975, 1976). Other authors see coincidences of interest cutting across or underlying the conflict between mothers and doctors (e.g. Arney 1983; Cornwell 1984) such that conflict is not inevitable; for Jocelyn Cornwell, the very separation of the concepts of the parties into two 'sides', suggests a dichotomy which was not found in a clear cut way in the accounts of her respondents (1984 esp. pp. 18-20).

On a number of counts, then, the subject matter of the following chapters is of importance within this thesis overall. Each chapter describes respondents' behaviour and experiences in relation to one of four areas of mothering; conception (and contraception); pregnancy; delivery; and child-rearing. Because of the ongoing importance of the last area in terms of women's everyday experiences, two chapters are devoted to this latter topic. A final Chapter draws together the themes in relation to the women as mothers. In each area, my aim is to draw out the

women's Concepts and to show how these differ from both medical and maternal perspectives dominant in Britain. I also look at the services and the women's experiences of them, and at other Options, from the women's point of view, and the extent to which migration can be seen to have changed informal support systems. I will seek to discover the women's individual and collective Interests in these areas of their lives.

In this way the data will relate to my analytic framework, (see chapter one), illustrating the use of the three key variables: Concepts, Options and Interests and showing how these did in fact emerge from the study. My purpose in all this is to shed light on a series of questions, some of which are thrown up by the literature, others by the respondents' own behaviour (as described in the last Part and as they emerge in the accounts themselves).

Questions raised by the literature mainly concern the compliance or non-compliance of minority ethnic groups with medical services, and reasons for this. The tendency of medical writers to view mothers as either co-operative or non-cooperative consumers is especially marked in respect of minority ethnic groups, who are variously condemned or wooed for their apparent reluctance to fully take up services on offer (e.g. Lumb et al. 1981; Beard 1982; Abraham 1982; Clarke and Clayton 1983; Veitch 1983). Groups which represent black people criticise such writings for the lack of attention paid to the services themselves, particularly those aspects of them which discourage Asian and Afro-Caribbean people from using them (e.g. Brent 1981; Homans 1982; Donovan 1983; Winkler 1983; Training in Health and Race 1984). Studies which focus on Asian culture and habits

without questioning racist practice in the health and education services are seen as furthering racism.

Other workers draw attention to the importance of class factors, arguing that lay concepts of childrearing and motherhood vary with class (working reports of Joan Hughes (1980) and Christine Buswell (1980) to Child Health Project Group, University of Warwick) and also that attendance statistics tell a different story when adjustments are made for age and class (Pearson 1983), showing immigrant groups to be in line with English people of the same social class.

Thus the literature raises questions concerning the importance of cultural and structural explanations in seeking to understand take-up of services. In the descriptions which I present of women's experiences and behaviours, I shall draw attention to these factors and their interaction as well as exploring the extent to which women's own Concepts and negative experiences of services (where such exist) deter them from future usage of services.

As described so far, the women's behaviour itself throws up questions which need exploring. It is clear from the last Part that receipt of health care can constitute a 'reason to go out'. Questions remain, however, concerning which forms of health care constitute such a reason and which do not and the reasons for this difference. These will be explored in this Part and the next.

Chapter Thirteen. Conception and Contraception.

1. Overall Ideology concerning Child Bearing.

Bearing children was positively viewed by all interviewed in overall terms. Children were described as the 'gift of God'; 'the business of women' and their mother's 'glory', or 'wealth'. It was clear that this dominant view included a sense of it being in the mothers' own Interests to have children. All saw it as a tremendous sadness and shame for a woman to be barren. Bearing children was clearly not viewed as optional.

Alongside this overall ideology ran another view which might be described as the women's experiential view of children and their effects on her - this view contained positive and negative aspects. On the one hand, children were seen as entertainment and company for their mother: women often said they would 'have another (baby)' if they were lonely or bored when older children went to school. On the other hand, children were seen as a source of work and worry for their mothers; thus a neighbour who had been sterilised was described as 'without worry' (of another pregnancy/baby).

2. Concepts of Contraception: Process and Change.

Whether to have children was not for any respondents an issue, so strongly did they all subscribe to the overall ideology. How many children and how often were, however, topics of discussion. In this discussion, it is possible to see a process of changing norms and concepts about contraception, in which

women's own experiences played a major part. This issue provided me, more than any other, with an illustration of the way in which Concepts are themselves complex and changing.

The starting point of the debate was always the Islamic view. Insofar as children were seen as the gift of God, there was a tendency to see all attempts at contraception as wrong, even pointless. I was often told that if God wants to give children, He will - they will 'come out of the earth'. There was a further view that God might punish you for attempting to prevent childbearing. However, Islamic scholars do see contraception as justified if it is to save the life of the mother or to enhance the quality of life of the child. The problem, at all levels of scholarship, is to define such overall principles in real terms. Respondents and their husbands debated the boundaries of the ideal Islamic practice no less vigorously than the most learned scholars. It was clearly of great importance to them that their individual practice could be seen to derive from their religious beliefs.

Discussions of religious principles were not, however, abstract debates. The women's own experiences, and those of their family members and friends were the material in terms of which the principles were thrashed out. There were tales of women who had used contraceptives straight after marriage and were then unable to conceive; the group view was 'she shouldn't have stopped it at first, now God won't give her any'. There were tales of mothers unable to care for too many children. There were accounts of the pros and cons of the various contraceptive methods. Reliability, side effects and discomforts were discussed and weighed up. These were not 'old wives tales', but based on first hand experience;

there was account taken of the fact that individual reactions vary. Some women had an ideal completed family size as their guide; others were just concerned to space children. Experiences were therefore the substance of the discussion of ideals and working out of Concepts. They were the clay moulded by ideas insofar as women would prefer to discuss principles in the context of an actual situation. They also provided fuel for the discussion, turning it this way and that, as group members had new experiences and brought them to the group.

It should be noted that these included experiences of health care encounters. My conclusion was, therefore, not only that health care behaviours were interactive but that concepts themselves were changed by health care interactions, although this was only one of a number of possible factors in the debate. Certainly the fact that women were repeatedly challenged by health workers concerning their contraceptive intentions (this is routine before a woman leaves maternity hospital following delivery) meant that the issue was constantly before them as a group. I am not implying that the women had a greater tendency to practice contraception as a result of these interactions (although this may well be so overall) - some experiences were negative. The process was complex and it would be hard to predict the effects of any one factor at any point: the point of importance is, however, that concepts were not fixed or predictable entirely on the basis of an awareness of the religious parameters of the debate, essential as such an awareness would be for anyone attempting to discuss the matter. Overall trends might be discernable, but there was no 'Pathan view of contraception' that would appear to have validity apart from this process of continual discussion and renegotiation.

3. Contraceptive Options.

The women's actual behaviour was of course based on the availability or otherwise of contraceptive Options. Contraceptive advice is available under the National Health Service, and equipment or drugs are supplied free of charge. Leaflets are available in the languages of minority ethnic groups. For these women the nearest applicable language is Urdu. There are no leaflets in Pukhtu but it would be no advantage if there were. Although there is a literary tradition in Pukhtu (see Ahmed 1976) a majority of contemporary Pathans do not read or write Pukhtu, but Urdu, the national language of Pakistan.

Generally speaking, there is unlikely to be a problem in obtaining contraceptive advice and guidance once women reach those responsible, although the nature of that advice may be biased towards control of fertility at all costs. A report by Brent CHC (1981) speaks of the 'preoccupation with the control of black fertility' (p.22) saying that 'more leaflets have been produced in Asian languages on birth control than any other topic', and 'getting black women to reduce the number of children they have, is often seen as more important than any anxieties they may have about the methods available' (p21-22). 'Black woman have also for some years felt that they are offered abortions and sterilisations much more frequently than white women' (p.22). Whatever this says about racism within the Health Service (and it says a great deal) it does mean that there were few barriers to my respondents' receipt of contraceptive facilities within the public domain. Characteristically (for they were women in a purdah society) the barriers were for them nearer home.

The critical issue for these women governing the availability of contraceptive devices was the degree to which the various measures were within or outside their own control. Use of the sheath is up to the husband. Some husbands chose this method, in which most wives concurred, though one wife was concerned about reliability. There was one husband who would not use it despite his wife's wishes. He wanted her to take the contraceptive pill. In respect of the pill, the opposite applied - this was in the woman's control. One was taking it against her husband's wishes; one refused to do so despite his wish that she should, and another two were interested to do so but not prepared to go ahead without their husbands' agreement. During the course of the study, their husbands did in fact agree to this, having changed their views concerning which methods were religiously acceptable.

Sterilisation was the most controversial of all issues. It was least acceptable in religious terms for both men and women. Women's Concepts seemed more strongly influenced by practical considerations than the men's, however. While both might agree that danger to life was a criterion and even that quality of life for the children was important, the dangers of childbirth were more apparent to the women and the reduced quality of life from too many children likewise. However, sterilisation requires the formal consent of both partners. It is only obtainable within the public domain and by the woman in person. Male sterilisations were never discussed as an Option.

Another method of birth prevention must be mentioned. This is self-induced abortion. Five women mentioned having tried to abort a child, two with their husbands' consent. It seemed as if abortion in the early months was a practice to which the women might have had recourse in Pakistan. There is an Islamic belief

that life enters the foetus on the 40th day (Pakistan FPA, undated). Before this time, therefore, the women did not see such attempts as religiously unacceptable. Many saw the 'hot' tablets that they were given by the G.P. to confirm pregnancy as being given to induce an abortion (since they confirm it by bringing on a period if the woman is not pregnant, this is not an unreasonable deduction). One took an overdose of these to induce abortion when the stipulated number failed to work. Another woman spoke of a local woman with special knowledge of these matters who had previously been an untrained midwife (dai) in Pakistan and had helped her in this way before. Self-induced abortion as a method of birth prevention had the advantage of being permanently available (although of doubtful success) and completely within the women's own control. Official abortion was, however, another matter, requiring both the husband's cooperation and consent. It was impossible for most women to even discuss this with health workers as their husbands were likely to be present. While contraception was a valid topic for discussion, abortion was usually not. One woman pleaded with us to help her to abort a child although she later seemed ashamed of this and acted as if she had not done so.

4. Interests

Overall shared Interests were in the conception and birth of healthy children. Economic interests seemed to work both ways. Thus in the long term, a large number of children would be in the family's interests although they might be a short term economic liability. Girls would be an economic liability in the long term

also. The families therefore had an economic Interest in the birth of sons but since this was not possible to predict or determine, one had to take the risk. Mothers had an Interest in the birth of daughters, but this was emotional rather than economic - they were seen as providing companionship as well as practical help to their mothers. One might postulate that the situation in Britain (high unemployment, free education and health care) would, at least over time, alter the perception of economic Interests. As I did not ask directly about this, I am unable to comment on whether this seemed to have occurred, however.

The women's own Interests were complex. Their self-concept was tied to their role as mothers and they undoubtedly shared the overall communal interests in having many healthy children. However, the effects of these children on them in the daily situation also influenced their Interests: what I called above the women's experiential view of children. As I have said, this worked both ways; women had an Interest in rest from continual work but also in the company and enjoyment provided by young children.

I am not here suggesting a model in which individual and collective Interests can be separated out such that one can speak of what the women themselves 'really' wanted as opposed to what they were supposed to want. I find such a model (which seems to underlie a number of feminist writings) inadequate even for the analysis of women in societies which are predominantly individualist. In the Pathan situation, in which the women's self image was deeply rooted in a sense of the collectivity and their identities, as well as their Interests, clearly bound up with their families, this did not apply. This issue is not one of personal interests vieing with those of a dominant group or of the

Table (vi) Contraceptive Practices and Views

As at October 1981. According to Current Contraceptive Practices. It should be noted that the order in which respondents appear in this Table does not correspond to that in other Tables.

<u>Views</u>	<u>Attempted Abortion</u>
<u>Those using no Contraceptive Measure at the time of Interview</u>	
Recently married. More children wanted.	-
No views expressed. More children wanted.	-
Previously used sheath. More children wanted.	-
Marital disagreement. Husband in favour of contraceptive pill. Wife wanted husband to take precautions.	Yes, with husband's knowledge.
Marital disagreement. Husband wanted a further child. Wife did not, wanted sterilisation. Husband refused permission on religious grounds.	Yes, without husband's approval. Ashamed of attempt but had been 'desperate'.
Husband and wife in agreement that contraception was against religious principles if the only reason were to give wife more rest.	-
Pregnant at time of study.	-
Pregnant at time of study. Family seen as complete. Wife to be sterilised. Husband had previously refused permission for this.	Yes, on several occasions against husband's wishes.
<u>Those using the sheath 'the rubber'</u>	
Exploring other options, except sterilisation. Family seen as complete.	-
Previously used contraceptive pill and sheath.	-
Successfully spaced family. Family now seen as complete.	-
Concerned about reliability of this method. Would not consider sterilisation.	Yes.

Table continued

Table (vi) continued

<u>Views</u>	<u>Attempted Abortion</u>
<u>Those using the Contraceptive Pill</u>	
Seen as religiously acceptable to space children. Husband had previously not allowed any contraceptive practices, on religious grounds.	-
Seen as religiously acceptable to space children. Husband had previously not allowed any contraceptive practices, on religious grounds.	-
This was against her husband's wishes.	-
<u>Use of the cap</u>	
Coil to be fitted soon.	Yes, without husband's consent.
<u>No details of current practice given</u>	
Was taking the contraceptive pill, but not at present.	-

collectivity; it did however, seem that the experience of bearing, and rearing, young children added an additional dimension to the women's views - one which often led them to prefer to curb their family size. Many found a large number of children just too much: there was a growing consensus that an overall four or five children was enough. Others saw their own tiredness and need for a rest between births as sufficient reason to space their families. Although their experiential reasons for these views were acknowledged, they were not usually the terms in which they were argued. Women's Interests seemed to affect the choice of experiences to be fed into the debate concerning contraceptive practice, however.

5. Discussion.

The contraceptive practices and views of focus respondents are shown in Table (vi). A number of the additional respondents and one focus respondent had been sterilised or were about to have this operation. Moreover, sheaths were currently used by four of the husbands of the 17 focus respondents and had been previously used by a further three and preferred by an additional one although not by her husband. The most common practice was the use of no contraceptive at the time of interview (eight respondents). In three cases this was due to a wish for another child, in one to indecision or disagreement over method, in a further one to disagreement between husband and wife concerning the wish for another child and in another to the view of both that to prevent conception was not religiously acceptable. Two women were pregnant at the time of study. Of the remaining nine couples the

sheath was currently used by four; the contraceptive pill by three; the cap by one and one would not give details of current practices. As in the case of the sheath, the number favouring the contraceptive pill increases when we take account of previous as well as current practice, as two further respondents had used this method. Comparing this with other published data, there are marked similarities to findings reported by M. S. Zaklana (1984) investigating the practices of 105 Asian women in Leicester. Patricia Beard's study of four main immigrant groups in Bedford (1982) offers some contrasts, however, mainly in respect of the popularity of the sheath (not found to be popular in her study) and the acceptance of sterilization (not used by her respondents) amongst Muslims. Both these studies start from a belief in the desirability of educating Asian families in respect of family planning, although M.S. Zaklana bases his suggestions on the respondents' stated preferences while Patricia Beard assumes a preference for smaller families on the basis of her own perceptions of the 'real' interests of the families concerned. I find her analysis questionable for this reason.

Although it is of interest to compare the details of my findings concerning contraceptive practices with those of other writers, my own concern is not primarily with those details, but with Concepts and their effects on behaviour. Two main points emerge from my study in this respect. The first concerns the process of development of norms of behaviour and Concepts and the part played in this by group experiences. This has been described.

The second is an issue which will be drawn together in the conclusion to this Part (Chapter Eighteen) since it emerges from all sections: it concerns the nature of the women's Concept of

motherhood which, I shall argue, contrasts with at least one dominant concept to be found in Britain and the West (Badinter 1981; Dally 1982).

Issues of conception and contraception inevitably relate to issues of being a mother. As Hilary Homans argues (1982), becoming a mother has different meanings for women depending on social class and ethnic background. For the Pathan women I interviewed being a mother was an ideal but also a normal state. It was an inevitable reality for most mature women. It was not optional; it was not in any way rejected but neither was it idealised. It led to work, but not to conflicts or guilt. It brought sorrow and joy. It was the fact of being a mother that gave a woman status and value. Being a mother was a passport to secure membership of the group of married women. It was security within the family unit. Questions surrounding conception concerned not whether to have children but how many and how often. For a woman there was simply no other acceptable fate than being a mother.

Chapter Fourteen. Pregnancy and Antenatal Care.

Pregnancy is a condition of a woman; antenatal care is a service offered to her in Britain. From a medical perspective, antenatal care is often seen as the window on pregnancy. Hilary Graham and Ann Oakley say that, for doctors, 'pregnancy means entry into medical care as an antenatal patient' (Graham and Oakley 1981:53). This is contrasted with the mothers' view in which pregnancy affects 'her occupational standing, her financial position, her housing situation, her marital status and her personal relationships' (Graham and Oakley 1981 :54). Despite the medical view of antenatal care as a indicator of pregnancy behaviours, receipt of antenatal care is only one of a number of behaviours which is specific to the period of pregnancy.

1. Behaviour during Pregnancy.

A. Awareness, Announcement and Discussion of Pregnancy.

None of the women I spoke to had told their mother or mother-in-law in Pakistan that they were expecting a baby although all sent tapes or letters containing news regularly. Some of these grandmothers-to-be had found out because neighbours visiting Pakistan told them - most only knew a child had been expected after it was born. Pregnancy, however obvious, is not to be discussed in front of children or one's elders, even women, unless they bring the subject up. Indeed, it seems to be a subject that is not much discussed at all. This was not because of lack of recognition.

Most of the women, and in many cases their friends too, were aware of the timing of their menstrual cycles (since menstruation

renders the woman unclean and so unable to pray, it is observable within a close circle of friends). A late and then missed period was the usual sign recognised, though many spoke of sickness familiar from previous pregnancies.

Most then told their husband - and some a friend. The husband then reported to the doctor either after four months or so to get the woman started on antenatal care, or at once if there was a problem such as sickness.

Pregnancy was one of the terms for which the translation team had difficulty in finding an adequate translation. The most commonly used term of which I had been aware in Pukhtu meant literally, hopeful, expectant (umedwara), but this was not a term familiar to either Fatima or Dilshad Khan. As discussed in Chapter Three, the terms preferred by individual members of the translation team varied on the basis of the sex, medical status and race. Overall I was told by respondents,

we hide it as much as possible. We feel sharm (shame, embarrassment) in company. We try not to stand straight, we pull our dupatta down. We won't tell brother, uncle or father (that's laid down) but we're also shy. We can talk about it amongst ourselves - to friends and sisters. Later when we can't hide it, mother and mother-in-law ask, but we can't mention it first to them.

There were slight variations in norms - one woman said a mother-in-law could be told but not one's own mother, another told her mother. One told a friend but not an older sister. Some were very 'shy' and told no-one except husband. But none declared it in words or demeanour, even when it was a most welcome first pregnancy.

This contrasts markedly with the behaviour of most English women, although there may be class variations here. In England, the dominant pattern is of excited discussions; Buckingham Palace makes a formal announcement in the case of the Princess of Wales; women's magazines subsequently discuss a royal pregnancy endlessly. On a more lowly scale, 'congratulations on your good news' cards are coming on to the market. The birth of a child is increasingly seen as part of a process which began with conception. Mothers of still-born children and those who have miscarried argue for the recognition of their distress as bereavement. In practical terms, the announcement of a pregnancy is necessary to procure release from work for maternity leave where the woman is in employment. It entitles a woman to free medicines if she obtains an exemption certificate, and free dental care too.

B. Preparations for the New Baby.

Amongst the Pathan women I visited, preparations for the new baby were not, on the whole, made beforehand. Toiletries were brought by the husband usually while his wife was in hospital for the delivery or even afterwards. Clothes for the new baby were given by family and friends after the birth. Names were decided after the delivery, often some time after.

Again this contrasts with expected behaviour amongst English mothers, who are seen as spending the seven months in which they know of the expected birth, planning and preparing for this; decorating a spare room as a nursery, laying in clothes, choosing a name. Medical literature given free to all women at antenatal classes and clinics reinforces this, one suggesting a schedule for the preparations and possible names for the infant and another incorporating an independent guide to baby products. (The Health

Care Foundation in association with the Royal Society of Medicine 1978). Actual behaviour may not be in line with this ideal, however: class factors and the birth number of the child can be expected to influence this.

C. Eating and General activity.

Diet during pregnancy is the subject of much health literature and advice. There is concern about Asian diets in this respect and there has been special emphasis on the encouragement of 'correct' dietary practices amongst Asian mothers. Thus, Rachel Abraham writes:

The nutritional deficiencies of the Asian population in this country have caused concern both locally and nationally. Here at Northwick Park we are just completing a study on approximately 1,000 Asian pregnancies to try to explain the differences in reproductive performance between the Asians of Harrow and the indigenous population - for instance, why there is a tendency for Asian women to have low birth weight babies. (Abraham 1982: 421)

Her sample were mainly Gujeratis who were Hindus (rather than Muslims as in my study) and her conclusions were that 'within the Asian population there are many differences and each woman needs individual advice based on her normal eating pattern' and that 'our general impression of the diets of the women... was that they were fairly adequate although there was a subgroup in need of specific dietary advice.' This could probably apply to any group of women and dispels anxieties concerning the inevitable 'deficiency' of Asian diets. These anxieties persist, however, and the very fact of studies which focus on this issue itself suggests this must be a 'problem area' (Brent 1981: 12 & 16).

Amongst my sample there was surprise at my suggestions that a special diet might be appropriate during pregnancy. This contrasts with Hilary Homans report of dietary restrictions among Asian pregnant women (1982). My questioning on this topic was limited. There was a recognition that women might not want certain foods due to their condition; for example, one woman could not face eggs when pregnant. All said, however, 'we eat what we like'. They were not aware of advice concerning diet given at antenatal clinics, though few would have understood it without an interpreter so advice seems to have been kept to a minimum.

Fasting was a topic of particular concern. Here the women were aware of disapproval from health workers. It is likely that the holy fasting month of Ramzan will fall during a woman's nine months of pregnancy. In Islamic practice, pregnancy constitutes a valid reason for not fasting. The women's view was different. Pregnancy is the one time when a woman can fast during the whole holy month since normally her period would render her unclean and thus unable to pray during part of it (see also Homans 1982: 255). The women therefore saw it as particularly important to observe the full fast when not prevented by menstruation. They felt that health workers advising them not to fast were doing so on a general basis rather than in face of specific immediate risk and that they did not understand the importance of their religious observance. Such advice was usually ignored. One pointed out with emphasis - 'they think we don't understand. We do, but our ways are different'. Here the concept of the woman as a physical vessel for the child (Arney 1983) contrasts with the women's own view of themselves as servants of their God.

In respect of other activities, certain actions such as

running or lifting were recognised as to be avoided (see also Homans 1982) but on the whole the condition was ignored. Loose fitting tunics (cameez) would be worn to avoid emphasising the condition and for comfort. Traditional baggy trousers (shalwar) easily adapted to pregnancy, and otherwise no special concessions appeared to be routinely made.

D. Attendance at Antenatal Clinic.

There is a perceived link between perinatal mortality rates and attendance at antenatal clinic, which is well illustrated in a Guardian report stating that:

A campaign to cut disease and death rates among Asian babies was launched yesterday. It follows reports that the children of Asian mothers are one and a half times more likely to die during or soon after birth.

The Minister has set up a working group on Maternal and Child Health to encourage women to accept antenatal care and to give advice on diet and services which are available.

(Veitch 1982).

The response of black groups is illustrated in a report by Brent Community Health Council, which comments (at an earlier date but in respect of this issue):

It is not clear how much truth there is in this but given the attitudes of some ante-natal departments this would hardly be surprising. (Brent CHC 1981: 17)

Given the lack of emphasis on pregnancy that emerges from the women's accounts already described, and their reluctance to go out, antenatal care would seem to conflict with culturally approved behaviour. Was this the case, and if not, what other factors were involved? My data shows that the early reporting of

pregnancy to a doctor and attendance at antenatal clinic was, indeed for most Pathan women interviewed, strange and rather unnecessary. For one family I heard of, the going to hospital for a baby and clinic attendance were the reason why the family returned to Pakistan, as they did not like it. But most accepted it as the way things are done here. Some spoke of the benefits of it - again on the basis of personal experience, their own or that of others - a baby lying across had been detected and turned to ensure easier delivery, other problems discovered and treated. Others went for fear of the consequences if they didn't - e.g. 'they'll be angry when we go to have the baby, they won't like it then' or 'they won't have all the details ready'.

Several spoke of their embarrassment telling their doctor of their pregnancy and of having to remove trousers (shalwar) to have injections in the clinic. But most had attended antenatal clinic. Their husbands had gone with them and waited outside, ready to be called in to translate if necessary. There was little or no comment on antenatal attendance although the women were asked if it was helpful. It was seen as a chance to be checked physically and this was recognised as a good idea even by those who clearly didn't like it much. Most had been told by their husband or other women what the system was and it was said to be easier when you had been through it before.

Although I do not have data concerning rates of attendance, it would seem from my interviews that factors of class and ethnicity as well as previous experiences of services were both of importance in determining this and other pregnancy behaviours. It is not sufficient to point to cultural differences in concepts of pregnancy, or to factors of socio-economic disadvantage or to negative experiences of health services alone although studies

emphasising one or other factor may serve to redress a balance in the literature. The women's Interests in a healthy outcome led them to accept what might otherwise be unacceptable. I turn now therefore to consider the interaction of cultural and structural factors and of the women's Concepts, Options and Interests in determining their behaviour.

2. Discussion.

The biomedical view of women as a vessel for the birth of a child has been put forward by W. Arney (1983). Hilary Graham and Ann Oakley (1981) have drawn attention to differences in medical and maternal frames of reference. A dominant Western concept of pregnancy may be seen as an idealised state of being for a woman during which mother and child begin to develop a unique relationship. This is clearly linked to the idealised concept of motherhood described by some writers (Badinter 1981, Dally 1982) which can be seen as being possible only in a historical period in which maternal and perinatal mortality rates are low (Badinter 1981).

In Pukhtu, the commonest way of enquiring about a pregnancy refers not to the state of the woman, but to the existence of a child or embryo. People ask literally 'Is anything there?' (هنا شيء؟) This may be seen to resemble the medical views of a woman as the vessel for a child. Other instances, such as when women took the opportunity to fast during pregnancy, thus asserting the importance of their own spirituality against what they saw as unproven dangers to the child, caution us against identifying these views with each other, however. What was

striking about the behaviour of my respondents and their discussion of it was not so much a different Concept of pregnancy but almost a lack of one except insofar as this was an accepted part of a woman's life cycle (see also Jeffery, R et al 1984: 234). My conclusion was that pregnancy was understated, even hidden and that this led to a conflict in face of the medical emphasis on the importance of maternal behaviour during pregnancy. However, 'understatement' implies a norm; 'lack of emphasis' is a negative. A less ethnocentric way of stating this might be to see as odd those dominant Western concepts - medical and lay - in both of which pregnancy has assumed considerable importance for different reasons.

Antenatal care in Britain is based on a concept of pregnancy which sees this as a special and important time rather than an inevitable and unremarkable phase of the woman's life. Thus, even where the mother's expertise is recognised (often it is not) as in asking her to monitor the baby's movements, it is still assumed that the pregnancy is a preoccupation for her just as it is the focus of her medical care.

Theoretically, antenatal care is available to all mothers; in practice, socio-economic factors make it more of an Option for some women than others. Attending antenatal clinics is exhausting, time consuming and expensive; for the woman with other young children (a majority of those who are pregnant), no means of transport and little money for bus fares, it is often not a viable possibility.

Other pregnancy behaviours are also dependent on financial resources. In the context of this study socio-economic factors are of relevance because all the mothers interviewed, like the majority of Asian people in the inner cities of Britain, fell into

the poorer socio-economic classes. The social position of respondents comparative to the other residents of Bradford was discussed in Chapter Eight. Car ownership and housing conditions will have particular relevance. The romantic ideal of buying a baby's equipment during the months of pregnancy is costly; Pathan respondents were perhaps fortunate in not aspiring to this as their English neighbours might do. In respect of child rearing, Pakistan television shows similar idealised advertisements to those found in Britain; this has not led to idealised and expensive aspirations in relation to pregnancy, however. Although less relevant to Asian women, recommendations concerning many of the other behaviours advocated in pregnancy (such as diet) are similarly dependent on socio-economic status and thus less of an Option for women of lower class.

Interests can work both ways in respect of attending at antenatal clinic. For many women in Britain they are against it. Even if the costs are not prohibitive, for a woman to attend regular clinics may be contrary to the Interests of other family members if another child is sick or needs meeting from school or a husband expects a meal ready. (See Graham 1979 and 1982 concerning the conflicting responsibilities which routinely face mothers). If the pregnancy is not a first one, the woman will probably have a good idea what to expect during delivery and be fairly confident that all is going normally. It often appears to be in the interests of the system rather than of herself and her child that she attends regularly. If she does have queries, they are frequently brushed aside or not answered (Graham and Oakley 1981 , Oakley 1979, 1980). Of course, other women may have difficulties which need monitoring but even when the procedures

seem to be in the interests of her baby, mothers rarely feel as if they are in her own interests as a person (personal experience and discussion with mothers).

It is important to note, however, that in the case of my respondents, it was their Interests in a successful outcome for their child which motivated them to attend clinics, contrary both to their own Concepts and inclinations and even at the high cost of compromising purdah observance. It was outcome that was most important for the women, and the National Health Service was seen by all to offer a high chance of a healthy baby and healthy mother. It was greatly appreciated for this reason. The most extreme observers of purdah kept the compromise involved in receipt of health care in the public domain (including antenatal care) to a minimum: one had had six children in hospital with no antenatal care and was always admitted in second stage labour and prematurely discharged herself two days later. However, others condemned this behaviour, and most accepted that it was in their medical interests to do more than this. Many said that in a different place you behave in a different way, and so conformed to all the expectations of the British system. For most there remained an underlying tension, however, between what they actually did and what they saw as right. From one woman this exploded angrily as 'we don't tell our mothers that we see male doctors'.

Chapter Fifteen. Experiences of Childbirth.

1. The Effect of Past Experiences on Concepts and Interests.

As Table (vii) shows, nine out of the seventeen focus respondents had given birth to a child in Pakistan as well as in Britain, the most recent being two years prior to interviewing. None had been in hospital, although I was told that it is increasingly seen as desirable to have a baby in hospital if the family can afford it. Eight births had taken place in a village, one in a town. In the latter case a nurse had been in attendance, but in all the others the only people present during the birth were female relatives and - in one case - the locally recognised midwife (dai) (see Jeffery. R. et. al., 1984 for a recent discussion of the status of the village 'dais' in North West India). One said that they would expect a doctor to be called if they were ill - he would probably be male as there has only recently been a female doctor in the village. In another case a doctor came before the delivery to give an injection to ease labour. In two cases there were severe medical problems - I was told that a placenta had to be removed (by a doctor who came to the village) 22 days later and another woman had to go to hospital after a month, due to pain and excessive bleeding, where she was found to need stitches. In that case there was no doctor in the village.

The hazards of village deliveries were thus familiar to respondents - either from their own experience or that of friends. These hazards seemed to reinforce their faith in the benefits of medical care such as received in Britain. However,

Table (vii) Live Births in England and in Pakistan

Respondent Number	Total Live Births	In England	In Pakistan
1	1	1	0
2	6	2 (twins)	4
3	3	3	0
4	5	4	1
5	2	2	0
6	6	4	2
7	4	3	1
8	4	2	2
9	7	6	1
10	4	3	1
11	2	2	0
12	4	4 (incl. one pair twins)	0
13	9	6 (incl. one pair twins)	3
14	2	2	0
16	3	1	2
17	5	5	0

the benefits of delivery in purdah in the village were also well known. Ideally, for 40 days the new mother would not work or get up from her bed - other women would care for her, cook special strength giving foods and wash and care for the baby. She would be given the child to feed it but otherwise allowed to rest and regain her strength. (See Gideon 1962 for a full description of very similar practices in the Indian Punjab.) For some women, their present position was freer - they could choose for themselves when they felt ready to resume work without the constraints imposed by their elders (masharan); yet for most, the demands of a new baby plus other young children meant that they had little chance to recover and many compared their situation badly with the care they would receive from female relatives in the village. One had attended her sister-in-law at the time of birth, and this woman's own return home from hospital to a house where nappies from the previous child were still lying wet or dirty was a poor comparison with the care she and her mother had then given her brother's wife. This contrast seemed to be a factor in the depressed state she had been in since the birth. For others, there was more help at home - other women in the area or their husbands had worked hard in their absence so they were not returning to a backlog of work. One described proudly how her husband had done everything, purchasing a layette and toiletries for the new baby - the only thing he had not done was to put it all away. Yet all took up the reins again on their return - the idea that they might have complete rest at home as in Pakistan, was not a possibility. We see here an effect of the changed social structure of the women's world following migration - although not isolated, many lacked practical support such as only close family can provide.

It was against this baseline then, that services were compared. Overall they were valued. The longer the stay in hospital the better - many argued against trends to discharge women earlier - pointing to the work that awaited them. This was despite the inconveniences and discomforts of hospital stay. It was not that they enjoyed the period in hospital - although a few did - more that they used the time, pleasant or unpleasant, to regain strength for the tasks awaiting them. Nurses and hospital staff were often seen as being 'like sisters'. Many made this comparison explicitly, describing being shown how to bath the baby in the same way as an older sister might show them at home - albeit by a different method. Most spoke warmly of those practices which conformed most closely to the village pattern. The hospital staff were seen as standing in for absent kin. However, not all did this as might have been hoped.

Not all the overt comparisons were with Pakistan, although for most it was the comparison with Pakistan that underpinned their appreciation of medical aspects of the British service. Some women compared recent and previous birth experiences in Britain - in each such comparison they felt that the service had deteriorated. Overall they felt themselves to be much less tolerated by staff. This was despite the fact that they knew the system better having experienced it before. Or perhaps it was because of this - their greater understanding having enabled them to see more subtle forms of rebuff. In terms of comparison, two women made the wry point that the pain was the same, wherever you were.

Before turning to look at the women's actual recent experience, a word needs to be added about home confinements. I

suggested to respondents that this might resolve the dilemma concerning receipt of maternity care in the public domain and consequent compromise of purdah. This was not positively received - it might jeopardise the medical benefits and anyway it would leave them with no rest at all. It seemed that while hospital confinement was a necessity, the resultant compromise was justifiable and led to benefits for the women in terms of their own Interests - Interests such as rest and strength building which they would not be able to use as the basis for demanding compromise were it not necessitated on other grounds. Purdah in Britain does not offer the same extent of support and comforts to women that are built into the system in Pakistan - home birth here would not be the same as it is there.

2. Recent Birth Experience in Bradford.

All the recent births had taken place in hospital. The women seemed to have been well aware when labour was starting at home. Some delayed telling anyone as they didn't want to be in hospital too long before delivery - one because she was frightened to go. They then told their husbands who either took them themselves or arranged for an ambulance. For some the ambulance was a matter for embarrassment as it announced that the woman was in labour - something she would be ashamed to feel that 'everyone knew'. But this was not so for all. Most husbands were present in the hospital during delivery, but none with his wife. The majority of women thought they would feel 'sharm' if their husbands were present during the birth, although this would not be contrary to purdah as there is no purdah between husband and wife.

Table (viii) shows the women's experiences during delivery

Table (viii) Women's Experiences During Delivery and Hospital Stay

Respondent Number	Experiences At time of Delivery		Experiences During Hospital Stay			Visitors	
	Language D'culties	Other	Food	Nurses' attitude	Roommates	Hospital	Home
1	Interpreter and Husband helped	-	-	Ignored her	Pakistani; a good thing	Some	Party after 40 days
2	Said "no" to everything incl. anaesthesia	-	Afraid to bring own	She was shy, but they treated her well enough	English	No	None
3	None, can understand	-	No problem	Well treated	Urdu-speakers; could talk	No	In Pak. older women make a party, not here
4	Yes, no details	-	-	-	They kept changing	Some, but not enough for her	-
5	Husband translated	No anaesthesia	All boiled, brought from home	Not as good as previously	Pakistani, could talk	Yes, all came	-
6	No problem	-	-	"like sisters"	(Pakistani, but could not talk as Urdu and Punjabi speakers	No	(All come with suits for baby when they leave (time
7	No problem	Asked to keep the gas and air machine	-	"like sisters"		No	
8	Nurses tried to help her understand	Caesarian, Police fetched Husband	Brought some from home	Not very good	Lonely, despite others in room	Yes, nurses were angry when they picked up baby	Many, "masi" and sister helped

Table continued....

Table (viii) Continued

Respondent Number	Experiences At time of Delivery		Experiences During Hospital Stay		Visitors		
	Language	D'culties Other	Food	Nurses' attitude	Roommates	Hospital	Home
9	Interpreter helped	-	Not liked. Nurses suggested she got some brought from home.	Very good to her	Company for her	Hb and children	None
10	No problem	-	-	-	Punjabis - can't talk	Not custom to come to hospital	Yes many
11	Had difficulty	-	-	Big fuss of her because it was Christmas Day	-	No	No help, some visits
12	Interpreter helped and she understands some herself	Great anxiety as it was twins and she had no experience of this	-	Worse than before. They don't bother if you're not English. Not allowed to draw curtains at visiting time	-	Hb and children	Gave party for twins
13	Yes, had difficulties	-	-	She felt she needed to stay longer, but Hb wouldn't ask	Could talk to them	-	-

Table continued

Table (viii) Continued

Respondent Number	Experience At time of Delivery		Experiences During Hospital Stay		Visitors		
	Language	Other	Food	Nurses' attitude	Roommates	Hospital	Home
14	-	Fear because previous delivery had been shorter	-	-	Felt that putting her with other Pakistanis was positive	Only Husband	All came at home, no party at "sunat" (circumcision)
15	Not this time. Previously cried because didn't understand	No anaesthetic. Didn't ask for it	-	Like sisters	Pakistanis; could talk	Hb and children. Not the custom for women to come	All came. No party
16	Has difficulties	-	-	Laughed at her and got angry with her	Urdu-speakers; could talk	No	All came at home
17	No problem. Hb helped	Was afraid of the machines because no previous experience of this	Insufficient	Much worse than before. Badly treated compared with English women	Punjabis. They were very upset by nurses	-	All fellow villagers came

and stay in hospital.

The sorts of problems experienced in hospital varied, as discussed below. Some spoke very positively of the whole experience - one otherwise very isolated woman assessed the whole of the world outside on the basis of her experience of how she was dealt with in hospital. 'Outside there are very good people' she said with surprise. Others were less enthusiastic.

A. Anaesthesia.

Anaesthesia was a subject much discussed - there was a feeling that women weren't given it as much now as previously. Some women said 'If you need it, they will give it'. Others wondered if you could ask for it if you wanted it but no one was sure. Most didn't like to ask or were unable to do so. One said 'no' to everything as she didn't understand - this included anaesthesia.

B. Communication and Attention.

Without English, the women could not ask questions. This cropped up often. One had wanted her husband to ask if she could stay longer as she felt ill and unready for discharge. He felt he shouldn't ask and she was indignant as an English patient had done so and had permission to stay. In this case she felt her lack of English was at fault, but others made great efforts to ask - about their baby's condition, or whether they could be shown how to bath it - and were ignored or rebuffed. Several felt that nurses either ignored or were hostile to non-English speakers and there were many examples given where English patients were seen to have been better treated. Some of the occasions when their customs were denied seemed to them unnecessary - a number of women mentioned the issue of pulling curtains round the beds during

visiting time: it was a matter of shame to be seen in bed by other women's husbands from some of whom one was in pardah. Paradoxically this would be a particular problem if they were in a room with other Pukhtu speakers. It would be solved by closing the curtains, but this angered some nurses, who said to one woman 'If you want to keep pardah, don't come to hospital'. However, such attention as was paid to them was noticed and appreciated - some spoke very highly of the care received. It seemed that a good impression was not difficult to create - language, food and other major problems were not the real barriers - women were impressed more by intentions and the feeling that people were trying to help them, were or were not sympathetic and whether or not they gave them time and attention.

C. Food.

Food was an issue, although many resolved it by getting food brought in and some said staff encouraged this. A few felt that food standards had deteriorated as portions were now too small for them to have an adequate meal if they left those parts of it which they could not eat on religious grounds and staff were not prepared to give them more of what they could eat. Only one mentioned special food being provided for them. This seemed overall to be an issue that was regrettable but more or less accepted, to be personally resolved if possible, otherwise endured and only a matter for real feeling if there was felt to be lack of helpfulness or sympathy on the part of staff. The idea that the hospital might provide halal (ritually killed) meat was seen as a good one, but too unlikely to hope for.

D. Company and Visitors.

The practice of grouping Pakistani women together was favourably viewed - many explained it as a positive factor so that

they would have someone to talk to. Of course it didn't always work as a number couldn't communicate with non-Pathans but the idea was appreciated. It was generally not the custom for female visitors to come to the hospital. This is because most would be observing purdah from the patient's husband who might be met there. This makes nurses as surrogate sisters even more important.

Although a few women expected visitors in hospital, most of them expected the women to call later, when they were at home after discharge. Most husbands came however, and their older children. One who did have female visitors was puzzled that the nurses were cross when they picked up the baby. I had myself hesitated to do so and when I asked her permission, she was surprised as she took it as a compliment that I wanted to hold the child. Physical contact between nurses and babies was commented on and seen as a compliment to the mother and demonstration of positive feeling towards the baby.

3. Back to the Domestic Domain.

For all but one, the period after return from hospital was one when visitors flocked to see them and the new baby. All would be expected to bring gifts. This giving of gifts was important. When given, the gifts were apparently almost ignored - if two sisters were present, the elder looked at it even if she were not the new mother, and although the giver was thanked, little attention was paid to the gift itself in their presence. But gifts were compared and assessed afterwards and could make or break a relationship. There were examples amongst respondents of the use of visiting and gift giving after a birth for the purpose

of healing a broken relationship. If the gift was accepted (and it would be chosen and assessed itself with care) the relationship resumed. The cause of breakdown would not be referred to. When we gave gifts protestations were made to us that 'you shouldn't have bought anything. It isn't necessary' and the equivalent of 'it's the thought that counts' but experience showed that these were conventional protests, and contrasted with the reality.

Likewise all women but one were inundated with visitors. Most saw this as something of a strain, but it was important, nevertheless. Many remarked wryly that no one came to help, although where women's networks were strongest there was evidence of help especially where the woman was still in pain after a Caesarian. Once there, if several visitors had come, they might well speak amongst themselves and apparently ignore the new mother after initial enquiries. However, refreshments had to be provided - particularly if it were a son, special sweets would be expected and bought. Some also bought sweets for a girl.

Most of the celebratory customs revolved round boys. I was told that 'we don't make so much fuss when a girl is born, but when they're married we do so much'. Even in the case of boys, there was a great deal of variation in customs and this was accepted; 'everyone has their own way of doing things'. Customs pertained to a village or a family. The most common was to throw a party when the boy was circumcised. Some of these would be large affairs involving the whole community and hire of a hall. One such which took place during fieldwork was referred to by most respondents visited at the time - especially the fact that men and women had been invited and separate rooms provided. The mother was not herself a respondent. Another more local party took place at home and cloth for suits was given to all female guests. The

cost was clearly enormous and included damage caused to property. Other respondents did not behave so lavishly, however, either for religious reasons - one respondent's family were very holy and saw such celebration as sinful (despite it being the predominant custom in the village) - or due to lack of older women to make arrangements. I was told that 'in Pakistan the older women (relatives) do it all, but we can't be bothered'. Certainly many found the visitors alone enough: 'They all come, it's like a party; that's enough'. Some families gave a party after 40 days (when the woman takes a bath and is again considered 'clean' and able to pray) whether it was a girl or a boy.

Shaving of the baby's head was also an important landmark. Again families varied in when this was done - for one it was always at the next major religious festival (Eid), for most within 40 days. Instances where it was left until the child was old enough to be ashamed were condemned. Many parents did this themselves at home. This custom is followed because the first hair is considered dirty.

With the end of the 40 days after the birth, the woman returns to ordinary life. Her necessary incursion into the public domain is over; she and her child have been received back into the family and community groups she belongs to by means of the visits made to them and, until the next time, she becomes merely a mother. Motherhood is mainly a state that is lived out in the domestic domain. Few of its demands take her beyond it, although the public sphere will soon claim her children. Apart from travel to Pakistan or on religious pilgrimage, only the health care of her children or herself may take her out again.

4. Discussion.

Women bring to the experience of hospitalised childbirth in Britain certain expectations and Interests, whether the situation is for them a new or a familiar one. It is on the basis of these expectations and the degree to which their Interests are met that they assess the experience. Insofar as they have choices concerning their own behaviour these will be made in part on the basis of these Interests and expectations also. In the foregoing accounts, some of these expectations and Interests have been drawn out. Overall it was the women's collective Interests in a healthy outcome and a secondary, more personal, Interest in a period of rest that determined their entry into the public domain at the time of childbirth and, once there, led to their wish to prolong rather than curtail their stay in most cases. Once in hospital, concepts of female modesty and of the ways in which interest and concern was expressed could be seen to underlie efforts to close curtains at visiting time, to view nurses as surrogate kin and to feel themselves valued and complimented (or not) by interest taken in themselves and their babies - particularly when this was physically expressed in the holding of babies.

Within the home, the changed structure of female networks following migration played a part in altering expectations of the help that might be received, and certain traditional customs were being dropped due to the lack of older women to take part. Thus, structural factors also played a part in determining women's expectations and Interests, both in hospital and on their return home. It is worthwhile to be reminded, however, that even in a non-migration situation the ideal of support is not always

possible. (See Jeffery, P. et al (1984) for a discussion of actual patterns of support following childbirth amongst Muslim and Hindu women in Bijnor District, Uttar Pradesh).

We must, however, look carefully at the Options as well as at the expectations and Interests that women bring to them. These 'treatment' Options (in this case the maternity services) are available to all women in Britain. However, the experience of them will be different for black and white women; for those who speak English and those who do not; for Muslims who cannot eat meat which has not been ritually killed, and for English women who can. Some of the women's experiences have been described.

The issue of food illustrates well the way in which apparently equal treatment for all results in quite different Options being available for members of minority ethnic groups. Equal portions of food are given to all patients; some of it is, however, unacceptable to Muslim women on religious grounds. Previous practice was to increase the helpings of those parts of the meal that were acceptable, resulting in a meal that was unbalanced in dietary terms and unattractive but sufficient in terms of quantity. The ideal solution of providing food that is acceptable to all religious groups is seen by respondents as unlikely. Rules which now preclude increasing the amount of certain parts of the meal result not in an 'equal' situation but one in which women are forced to choose between going hungry or compromising their religion. In view of the emphasis on breast feeding and on links between diet and milk supply (Whichelow 1979) it is surprising that this is not seen as important even from a medical perspective alone. Staff who cannot alter 'the system'

condone and even encourage the supplementing of the women's meals from home. Patients are glad of this. It is a short-term solution but does not challenge the underlying racist practice of the hospital. Such changes have, however, been made in Nottingham where a catering officer says that the only real issue is that of willingness (Training in Health & Race, 1984).

A number of writers speak of the difficulties Asian women experience in maternity hospitals (Donovan 1983; Winkler 1983: 51, Homans 1982) and an advocacy service set up in a London Maternity Service is reported as having made childbirth less traumatic for women for whom English is not their first language (Karpf 1985).

As with antenatal services, maternity services are also differently experienced by various groups of English women. The accounts by Ann Oakley (1979, 1980) draw attention to the differences in medical and maternal Concepts which underlie these, and to the recent medicalisation of childbirth in Western countries. In this section I have not attempted to review these arguments as many have already been referred to. Rather, I have taken the experiences of my Pathan respondents as the starting point, indicating factors which have seemed relevant to them.

Chapter Sixteen. On Being a Pathan Mother in Britain.

In most writings concerning the rearing of young children, 'it is the child who is at the centre of the stage' (Kitzinger 1978: 15). In this Chapter and the next, my focus is not the child, but the mother - her experiences as a mother and her child-rearing practices and their logic from her point of view.

The dominant focus on the child is in line with the dominant concept, discussed above, in which the pregnant woman and later the mother is seen as a vessel for the child. In recent years, in the West, this has been combined with an idealisation of the bond between mother and child similar to the idealisation of pregnancy discussed in Chapter Fourteen. In respect of child rearing, then, the mother is the means of her child's development and in this respect alone considered of great importance by all schools of psychiatric thought (from the behaviourists to the Freudians, see also Winnicott 1964). A few recent writers have changed the focus of attention (Badminter 1981, Dally 1982, Kitzinger 1978), based on an awareness that this supposedly ideal relationship is not always experienced as such by mothers, and on awareness that it is culturally specific.

The Chapter describes and considers the accounts of my respondents concerning mothering; particularly its effects on her. The issue of who helps her with the children is clearly of importance in this. Of all the aspects of being a mother which have been considered so far, daily experiences of childcare are likely to have most relevance to issues of the women's mental health. As with their experiences of childbirth, expectations (and hence the definition of situations and experiences as normal

or not) can be expected to influence womens' perceptions of their current situation.

1. Overall Determinants.

I have already drawn attention to the central place of being a mother in the self concept of those interviewed. To be a mother is the Pathan woman's expectation and fulfillment, but its costs are high, albeit completely accepted. Many, but not all, women spoke of the tiredness and hard work. The strains of motherhood clearly depended on the number of children she had and on her social and living situation. It also depended on whether or not she had reared previous children in the village in Pakistan - most who had, felt that child rearing there was much easier - 'you let out the children when you let out the chickens - they come back when they're hungry' or again 'my elder children never knew who their mother was, so many people played with them'. A few who had children in England spoke of the benefits here such as cleanliness, food that is easier to prepare and availability of baby products, but mostly the benefits for the mother were in child rearing in Pakistan, not England - at least in the early years.

Table (ix) shows the number of children currently in the mother's care, whether she had experience of child rearing in Pakistan, and any of her children currently living elsewhere. There were no children in care of the local authority or living with a single parent, either the respondent or a previous spouse. None admitted to the husband having another living wife and children elsewhere and there were no divorces.

Table (ix) Numbers of Children Currently in each Mother's Care, with Ages. Other Children Currently elsewhere and Experience of Childrearing in Pakistan

Respondent Number	Children currently in M's Care			Others now elsewhere	Experience of child-rearing in Pakistan
	Number	Age of Oldest	Age of Youngest		
1	1	1 year	1 year	None	None
2	4	7 years	2 years (twins)	2 - married ♀, "mad" son Both in Pakistan	Yes
3	3	4 years	< 1 year	None	Yes
4	4	10 years	2 years	One 13 year old girl; extended temporary visit Pakistan 4 stepchildren (3 married and 1 Pakistan)	No
5	2	4 years	< 1 year	None	No
6	5	10 years	< 1 year	None	Yes
7	3	4 years	< 1 year	One 3 year old boy in Pakistan with maternal grandmother	Yes
8	4	6 years	< 1 year	None	No
9	7	10 years	< 1 year	None	Yes
10	4	7 years	1 year	None	Yes
11	7	11 years	1 year	None	No
12	4	7 years	1 year (twins)	None	No
13	7	17 years	1 year	2 married ♀s in Pakistan	Yes
14	2	3 years	1 year	None	No
15	4	11 years	1 year	None	No
16	3	4 years	< 1 year	None	Yes
17	4	7 years	< 1 year	None	Yes

2. An Extended Sense of Mothering: Informal placement of Children with other Family Members.

What was striking, however, was the number of references made to the informal adoption of children within the family. This only directly affected two focus respondents - both of whom had left children (one a teenage 'mad' boy, and one baby boy) with maternal grandmothers on a semi-permanent basis. However another focus respondent had a daughter on a temporary (but extended) visit to Pakistan and the mother of the 'mad' son had intended to let one of her two-year-old twins be raised from birth by a distant relative in Bradford. She had missed the child so much that she got her back after two days. Four other references were made to such arrangements - one additional respondent had taken a child to Pakistan at the age of five and now planned to bring him back, after three years. Although she had missed him, it had been necessary because he had been ill here 'through being inside all the time' - he was nervous, afraid and unable to mix but was reputed to be better now and the mother had no fears that a return to England would lead to a recurrence of the problem. Two other references were to people not met in person - one a childless aunt in Pakistan who had adopted the twin son of a family in Bradford and who had recently died having been a mother to him for twelve years; and the other a widow in Pakistan who had reared the son of a widow from another village and planned to arrange for the marriage of the boy, now twelve years old, to her own daughter's daughter currently a baby. In the fourth case one respondent had herself been raised by a maternal grandmother in a neighbouring

village to that of her parents.

The reason for such arrangements was usually some problem - a childless or lonely woman helping out an overburdened one, or some danger to the child from being in Britain. I did not personally meet any mothers who had deliberately sent daughters back at puberty to safeguard their moral future but I am told by those who know such families in Bradford that this is not uncommon. Extended temporary visits to Pakistan were also made - by teenage children, elderly mothers in law and indeed, *whole families*. The latter is, in British terms, not as surprising as the splitting of nuclear families for such visits. This data all points to a very strong sense of extended family unity and of homeland and a lack of emphasis on the exclusive mother - child relationship. Of one child I was told - 'he is in our place, with our people, so it is all right. He is happy'. The welfare of the child was important in such decisions, but was assumed to lie in his or her security within the wider family - I was told that 'young children don't know who their parents are, so it is all right' - the sorts of long term psychological problems of personal identity that occurred to me did not seem to be a cause for concern, even though some were apparent - as in the case of the step-mother aunt who died leaving a child mourning a mother and refusing to accept his natural parents who wanted to comfort him. Anyone who finds such a system strange should consider the horror with which Pathan women viewed our system of divorce and consequent one-parent children, and adoption outside the family. There is also an upper-class English tradition of boarding school from an early age.

As to where the children themselves might be happier, most mothers felt that although life in Pakistan was more enjoyable for

children because of the good weather and greater freedom to play outside, they accepted wherever they had been born and usually preferred the place they were used to which was, for most of them, England. Many said they were here 'for the children' but this referred to their education and future prospects rather than present happiness. Probing for any feelings that their children were missing out on village life produced little reaction. Mothers said - 'our time was different, theirs is different'.

3. The Practicalities of Mothering.

The mothers' day was long, particularly in the summer when prayer time is early and of course when there was a young baby to be fed first or last thing. During Ramzan, the presence of young children and school children meant that a woman was unable to catch up in the day time on sleep lost at night. Five focus respondents consistently complained of tiredness and overwork - these were those with seven children or young twins. Others spoke of frustration with the children more at holiday times, which for some brought (to add to the under-fives already there) older noisy lively children home all day with little outlet. But quite a number did not react to the suggestion that they were hard pressed and most said they liked young children. The woman with only one child spoke of the company her daughter gave her and how lonely she would be otherwise.

The presence or absence of play facilities and space outside the home was critical for the women's happiness. Unfortunately, only one area provided this - in others, playing in the park or on the street had to be discouraged due to racist attacks by white

youths. An all Pakistani area was safer for the children to play out in, although maybe less desirable for other reasons.

I asked women what time was best for a mother - several said that whatever the age of their children, there were always worries, others that whatever their age, you look forward to the next stage - when they are out of nappies, at school etc. Most agreed that a mother had a little more time once the children were at school and it was common to talk of children as 'grown-up' when they were school age. Some talked of marriage prospects: there is an Urdu saying that 'You begin to fear life when your daughter grows up'. Clearly the retention of Pathan customs by their children mattered to the mothers - the issue of language was heatedly discussed and reference made to Pathans who had been raised here and could speak no Pukhtu. Mothers were proud that Pukhtu was spoken at home and was familiar to their children as a consequence.

The attitudes of husbands to the women's role as mothers inevitably affected some of them. There were several instances of husbands saying 'I don't know what you do all day'. This was mostly shrugged off and most women felt secure enough in their own role not to let this affect them but where the woman had a lot of children and few close female relationships, this criticism from her husband added to her despondency. The women themselves sensed the difference between such remarks made as a standing joke and when they were made as an accusation.

Fathers' attitudes to children were generally more benevolent than their attitudes to their wives. There was a tendency for fathers to be reported as saying that the children should not be denied anything (e.g. money for school trips) and they seemed not to resent the demands that young children made on them or their

wives - even to the extent of being pushed out of bed in favour of one or more children sleeping with their mother. In most cases it seemed that the husband expected his meals to be ready and his clothes clean but otherwise a woman was expected to give much of, if not all of, her attention to the care of her children. If the husband felt that she was neglecting her duties towards the children, he would become angry with her. Usually there was a strong almost formalised bond between the mothers and their children which prevented the children complaining to their father of their mother's treatment - this was explained to me in terms of the children preserving the purdah of their mother (although there is not supposedly any purdah between husband and wife) - an example of the sense of the term being extended to mean something like confidentiality. The family where this did not happen was one where the older children were those of a previous wife and the woman concerned seemed to accept that children who were not one's own 'blood' could not be expected to side with their mother inevitably. She suffered for it, however.

4. Mutual Support in Respect of Mothering.

Table (x) shows the people to whom the focus respondents turned for help with the children. Two women felt that 'no-one' helped. These two were the same two who were felt by the researchers to be most unhappy - a view which coincided with their own estimate of their situation. They were not isolated women - both were members of flourishing networks within which other women felt well supported. The difference between people coming and people 'coming to help' was referred to by several women, these

Table (x) Mutual Support in Respect of Mothering

Respondent Number	Who Helps	Proximity
1	"Masi" = paternal aunt Older sister	In street - seen as like M-in-law would be in village Across town
2) 3)	Each other to a limited extent	Joint household
4	"No-one"	
5	Sister to some extent	Joint household
6) 7)	Each other a great deal, M-in-law when present	Joint household
8	Sister, network members	A few streets away close neighbours
9	Husband	
10	Sister-in-law	Next door neighbour
11	"No-one"	
12	Husband and close friend - "like a sister"	A few streets away
13	Network members	Close neighbours
14	M-in-law if present, husband, sister	A few streets away
15	Fellow villager or husband	Close neighbour
16	"Pupo" = maternal aunt	A few streets away
17	Husband, friend	A few streets away

included. The only other woman with no female supportive relationship was the one who was totally isolated by reason of observing very strict purdah. However, her husband took a great deal of interest in the children, including sharing their practical care. Four other women also mentioned their husband when asked who helped them with childcare. In respect of who they discussed the problem with if worried about the children, a distinction was made by some between health issues and behavioural issues; also between practical help and advice. The husband, and through him the doctor, were seen as appropriate people to ask for advice. However, behavioural issues were more often discussed with other women. Older aunts and related villagers were seen as particularly helpful in practical ways when present - their own children having grown up, they were happy to care for young ones from time to time, and often a particular child had developed a special relationship with an older woman in this way and might stay with her for short periods.

Where a network was close and a number of women from the same village lived in close proximity, with easy access to each others' homes which did not necessitate 'going out', the care of children often seemed fairly communal and the children played together a great deal. However, it is interesting that even in such a set-up, any formalised arrangement of substitute childcare (as when the mother went into hospital, for example) would be made with the closest kin member even when they lived a few streets further away. You could ask help from relatives in a way that you could not ask it of fellow villagers, and for this reason women missed the much more extensive female kinship network in Pakistan. There were limits to the help that could be expected of and given by non-relatives, frequent though interaction with them might be.

Visiting and helping were not the same thing. Thus a woman might not be socially isolated but this would not mean that she was well supported in a practical sense. Where a friendship became so close that it involved mutual help, it was designated in kinship terms e.g. 'She is like a sister to me'.

In the three joint households, the interaction between sisters living together was not the same in each instance. In one, there was extensive mutual help with few apparent boundaries. In the other two, housework was shared more than childcare. The women made clear in their remarks that their mutual support in this respect had limits.

5. Discussion.

Generally, motherhood was accepted as the only possible life for a woman. Because of the average family size it was for most a hard one in physical terms. The mothers bore all the practical burdens of parenting, especially in respect of young children. They would be subject to their husbands' censure if felt to be failing in their duties towards the children. It was however a status in which they had considerable pride and prestige and which formed the basis for relationships within their own female network, as well as their standing in their own families. Hard though the work associated with rearing young children was, several commented that the real anxieties of motherhood were worse later when the children grew up, particularly if they had grown away from their parents as a result of education in Britain. Because most of the mothering of young children can be conducted in the private domain, there were few cultural conflicts for the

women in respect of it. Intrusions by health services in the form of the health visitor will be discussed in the next chapter on health and illness.

In considering the effects of mothering on the women's mental health, a number of factors need to be taken into account, therefore. On the one hand, there was the status of being a mother and the women's complete acceptance of their total responsibility for young children. Unlike many English mothers, they had few role conflicts in this respect. Whereas English working-class mothers might be forced to go out to work for economic reasons, with consequent problems of managing two jobs (outside and in the home) and worries in respect of substitute childcare, there was no pressure for the Pathan mothers to do so, whatever their socio-economic circumstances. Neither did they suffer a conflict of aspirations such as professional and middle-class white mothers increasingly seem to. In respect of expectations of help from fathers, the situation was also clear cut, and although a father's attitude and willingness to help with children could be important in terms of easing workload, it seemed to have fewer implications for the marital relationship than might be the case in situations where the sexual division of labour is less clear cut. See also Chapter Nine above concerning this.

On the other hand, migration and changes in social situation consequent on this had changed the nature of mothering for those women. Children had less space for play; fewer outlets or adults for company and the weather kept them inside much of the time. The woman's own kin were not available to give such emotional support and practical help as they might have been able to offer in Pakistan (the latter factor would of course depend on their physical proximity, even in Pakistan). Neither were households

joint ones made up of a member of generations of the husbands' kin such that practical tasks could be shared. Although the situation is often a hard one for women in Pakistan too, and it would be wrong to assume that there would always be more practical support for individual women, the British situation inevitably tended to be more restricted, according to the women interviewed.

The nature of mothering in Britain was therefore not the same as women expected from their own upbringing. Changes seemed to be suffered most by those who had reared children in both situations however. Others accepted the constraints following migration because they accepted completely their own role as mothers. Personally, their introduction to the work involved in this was, for most, in the British situation. They might have an idealised notion of how it might have been in Pakistan, but most accepted the present situation, hard as it was in practical terms. The context of their role as mothers was one in which this was, together with maintenance of the home and of social relations, their primary, even their only responsibility.

Data concerning the women as mothers must, however, be considered in the light of the women's overall social situation, as already described in Part II. The supportedness or otherwise of their situations varied within the group of women interviewed, as we have seen. For those women most secluded, their children and their role as mothers was their major work and preoccupation: to some extent, it counterbalanced their social isolation. Where the women were unsupported (rather than isolated), childcare became an issue which illustrated their lack of support, however.

Chapter Seventeen. Child-Rearing Practices.

This chapter describes a number of the mother's child-rearing practices in an effort to demonstrate the rationality and logic of these from the mothers' point of view. It is my intention to draw out of these the Concepts and ideals which inform mothers' practices as well as the structural and socio-economic constraints which limit Options for them in this country.

The reasons for my interest in this topic is that it is, like pregnancy and childbirth, an area of interaction between the mothers and health workers. To some health workers, the women's ways of rearing their children seem misguided and not in the best interests of the child as these are defined within the health care system. While some realise that child-rearing practices are socially and culturally determined, fewer are aware of the differences that exist in relation to the aims of child-rearing in different cultures and countries. It is a question, not just of how best to rear children to a given ideal personality etc. but of what that ideal is. This ideal concerning the goal of socialisation (the 'perfect person' as defined by any culture or social system) is closely linked to Concepts of the child and of adult-child relationships and can be seen as one of the women's Interests in their work of child-rearing.

I referred at the beginning of this Part to the paradox facing state systems of medicine and education in which the critical early years of a child are outside their direct control. Systems of surveillance which have developed to influence practices within the home are based on ideals concerning the aim of child-rearing and the means by which this is best attained. Since both these ideals are culturally defined and structurally

influenced (Kitzinger 1978, Parekh 1974), it is not surprising that those groups who receive most critical attention are those furthest removed from dominant ideals: minority ethnic and lower class groups. Not surprisingly either, the health of these groups is worse than that of the general population (Townsend and Davidson 1982). In seeking explanations of non-compliance or deviance, those writers who take for granted the ideals on which practice is based tend to focus on what are seen as the deviant or strange behaviours of those who do not conform. This has been described as 'victim-blaming' (Crawford 1977) and, in respect of black groups, as 'cultural racism' (Ahmed 1984: 4).

My aim in this chapter is not, therefore, to document a series of odd behaviours. Areas of conflict with health workers are on the whole, the subject of chapters in the next Part rather than this, although some aspects of these interactions are discussed here. In these, the Concepts and Interests of health workers also become more apparent, to the extent that we can look at and question the universality of dominant Concepts in respect of child-rearing, and their uncritical embodiment in health care practice in Britain.

1. Infant Feeding.

A. Breast feeding.

As can be seen from Table (xi) all the mothers who commented on this were in favour of breast feeding babies. The most oft-cited reason was the religious one, which is that it is the right of both mother and child for the baby to have its mother's milk. 'We say that it is the mother's right (hug) to give her own milk,

Table (xi) Breast feeding

Respondent Number	In favour of breast feeding	Reasons	Last child			Previous children	
			Breast fed?	How long	Why Stopped	Breast fed?	How Long?
1	?	-	No	-	No reason given	No previous children	
2	Yes	Religious	No	-	Didn't try	Yes	2 years + 1 year
3	Yes	Religious	Yes	40 days	Dried up	Yes	2 months
4	?	-	Don't	know			
5	Yes	Religious	No	-	Tried; baby ill	Yes	2½ years
6	Yes	Religious + (good for baby)	Yes	8 days	Dried up	Yes	5 months
7	Yes		Yes	? days	Dried up	Yes	Longer in Pakistan
8	Yes	-	No	-	Mother ill	?	-
9	Yes	-	No	-	Tried, no milk	Some yes, some no	Varied
10	Yes	-	Yes	A few months	Dried up	Yes	A few months
11	?	-	No	-		No	-
12	Yes	Religious	No	-	Didn't try	Yes	"Not long"
13	Yes	-	No	-	Mother ill	Yes	20 days
14	Yes	Less work	Yes	1 month	Baby refused	Yes	2 months dried up
15	Yes	-	Yes	2 months	Dried up	Yes	20 days dried up
16	Yes	-	Yes	20 days	Dried up	Yes	20 days dried up
17	Yes	Easier, child likes it, gets more used to mother	Yes	4 months	Dried up	Yes	Until it runs out

it is holy (sawab) to breast feed. It is the right of the child to have his own mother's milk and confers on the mother the right to ask things of the child'. One mentioned the belief that it is by the smell of the milk that the child will be able to recognise his/her own mother after death. Some mentioned more practical reasons in its favour - it is good for the baby, the child likes it, it is easier, the child gets more used to the mother. There was no doubt, however, that it was the bottle feeding or stopping breast feeding (particularly before the stipulated forty-day period) that had to be explained or excused, not vice versa. In view of this, it is interesting that of the 17, eight did breast feed their last child and eight did not - one did not comment on this.

Of those who were not breast feeding, two gave no reason. Two did not try to breast feed - both had twins and one was 'shy' even though previous children had been breast-fed, and her husband advised her not to try to do so with twins; the other had attempted to breast feed a first child who 'wouldn't take it' so did not try to breast feed the twins.

Two others wished to breast feed and gave up - one had 'no milk', the other a baby with breathing difficulties who did not readily take to the breast so the staff gave the mother pills to dry her milk. Two women were themselves unwell following delivery - one after a Caesarian section, the other with a breathing disorder on the basis of which a doctor advised against breast feeding lest she passed it on to the baby.

Of those who did breast feed their most recent baby, one stopped after a month because the baby refused the breast and the father said 'Why are you making her miserable, give her a bottle'. The remaining seven continued until their milk dried up - they

usually felt that this occurred prematurely. A number had breast fed children for considerably longer (up to two and a half years) in Pakistan. Only one had had such an experience in Britain. A number said that they had experienced this problem in Pakistan also - there too their milk did not always continue to be produced for as long as the baby wanted it, but for most the problem of milk 'drying up' was associated particularly with Britain.

Three sorts of explanation were given for not breast feeding (or for milk drying up prematurely). The first had to do with status. Some older women said that some younger ones just don't want to - 'they say that ordinary (i.e. less sophisticated) people breast feed, therefore they don't want to'. The older women saw this as a matter of regret. To some extent this social reason is linked to the easier availability in this country of an alternative. While it is true as some pointed out that 'everything is available there (in Pakistan) now' - it is still true that it remains the norm in the village to breast feed and harder to keep other equipment clean there.

The second type of reason for 'why the milk dries up' was a folk belief. This belief is that hearing the voice (awaz) of a woman who is unclean (due to having just had her own baby) dries the milk of a nursing mother. Since all women have their babies in hospital and share a room with other women in a similar state, this could account for the drying up of milk so early. This explanation was offered by one respondent who claimed that 'all the older women here say this is the reason'. I suggested this explanation to some other respondents - four had heard of it but thought it was probably not the reason, one had never heard of it and a friend had to explain it. Thus it did not seem that this

explanation was one that women wanted to go on record as concurring with, whatever their private views.

The third type of explanation was linked to physical factors. The climate, drinking cold substances and getting cold after a bath during the forty-day period as well as the amount of rest and food the young mother had were all suggested as reasons. In Pakistan, the new mother not only rests, she is given special food - rich halwa made with pure butterfat. This is to give her strength and it is a matter of pride amongst the older women to make it for the new mother. It is a sign of their care for her and the expense they will go to (see Sharma 1971: 146 and Gideon 1962: 1230). But it is not something a woman will trouble to make for herself, so most women in Britain do without. Although this explanation was only offered twice, (most women professing inability to understand the puzzle of why milk dries up quicker in Britain), it is one that ties in most closely with the evidence concerning the effect of better food for nursing mothers on the milk supply, as a study of 300 women in Cambridge showed (Whichelow: 1979). This then, is yet another example of the effect on the young mothers, not of isolation, but of the changed structure of the female networks following migration.

B. Bottle feeding and weaning.

The mothers who were bottle feeding their babies were all managing well - three reported that their babies had started vomiting at four months or six months and that they had changed from dried to fresh milk on the advice of their Health Visitor or Doctor and that this had cleared up the problem. No-one reported any other difficulties although some had changed milk brands to find the one which suited the baby best. All were able to tell me how many ounces the baby was currently taking and how often. The

Health Visitor's advice was said to be welcome although practices such as keeping a bottle warm on the fire clearly persisted despite her disapproval. Babies were started on proprietary baby foods - either tinned or dried products as long as they did not contain meat - at four to six months, although the bottle was often not discontinued until the child was two years or so. Generally mothers did not report problems with infant feeding. Proprietary foods were used for convenience rather than because of any feeling that they were superior to the ways in which infants were fed in Pakistan.

2. Sleep times of children.

Respondents were not consistently asked for information about their children's sleep times but this information was recorded if mentioned and sometimes directly asked if it was relevant to the topic being discussed. The information is given in Table (xii).

It is generally seen to be Pakistani custom to allow children to stay up late at night. This was confirmed by respondents, particularly these who disagreed with it. Two had a particular policy of early bed for the children (i.e. 7-8 p.m.). This was regardless of the ages of the children and in both cases applied to all - in one family the oldest was 7 years, in the other 13 years. Both had a pre-school child also. One did this because it was good for the mother - it enabled her to get more rest. The other because it was good for the children. In five other cases bedtime was also the same for all the children in the family - in two instances this depended when darkness fell and was usually 8 p.m. in winter, later in summer. In the other three it was

Table (xii) Sleeptimes of Children

Respondent Number.	Ages of Children	Bedtime	Reason	Where they sleep
1, 4, 5, 6, 7, 9, 11, 12		No reference to this		
2	2 year old twins) 6 yrs.) 10 yrs.)	8 p.m. winter, later summer.	When dark.	One alone, one with mother. Mother gets up 2 or 3 times a night to twins.
8	3 yrs.) 5 yrs.) 6 yrs.)	9 or 10 p.m.	None given.	-
10	3 yrs.) 5 yrs.) 7 yrs.)	7 or 7.30 p.m.	To let mother get more rest. This was con- trasted with 'Pakistani custom', seen as better for mother.	-
13	1 yr.) 5 yrs.) 9 yrs.) 11 yrs.) 11 yrs.) 13 yrs.)	7 or 8 p.m.	Very firm about this. Not good for them to stay up.	Baby sleeps alone.
15	1 yr.) 5 yrs.) 7 yrs.) 11 yrs.)	All in bed by 9 p.m.	-	Baby alone in cot. (Table continued)

Table (xii) continued

Respondent Number	Ages of Children	Bedtime	Reason	Where they sleep
3	1 yr.	A lot in day, less at night	-	-
	4 yrs.	8 p.m. in winter, later in summer.	When dark.	-
14	1 yr.	Twice in day.	-	In cot alone.
	3 yrs.	8 or 9 p.m. plus once in day.	-	Sleeps with mother.
16	1 yr.	9 p.m., sleeps through, also in day.	-	In pram, going to buy cot.
	2 yrs.	8 p.m., plus sleep in day.	-	-
	5 yrs.	Later than others.	-	-
17	1 yr.	-	-	With mother if cries.
	1 yr.	Earlier than sister (3 yrs.)	Father puts to bed.	Alone.
	3 yrs.	11 or 12 p.m.	When mother sleeps.	Alone.
	7 yrs.	Variable.	-	Sleeps with mother.

consistent throughout the year; in one 8 or 9 p.m., in another 9 p.m. and another 9 or 10 p.m. Thus for seven out of the nine mothers who commented on this, the age of the child was not a factor in when he or she went to bed. (Infants were excluded, of course, because their sleeping and waking times were more erratic.) The remaining two families showed some variation in the bedtimes of the different children, but this was not necessarily age-related: one three-year-old consistently waited until her mother went to bed at 11 or 12 p.m. Her younger sister slept earlier, as did her older sister who had to get up for school next morning.

Specific children regularly slept with their mother. Of one pair of twins, one always slept with her mother, the other alone. The small babies were most usually said to sleep alone in a cot, although one slept with the mother.

It seemed that mothers were often happy for young children to be up in the evening - this was when other people might visit - and then for them to sleep on in the morning when the mother could get on with her housework in peace. For one woman, this was a pattern she was reluctant to break and it made the child's entry into nursery school difficult - it was 'too early' and would mean changing the whole pattern of the day. Certainly when guests were present, even quite young children would stay with the adults. 'Baby sitters' were not used - for one thing parents rarely went out together, and if they did go out at the same time, children would be taken along. Generally there was much less attention paid to any individual supposed 'child's needs' but more inclusion of children in all family events. This echoes a pattern which Christine Buswell found in her sample of white Coventry mothers (Buswell 1980). Some separated the world of the child and the

adults, others joined the children into the adult world. These practices seemed to be related to differing ideologies which were to some extent, but not exclusively, class related, there being less separation in working-class homes.

3. Nappies and Toilet Training.

I had expected to find the mothers having difficulties in this area, since nappies are not regularly used in the villages in Pakistan in the warm weather and there is thus not the same emphasis on 'getting them out of nappies' as is found in Britain. However, this was not the case. Three were using disposable nappies. The only difficulty mentioned in this connection was one mother whose husband varied the type of nappies he bought for the baby, some did not keep her dry and the mother wished he would stop 'messing around'. Five women referred to putting a special effort into toilet training - two because another baby was expected. There was discussion about the fact that some children even in the one family became dry sooner than others, but overall, ages at which children were out of nappies in the day and at night seemed comparable to children of other groups.

4. Developmental Play.

Play materials and books were not evident in the houses and children were not encouraged to learn in the pre-school years through developmental play. They were never without company, however. The environment was bright and full of conversation. While children might not be taught or read to, they were in an

environment where they heard adults and other children speaking constantly. Quite young children helped in the home in various ways; girls of eight or nine took responsibility, for younger children or for ironing, for example, in ways that are not common in English households.

An interesting discrepancy emerges from Mary Whitelocks' study (1984) concerning the difference between respondents' beliefs concerning the need to stimulate young children and babies, and what she observed as lack of stimulation and attention in the homes visited. She could not explain the fact that 100% of respondents thought that having bright toys near the baby would make him/her move about more and see better, and yet none were apparent on visits, nor that 80% thought talking to the baby would make him/her talk earlier, yet few seemed to talk to their babies (Whitelock 1984: 20). I mention this because it connects with a study by Kathleen Griffiths (1983) and is an observation which tends to dominate discussions among white professionals of Asian child-rearing practices. 'The children don't play', 'they aren't used to toys' are typical comments of playgroup leaders, nursery and infant teachers and Health Visitors.

It will be useful to see if my data can throw light on this topic. There could be one of two explanations for the discrepancy found by Mary Whitelock. Firstly, her observation could be correct in which case there is a genuine discrepancy between stated beliefs and practice. Several reasons could be suggested. The most likely is an awareness of white norms and preoccupations in this area leading to an overt stated agreement with what was recognised as the 'right' answer in they eyes of the interviewers. There is a cultural tendency to agree where possible which would reinforce this. Beliefs may not therefore coincide with the

stated response. On the other hand, this may be an ideal recognised by the women but precluded by Options (toys are seen as expensive) and by other Interests. This last suggestion accords both with discussions I had with respondents and with Fatima, and with the second type of explanation; that Mary Whitelocks' observations did not reflect that real situation in one of several ways. Firstly, the toys might be brought out when visitors are not present. Secondly, other methods of stimulation and attention might be predominant and also not employed while visitors were present. Certainly I found that toys are differently viewed. Fatima and her husband brought expensive toys for their children but these were cleared away when visitors might be expected. These aspects of life were not expected to intrude into adult life in which the home was kept tidy (at least one reception room) always ready for visitors. It was only as I stayed with the family and got to know the children that they brought their toys to me. This family was relatively 'Westernised'. On the other hand, the children themselves were not kept from adult visitors or from company. They therefore received a good deal of stimulation in this sense being included in all family and other events. There was, however, a strong expectation that they would be 'good' in front of other adults, i.e. undemanding and quiet. They were not expected to initiate conversation. This led to an impression of passivity even apathy not typical of their behaviour at other times, as we shall see below. Babies were not left in prams or cots with or without mobiles and colourful pictures, but constantly handled and passed around. Every visitor would be expected to hold the baby and admire him/her. The 'paraphernalia' of an English infancy and childhood was replaced, to some extent,

by human contact. Behaviour with guests, (including professional visitors) was, however, dominated by strong norms of hospitality and correct behaviour.

Toys were not regarded as everyday things but as special and there was a belief in the destructiveness of children who would easily destroy toys or the home (with crayons etc.) In India and Pakistan, toys are shoddy and easily broken. 'Good' toys were until recently almost impossible to find. Most parents could not believe that toys might be durable: those that are tend to be more expensive and not so immediately attractive or familiar. While there may be some truth in the notion that Asian parents are unfamiliar with children's playthings and therefore do not buy or use them much, it was not therefore true from my study that children did not play or were unstimulated. Toys are very recent phenomena in the West in the commercialised fashion in which they are currently predominant. A whole culture has developed around them: I suggest that this culture is not itself neutral or 'natural'.

5. Milestones, Behaviour, Schooling and Aspirations.

Mothers seemed well aware of their babies milestones and discussed the ages at which they walked, talked etc. Such discussions were very similar to those of English born mothers. One commented that in Pakistan you notice these matters less as the children are not with you all the time. Also that a mother teaches her child more here through being with him/her more, so the children are more forward.

Several mothers talked of their three - or four-year olds as being ready for nursery or their husbands having put the child's

name down. One had intended to do so since an older child had experienced great difficulties at school initially due to language and both mother and father felt that the younger son would be better off if he went to nursery first. However, when it came to it, it was too much trouble to take and fetch him all the time and the mother was glad to have the child home with her for company. The children's need to learn English is not the only or even necessarily a major family priority - this is not because parents 'do not care' but because other factors are important for them, such as the overall family schedule, and may conflict. Some of the preschool children were attending nursery, however.

In discussions of children, an ideal of behaviour emerged. One group of women asserted that 'your children are good, ours aren't, you teach them from the start, we spoil them'. However, this contrasted with the observed behaviour of children when we visited, and with other remarks. Mothers frequently declared that their children were 'naughty' but there was a noticeable lack of interruption by children during interviewing. The contrast with the behaviour of average English children was marked. It was not unusual for three under-fives to be present during an hour-long interview without seeking adult attention or seriously disrupting the conversation. In only one home did the children make demands and have to be overtly included and paid direct attention - Mrs Khan found these children most unusual and too active and demanding, even naughty. In contrast, I found these children very similar to my own and responded instinctively to what I saw as their natural curiosity and wish to be involved. In one other home, the children were all declared by their mother to be 'bad children, with very bad habits, not good like other peoples'

children'. Yet this seemed to be a fairly token comment as one of the same family was also seen to be 'naughty' even by contrast with the others, and not to be shy of others as he should be. This was put down to having spent ten months in hospital amongst English nurses, where he 'got used to you people' and stopped being bothered by strangers. His eyes were said to be 'like your people' - a reference to the fact that he would look you straight in the eye. He was certainly the only child in the family who would accept a sweet from me. Of course, a foreigner is strange and threatening to young children who are not used to them and it may be that it was my presence that curbed the children's behaviour. However, it was apparent that mothers praised shyness and undemanding behaviour in their children, particularly when guests were present. Rowdiness was condemned as naughty, mothers frequently described their children as spoilt or naughty.

In older children devoutness was praised, as in the case of a nine year old girl who had been determined to keep the fast although not yet of an age when this was expected. She had broken down at school and been sent home but her mother was clearly proud of her even so (see also Homans 1982). There was an anxiety amongst parents for their children to 'do well'. Several were keen to protect their girls' honour as they grew up - there was a growing demand for separate schools for girls after twelve years - this was the overriding concern of one of the husbands in particular, and has subsequently become a proposal of the Muslim Parents Association of Bradford (Parkin 1983). One family were anxious to return together to Pakistan, but most just wanted their children to do well, to get on, to marry within the family and to have a good Kismet or fate. The only two specific aspirations mentioned were both that a son should be a taxi driver. This was

in order that the mother would be able to get about more. For most, however, these things were too far ahead.

It is interesting that while they were prepared to envisage their sons marrying white girls, the reverse was unthinkable. This is because a woman becomes subject to her husband on marriage - thus a Pathan girl would lose all her heritage, including her religion, if married to a white boy. In contrast, a white girl marrying into the community would be expected to follow her husband's Pathan ways. Such girls were much praised.

Even when they had school-age children, several mothers did not know the names of the schools, the dates of or reasons for holidays and had certainly never visited the schools. In some cases school friends regularly came to play, and mothers welcomed them - black and white. A number of mothers said that they were glad to be here as their children would get a good education. Some parents regretted their own lack of attention to their studies when young. But however positive their overall view of what education could do for their children, it was not a world they shared with them in any way.

The matter they identified with most closely was their children's complaints about school meals - the boiled vegetables that they had themselves experienced in maternity hospital. School matters inevitably impinged most when they contravened other customs - such as swimming. It was hard then for mothers at least (possibly fathers too to a lesser extent) to see such issues in the overall context of the child's schooling generally. However, the school liaison teachers were welcomed and highly regarded and seemed to do a great deal in bridging this gap between home and school.

To some extent, however, their school age children had left home and the private domain and were only the subject of much discussion during the holidays. With several younger children under five, the younger ones' needs would be the mother's main preoccupation and a number, when asked about the future, were not surprisingly, just looking forward to the day when all their children were 'grown up' and out of nappies.

6. Discussion.

In the foregoing description of Pathan women's child-rearing practices, we can discern a concept of mothering and of the child which differs from that which is the ideal in English society. The mother-child relationship is important but not idealised; its costs well recognised and accepted. It is a less exclusive relationship, rooted in an extended family system and sense of collectivity which also underlies the women's own self-concept. The cherishing and indulgence and sometimes harsh punishment of children common in the Indian sub-continent has been described by Ursula Sharma (1971) in whose book the key character, an immigrant mother named Satya, comments of England that 'here they discipline them less but they love them less' (Sharma 1971: 157). Verity Saifullah Khan's work also concerns immigrant families and changing patterns of childcare following migration, and she describes the frustration and exhaustion of mothers coping in more difficult circumstances in Britain (Saifullah Khan 1974).

This comparative aspect emerged from my data in the accounts of women who had reared previous children in Pakistan, as we saw in the last chapter. We see here the effect of situational factors; while ideals of childrearing might be essentially

carried over, the Options for mothers are different in Britain. It would be wrong, however, to present all the difficulties experienced as due to altered circumstances following migration. As already stated, the ideal of behaviour was also different. Just as concepts of motherhood and of the mother/child relationship differed, so did concepts of the perfect person; the goal of socialisation.

Bikhu Parekh discusses differences in Indian and English characters saying 'One is communitarian, the other is individualistic' (Parekh 1974: 62) and analyses the way in which child-rearing practices are geared to the creation of people according to a certain ideal.

These ideals can be seen in the childrearing practices of the women interviewed. Child and adult worlds were not separated - children were included in adult visiting and events. The experiences of childhood were quite different to those that might be expected a by 'typical' English child. They were, however, consistent with a different ideal of adult behaviour as well as with a different understanding of the needs of a child, in addition to being constrained within those ideals by situational factors.

The English ideal of individual achievement leads to studies which find those child-rearing practices which fail to encourage this deficient. The pre^coccupation with developmental play (itself a recent Western phenomenon) illustrates this well and the theme of an apparent lack of play materials in Asian homes is a common one (e.g. Jackson 1976; Griffiths 1983). Studies do not concentrate on the ability of children to participate in or understand adult life, on which those children who have been less physically

separated might score highly. Work such as that by Dr. K Griffiths (1983) concerning the relationship between child-rearing practices and lower levels of later achievement in minority ethnic groups is dangerous because it takes for granted ideals which are culturally specific and suggests to many that people whose practices are not oriented towards these ideals do not know how to rear their children.

Verity Saifullah Khan looks at conflicts between Asian notions and those which underlie the educational system in Britain. She says that

To encourage questioning, inquisitiveness, to develop individual talents and self reliance of the child are, in the extreme, in conflict with Asian notions, such as the authority of elders, conformity etc. (Saifullah Khan 1974: 296)

and then she goes on:

The fact that education in Britain is not seen as a threat to the traditional family composition and relationships, to the traditional status hierarchy and status quo in general (which, in many instances proves to be the case) is due to emphasis on education as an instrument to better things, and to the parent's lack of understanding of British educational methods. (Saifullah Khan 1974: 297).

Some aspects of education are, of course, queried and seen as a threat. Examples such as sex education, dress for sport and swimming and the mixing of the sexes in secondary school are the tip of an iceberg. These are the issues of which parents are aware and have led to proposals for separate schools for Muslims (Parkin 1983). However, my respondents spoke of the value of education: their overall interests were in the better training

offered to their children here in Britain.

The issue of language skills illustrates the way in which peoples' Interests relate to an ideal of behaviour and to their own self-awareness. Early experience of the mother tongue alone may facilitate or retard the acquisition of language skills. Vivien Stern, then Principle Community Services Officer, CRC, reported in 1976 that

There are differences of opinion about language development and about the appropriate time for a child to be learning a second language. It might be better for a child to develop concepts in his mother tongue before learning a second language. (Stern 1976: 1).

This contrasts with what Dr. Griffiths describes as 'the problems of many Indian and Pakistani children who are conversant only with their mother-tongue at home' (Griffiths 1983 :402). The point is, however, that for those Pathan mothers I interviewed it was a matter of great importance that their children spoke Pukhtu. It was, moreover, the only way in which they could speak to them. For them this far outweighed any slight retardation in individual achievement even if this could be shown to result.

The influence of the Interests of various individuals can be seen throughout their accounts; in the mothers who wanted their sons to be taxi drivers; in the way in which hours of school and nursery conflicted with social patterns of the family; in the care of children outside the nuclear unit either for the sake of the child or of a childless relation.

There are studies about health in childhood not dissimilar to that by Griffiths which show how different patterns of childcare can have adverse consequences for infant and later

health; the use of lead based cosmetics (surma) has received much attention as has the practice of cousin marriage, and the vitamin D and rickets debate. These are all mentioned by Dr. John Black (1985). His discussions are more sensitive than those of Dr. Griffiths and his emphasis is in many instances on changing the system to fit people's circumstances rather than vice-versa (e.g. provision of evening clinic times) and attempting to understand cultural patterns in order to adapt to them when possible rather than (overtly, at least) to change them. Black people argue, however, that focussing on particular difficulties makes out that it is the ethnic groups and their cultural beliefs that are the problem. As Brent CHC put it concerning rickets and Vitamin D:

One of the reasons why white children avoid rickets is because the British Government supplements margarine with Vitamin D. The problem could be overcome very simply by also including Vitamin D in chapati flour or other foodstuffs, and black organisations have repeatedly asked the DHSS to do this over the last few years... White mothers are no better informed than Asian ones about the need for Vitamin D in the diet. Yet all the publicity about the inadequacy of Asian diets creates the impression that Asian mothers do not know how to feed their children properly. (Brent CHC 1981: 16).

Structural factors are well illustrated in this issue both in the fact that migration combined with poor socio-economic circumstances has led to the relative deficiency of Vitamin D compared with the situation in Pakistan, and in the fact of Government concentration on re-education and on feeding practices rather than on central supplementation such as is routinely provided for white groups. Such action is seen by black groups as

racist.

Analyses which concentrate only on cultural practices and ignore structural factors are deficient. So, however, are cultural analyses which start from assumptions concerning the ideal relating to the culture of the analyst, rather than of those observed. The cry for black workers to study black people arises because they are unlikely to have such biased assumptions. Some, however, subscribe to dominant white cultural values. Even a white researcher can paint a fuller picture if the ideals of the group in question are accepted. Nowhere is this more apparent than in respect of childrearing practices.

Chapter Eighteen. Mothering: Medicalisation, Migration and Mental State.

This chapter attempts to pull together some of the strands that have emerged from the data concerning the women as mothers which has been presented in the previous Chapters of this Part of the thesis, in order that these strands might contribute to the overall subject of these women's mental well - and ill-being and their interactions with health workers. It also looks at the answers provided by these chapters to three initial questions: the effects of mothering on women's own mental state; the effects of migration of women's experiences as mothers and the issue of medicalisation.

Answering these questions has not, however been my only aim in these chapters, each of which has concentrated on detailed behaviours and experiences relating to a different aspect of mothering. In each case, I have been concerned to draw out the logic of women's behaviours when understood from their own point of view and in the light of their own ideals. I have inevitably been concerned in part with interactions with health workers in respect of the services in each area: a theme taken up more fully in the next Part of this thesis. In this context, their value has been both in putting into sharper relief the women's own Concepts (especially when these contrast with others) and in seeking to explore the issue of medicalisation. Each Chapter has illustrated the use of my analytic framework as a way of understanding women's behaviours. This enables us to see similarities in the different areas of data although each chapter has emphasised those aspects which were most clearly dominant in respondents' accounts.

1. Concepts.

Women's Concepts have emerged clearly in respect of each area of experience, and these concepts have been differentiated both from dominant English views and biomedical ones. In Chapter Thirteen we saw that motherhood was viewed as an ideal but normal state for a woman, desired but not idealised. Two views within women's concepts were distinguished: an overall ideological view (in which children are highly valued) and an experiential view (in which the women referred to both joys and sorrows, benefits and costs in mothering). This may offer some parallels with Jocelyn Cornwell's public and private accounts (1984) although this is merely speculation at this stage. Chapter Fourteen showed up a lack of emphasis on pregnancy which contrasted sharply with both dominant lay and biomedical views in Britain. In Chapters Sixteen and Seventeen, differences in the way of viewing childhood, the mother - child relationship and the 'ideal person' or aim of socialisation become apparent. There are indications, however, of similarities between my respondents Concepts and those of working class British groups: similarities which can only be structurally rather than culturally based. It is salutary to remain aware that lay concepts amongst the indigenous population also differ from each other.

2. The Issue of Medicalisation.

What evidence was there of the medicalisation of women's Concepts of childbearing and rearing - traditionally an area of women's expertise? A paradoxical picture emerges. On the one hand, women seemed to have embraced almost totally the view that

birth should be medicalised, and it was the high technology aspects of this that they valued most (although they did not usually enjoy the experience). In other areas, they resisted attempts of health workers to override their own knowledge and expertise: the use of surma, fasting in pregnancy, were examples of areas where women listened to advice but quietly 'did their own thing'. Women appeared to differentiate between those aspects of life which they knew to be life threatening and those which were not. They also distinguished between illness and behavioural issues. Thus the advice of older women would be sought concerning many aspects of child care, whereas in sickness episodes, the husband and medical experts would be asked directly. It seems important too to distinguish between the medicalisation of the women's behaviour and the medicalisation of their Concepts. Women often deliberately 'used' the medical services, not because their concepts were similar but because their overall Interests coincided. Thus they attended antenatal classes because they believed that this might facilitate delivery (if only by earning the approval of health workers). Their Concepts of pregnancy seemed untouched. They sought longer rather than shorter stays in hospital, not because they saw themselves as ill but because they felt a need for rest - a need that is recognised in the village situation but not in Britain, where mothers are expected to resume full duties very quickly. Whereas biomedicine sees the pregnant woman as needing special care but not the post-partum woman, my respondents had an opposite view.

My analysis suggests that the Interests of the actor must be considered in any discussion of medicalisation. These may coincide with those of biomedicine even when Concepts differ and

remain different. The women could be seen to be making reasonable choices concerning which aspects of medicine to embrace and which to reject. Even when they were forced to comply, this did not imply that Concepts were altered. Following chapters will consider to extent to which Concepts of general health and illness differed from those of biomedicine.

3. Migration.

In the course of describing women's behaviours in these areas, I have considered the extent to which migration has altered the experiences of mothering for those interviewed. That it has done so is not surprising. The tension between belief and practice that results from seeing male doctors arises from the mode of service delivery in Britain; a situation that would be different in the hypothetical situation of widespread antenatal care in Pakistan which would be offered in such a way that purdah were not compromised. New and valued opportunities consequent on migration give rise to new conflicts for women.

Migration has altered the women's experiences within the domestic domain too. The daily work of child care is harder, women's expectations of practical help and support are lessened, some celebratory practices abandoned in face of a lack of older women to arrange them. Migration has not, however, altered women's aspirations for themselves as mothers. It has affected the practicalities of life, rather than the women's views of what ought to be.

4. Mental State.

Chapter Sixteen described in detail the women's experiences as mothers. Undoubtedly there were pressures - the proverb quoted at the head of this Part points to the draining effect of child care on women's own health. Another respondent said of her children that 'they eat my brains' (مارئغده خري) - a Pukhtu idiom that is singularly expressive of the strain from children's constant demands and noise. Despite migration having increased the work involved in mothering and pressures due to material circumstances of weather, confinement in the home etc., mothering was totally accepted by all women, leading to an absence of role conflict in respect of it, and the women's experiences have to be viewed in this context. For women themselves, the drudgery and pressure was acceptable because mothering was normal and acceptable. Children provided company for the most isolated women and the constant pressure of physical work left little time for reflection or brooding. On the other hand, there were tensions for women.

As we have seen, some arose from the necessity to interact with health services which embodied a different ideology and in which women met unkindness and racism on [^]many occasions. I have to conclude, however, with some people with whom I discussed early research proposals, that this time of life, when women were rearing young children, was one of fewer (rather than more) conflicts for Pathan women in Bradford compared with later stages in the life cycle of a woman. Despite the work, there were many positive experiences of mothering and women had confidence in their own expertise in this area - confidence that had not been

undermined by health workers.

5. Interactions with Health Workers.

In exploring issues concerning the interaction between those interviewed and health workers, I would suggest that my analysis represents an advance in two ways over some of the others reviewed. Firstly it illustrates the complexity and sense of process that characterises the women's actions. Writings which concentrate on 'one side' of health care interactions, stressing either the patient's non-attendance or the racism in the system inevitably lack this sense of movement and continual negotiation and change. They also fail to show how it is aspects of the women's own beliefs which both encourage and discourage use of services, and aspects of the services themselves which are both the incentive and a disincentive to this. Ironically it is the medicalisation of birth which most appeals to Pathan mothers, unfamiliar as this is, since it offers promise of a better outcome for mother and child.

Secondly, both cultural and structural aspects are stressed and their interaction is illustrated. Thus the distinctiveness of the women's actions and beliefs is brought out at the same time as aspects of common ground with other groups - black and white, Muslim and non-Muslim. For both the women and the health care workers, ideological and circumstantial factors determine Concepts, Options and Interests.

The end point of the analysis is some understanding of the nature of the women's concepts in these areas of mothering and of the effect of mothering on their own health. These understandings are both relevant to my overall purpose concerning concepts of

mental well - and ill-being. The first is relevant because concepts of well -and ill-being share many features with other health related concepts: the theme of collectivity, for example emerges from all chapters. The effects of mothering on the women's own health has aetiological significance in respect of mental well- and ill-being because childcare is a major part of their lives. I have therefore looked at the satisfactions and frustrations they find in this work.

This Part has been much concerned with interactions with health workers: the next chapter takes up this theme in more detail, setting the interactions with maternity and child health services in the wider context of health care. Indeed, I have deliberately avoided discussions of the mothers' perceptions of health visitors in this Part on mothering, despite the role of Health Visitors in respect of children under five years. This is to enable these views to be seen in the context of views about the primary health care team, whose most prominent member, the General Practitioner, is discussed in chapter twenty. The opposite decision could as justifiably have been taken, to enable discussion in the context of the women's views of mothering.

However placed in this work, interactions with health workers will clearly affect the women's future readiness (and ability, as we shall see) to contact the health services in the event of distress or mental ill-being. Therefore both the interactions described in these chapters and those in the next are relevant to my aim concerning mental state.

PART IV. GENERAL AND MENTAL ILLNESS: DEFINITIONS OF NORMALITY AND OF APPROPRIATE BEHAVIOUR.

کہہ بیمار ہو یا نہ کہہ خوشحال ہو یا غم
خوب کار کو جو
جب غم کنیں کیے

Whether we are well or ill, happy or unhappy, we do our work.

I place it (unhappiness) quietly on my heart.

(Pathan Respondents).

My concern in this thesis has been to explain various sorts of behaviour on the basis of the interaction of the respondents' Concepts, the Options available to them and their Interests. Further I have shown how concepts themselves are complex and reflect factors other than ideology: incorporating aspects of past experience, expectations of the future and definitions of the present which are rooted in structural factors. This framework has provided me with a useful way of presenting material concerning Social Interaction and Purdah Observance (Part II) and behaviours relating to the bearing and rearing of children (Part III). Here too this framework offers a way in which the women's behaviour and experience in respect of both general and mental illbeing can be understood from their own perspective. The concluding chapter to this Part indicates how this is so, drawing also on some of the material previously presented, thus reflecting another fundamental orientation which is that health and illness, and particularly mental health and illness can only be understood fully within the context of an understanding of the women's lives. This parallels Jocelyn Cornwell's approach (Cornwell 1984).

It will be seen that this Part brings together two areas of ~~data which were collected separately: data relating to general~~

data which were collected separately: data relating to general health and illness behaviours and data relating to mental well - and ill-being. I do this because of a wish to relate the data in both areas to a body of literature concerning Concepts of health and illness and because the themes which emerged from my data in respect of each area were markedly similar. In addition, psychiatry is a branch of biomedicine in this country: this means that, in practice, treatment paths to specialist psychiatric care lie through general health services. Women's experiences of these services will therefore be relevant to their readiness to seek help for other disorders; any complaints of a minor nature which are seen by doctors to have a psychiatric basis will in fact be treated by general health practitioners and seen by them as 'illness' if not by the women. The fact that data was sought which related directly to unhappiness and mental state is, however, a safeguard here, as I discussed these issues with women in addition to and independently of asking about illness. In my presentation I have not sought to integrate this data within chapters until the concluding one: this enables the Concepts which emerged to remain connected to the discussions from which they were drawn.

The retention of two main topics within this part might be seen as 'breaking up' the reporting of data relating to Concepts of health and illness. This data is introduced in the first chapter concerning literature and then discussed as it arises; firstly from the general health discussions and, later, after the presentation of material concerning mental state. To break these discussions up is no bad thing, however, since my focus is not Concepts alone but health care behaviours and interactions.

Continuity in relation to material concerning Concepts is retained by the use of a common series of headings in the chapters where the focus is on Concepts. These headings relate to themes arising from the literature and enable the reader to connect the different areas of data with each other and with other writings.

My aim in the literature chapter is not to discuss other writings in terms of the framework I am myself using or to seek a synthesis of those works discussed. The studies referred to are diverse in focus of attention, methodology and theoretical assumptions: not all share my concern with Concepts as one of a number of factors influencing behaviour. They have been selected, however, because they raise issues which seem of importance in relation to my data. At the end of each section, therefore, I draw out questions which might usefully be asked of my data in respect of the Pathan women studied. These I attempt to answer in the later relevant chapters. It is the answers and the emphases which emerge from my work which have led me to find my own framework a useful way of understanding respondent's behaviours. The last chapter therefore draws the material of this Part together; relating to each other the data in respect of general health and illness and that concerning mental ill-being, and relating my framework to the themes identified from the literature.

Chapter Nineteen. The Literature Concerning Concepts of Health and Illness: Some Major Themes and Questions.

Reference has been made to the growing literature concerning concepts of health and illness and the relevance of this to my current concerns. These topics have been addressed by writers from a variety of academic traditions: from social historians through social ~~psychology~~^{psychology} and medical sociology to medical anthropology and by a growing number of practitioners also. Transcultural Psychiatry may be seen as a meeting point of academic and practical interest: issues of cultural relativity pose urgent questions for psychiatrists working overseas or with minority ethnic patients. This challenge is not so acutely felt by other doctors most of whom can ignore threats to the universal applicability of their expertise. As an academic discipline, Transcultural Psychiatry has been seen as one of the major branches of medical anthropology (Helman 1984: 141). My purpose here is to identify themes in this literature which relate to my data and questions which might usefully be asked of it.

I have already referred to some of these themes. For example, chapter one started from the issue of differences between lay and medical conceptualisations of health and illness (p.1f) and went on a bit later to consider the extent to which these should be seen as inevitably distinct and/or in conflict (p.14f). In addition, the issue of cultural and structural influences both on concepts and on behaviours was there introduced as an important one, and a number of references were made to the fact that writings demonstrate differences in emphasis and perspective to the extent that their theoretical understandings are not

necessarily compatible. In Chapter Six, the works of Jocelyn Cornwell (1984) and Claudine Herzlich (1973) were referred to because of their emphasis on the interactive nature of concepts of health and illness - an emphasis that is relevant both to my overall argument and framework and to the discussion of the importance of the relationship (s) between the researcher and those people studied. In this chapter, I will set these in the context of the literature from which they emerge.

1. Disease, Health and Illness.

A distinction made by many authors (e.g. Eisenberg 1977, Fabrega 1973, Field 1976; Helman 1984; Kleinman 1977 and 1978) is that between 'illness' and 'disease'. This distinction is now commonly used within medical anthropology and medical sociology. David Field defines the two terms thus:

'Disease' ...refers to a medical conception of pathological abnormality which is indicated by a set of signs and symptoms. 'Illness', on the other hand refers primarily to a person's subjective experience of 'ill-health' and is indicated by the person's feelings of pain, discomfort and the like. ... to say that a person is ill implies that the consequences of such a state transcend the merely biological and physical consequences of organic malfunction and affect his whole social life in important ways. (Field 1976: 334 - 335).

He goes on to explore the consequences of calling a person 'ill' and makes the point, made also by others, that a person can have a disease without feeling ill or feel ill without having a disease.

The diagnosis of the presence or absence of disease may or may not be problematic. The 'set of signs and symptoms' are investigated by various means. For the patient, it is the doctor's pronouncement concerning the presence or absence of 'disease' that counts, often it will legitimise or not an illness experience (see Cornwell 1984) and this legitimation has social importance.

The bases on which health and illness are defined are more various. An important distinction which has emerged from empirical work is that between functional and existential definitions. Thus, some people see health as the ability to do certain things; illness is then often defined by whether or not the person is able to work. Others see health as a state of optimum being with various dimensions (physical, mental spiritual). Alphonse d'Houtaud (1981 and d'Houtaud and Field 1984) has explored these themes in respect of a large sample of French people presenting for routine medical checks (the sample is from this point of view not a general population sample) and has found that age and social class seem to be factors which relate to those different views, the tendency being for older and lower-class people to define health in a functional way. Claudine Herzlich's earlier work (1973) found that her respondents saw health and illness as factors of the relationship between the individual and his/her way of life; some saw health as a state of equilibrium, some as a reserve (like a capital asset which could be used up and needed to be maintained), and others as the absence of illness (Herzlich 1973: 55f). She also found three main ways in which illness was viewed: as destructive, as liberator and as occupation (1973, Chapter 8). Her work has been developed and

used by other writers (e.g. Williams 1983; Pollock 1984; Pill and Stott 1982 as well as d'Houtaud already mentioned), who have identified social factors which coincide with these views of health and illness in different social groups. Two further concepts have been distinguished by other writers. These are 'strength' (Williams 1983), which Scottish people distinguished from health and 'disorder', which David Locker (1981) distinguishes from illness.

We must therefore see how disorder and illness are defined by my respondents. Intra-group comparisons on the basis of sex, age or class will not be possible due to the small sample and its relative homogeneity, but it will be of interest to see if themes emerge from my data which bear a similarity to those relating to other groups described in the literature and, if so, if we can identify common cultural, religious or social factors.

2. Illness and Normality.

A further distinction must be referred to at this point. It is clear from the literature that what people find normal and acceptable in terms of their own experience and behaviour (and that of others) does not always coincide with the definition either of disease or of illness. David Field discusses this issue (1976: 336-7) as does Cecil Helman in relation to both physical and psychiatric disorders (1984: 70 and 142f). It also emerges from Gilbert Lewis's work (1975: 1978) in which it seems to be the absence of a particular cause which leads the Gnao people to view certain diseases as acceptable and not requiring particular precautions. I will return to the issue of causality below. The important point here is that it is often the question of whether

or not illness is viewed as abnormal and/or unacceptable that leads to the seeking of treatment (see Blaxter and Paterson 1982; and Helman's discussion referring to other studies 1984: 70).

In respect of my data, therefore, I shall look, not only at how illness is defined and (particularly in respect of mental ill-being) how this relates to biomedical disease categories, but also at whether or not suffering is viewed as a cause for action; under what circumstances and what sort of action it leads to. Are functional or causative notions important in deciding this?

3. The Distinction between Medical and Lay concepts.

Arthur Kleinman (1978) has suggested that illness may be differently conceived in what he identifies as three arenas within any 'health care system': the professional, the folk, and the popular arenas. In respect of any particular illness episode, therefore, the healer and the healed may have different 'Explanatory Models' (EMs) deriving from different arenas. These arenas are seen as cultural sub-systems. EMs may or may not be compatible, leading to understanding or not in health care encounters. Disease EMs are associated with the biomedical perspective, to be found in the professional arena in most health care systems. Arthur Kleinman's search for a theoretical framework within which medical systems can be compared as cultural systems seems to offer a useful way of drawing together the large number of empirical contributions to this field of study. This is, indeed, his purpose. I have difficulties with the model which derive, I think, from its dual focus: on the individual encounter and the EMs of individual participants on the one hand, and on a

postulated health care system (with its three arenas) which is geographically specific as a whole and culturally homogeneous overall. These two foci conflict at times. For my respondents as potential patients, the three 'arenas' of their health care system were not coterminous nor did they form a cultural whole. If the focus was on the 'health care system' in the area in which they lived, on the other hand, important parts of the respondents' medical systems would be excluded.

In addition to my working difficulties with the model, however, there are some fundamental issues which need to be answered relating to the framework proposed. Firstly, are the EMs of biomedical and lay people that distinct in practice? In his empirical work, Cecil Helman suggests that they are not, and identifies a moving together of lay and medical perspectives. He describes a process of interaction between these (1978). Jocelyn Cornwell also finds both disease and illness concepts in the accounts of her respondents and it is partly on this basis that she sees this as implying a false dichotomy between lay and medical. Her 'commonsense beliefs' incorporate medical as well as popular understandings (Cornwell 1984: 118). As the process of medicalisation progresses, is it helpful therefore, to have a framework based on difference?

Secondly, some writers see an overall underlying structural conflict between the three arenas such that they cannot be considered within the same framework. (This is almost the opposite view to the above.) Ronald Frankenberg represents this view in his original criticism of Arthur Kleinman's paper (Thomas 1978). Insofar as the three arenas are based on a structural division of labour in society between healer and healed, there is, such critics would argue, conflict built into this relationship which

is necessarily one of authority and differential power. Conflict is not therefore a failure to communicate due to different sub-culturally derived understandings (as Arthur Kleinman suggests) but a process intrinsic to the system. There are powerful echoes here of the criticisms made by black writers in respect of culturalist explanations of racial conflict, in health care and other areas (e.g. Sivanandan in Parekh 1974; Littlewood and Lipsedge 1982).

Ronald Frankenberg is not the only author to see medicine as an institution of social control and conflict as inevitable in the meeting between doctors and patients. Jocelyn Cornwell reviews such works and finds herself speaking of 'critics or sociologists' (1984: 19) including writers such as Ivan Illich (1976) and feminists such as Ehrenreich and English (1979) with the radical sociological theorists who take this view. She sees such champions of patients as in practice invalidating ordinary people's views of health, illness and health services because where people/patients do not see themselves as in conflict with health workers, they are deemed to be suffering from a failure to perceive their own real interests. This issue relates to women's perceptions of themselves and to ethnic minorities also, both of which are relevant to this study.

Jocelyn Cornwell's answer to the question of whether or not there is an underlying structural conflict between Kleinman's three arenas would therefore be negative, I suspect (she does not refer to his work). Her reason would probably derive from the point already made that these arenas are not in practice that distinct - the views of her respondents incorporated professional and popular understandings. Moreover, she identifies a complex

interweaving of interests on the part of health workers and patients: interests that sometimes coincide. The theme of interests is also identified by W. R. Arney in relation to two histories of obstetrics. He sees a conjunction of interests between both women and medical practitioners as part of a new structure of power (Arney 1983).

My study started from an assumption concerning the difference between lay and medical concepts of health and illness on the part of my informants. In describing their views, therefore, I shall be asking how far this assumption was true in this instance. I shall also be looking to identify the respondents' Interests and asking how compatible or not they are with those of the health workers. In view of the fact that I accept that the medical perspective is not unitary (this is particularly true within psychiatry), I will need to clearly indicate what (or who) are taken to be representative of it and, if possible and relevant, what sorts of biomedical or psychiatric viewpoint(s) are thereby represented. In respect of general health care and contact with health workers, I will look at areas of conflict with the Pathan respondents and explore the extent to which this seemed to derive from different conceptual frameworks. Such differences as are found might arise from lay/medical differences and/or cultural differences and/or conflicts deriving from the power relations either in the lay/medical relationship or in the black/white one. These factors may be impossible to distinguish, but it is clear from the literature that any or all may be present.

4. Factors influencing popular/lay concepts.

I have already mentioned above, that class-related factors have

been shown by Alphonse d'Houtaud (1981) to be important in influencing lay concepts of health and illness. Roisin Pill and Nigel Stott (1982) have identified variations within a socio-economic group which relate to level of formal education and home ownership. For Joan Ablon's Samoan respondents, religious factors, the supportive nature of their own community and a powerless position within society are suggested as the factors which determine illness behaviour (Ablon 1973). Jeremy Seabrook's description of the ideas of Northamptonshire bootworkers in the last century illustrates similar themes (Seabrook 1973).

In addition to these aspects of the group concerned, some characteristics of the wider society have been shown to affect concepts of health and illness at any point in time. The nature of the health care system overall is one such factor; specifically the availability of a service free at the point of delivery (Helman 1978; Blaxter and Paterson 1982, Stacey forthcoming) and the wider associated existence of a welfare state (Cornwell 1984) have been identified as influencing concepts of members of that society. This difference is often identifiable in different age groups within a population in which such a system (e.g. the NHS in Britain) has been introduced at a given point in time. It will be of interest to see whether my respondents' Concepts of health and illness seem to have been altered by the recent move from a situation with poor health-care resources and facilities (in Pakistan) to one with a wide-spread and biomedically sophisticated system of health care services (in Britain).

In looking for structural factors in my data, I will be seeking to correct a tendency within the literature relating to

the health beliefs and practices of lay minority ethnic groups which emphasises cultural factors. As stated in chapter one of this thesis, such emphases tend to create a picture of exotic or quaint customs and beliefs which relate to the country and culture of origin and must either be tolerated and allowed for, or challenged and changed. By showing the structural factors which influence and sustain concepts and by demonstrating similarities between the group interviewed and other, culturally different groups (including some indigenous ones), this tendency will be challenged, as it was in the data relating to interactions with maternity and child health services in previous chapters.

5. Different Medical Perspectives: the Case of Transcultural Psychiatry.

Early transcultural studies concentrated on looking for universal symptom clusters across cultures. Arthur Kleinman criticises these, calling them the 'old transcultural psychiatry'. Using the distinction already discussed between 'disease' and 'illness', he says that these studies have been preoccupied with disease 'as an entity, as a thing to be "discovered" in pure form under the layers of cultural camouflage' (Kleinman 1977: 4). Disease, he says, is an explanatory model, not a thing. Moreover, he claims that

Psychiatric categories are bound to the context of professional psychiatric theory and practice in the West. Psychiatry must learn from anthropology that culture does more than shape illness as an experience; it shapes the very way we conceive of illness (1977: 4).

He therefore suggests that a 'new cross-cultural psychiatry'

is emerging based on these understandings and uses examples of the somatisation of depressive illness amongst Chinese people as an example of the way in which culture can be seen to shape normative and deviant behaviour.

Not all agree with Arthur Kleinman's assertions. Some maintain, with K. Singer (1977), that we cannot assume 'as he does without adequate evidence that Western psychiatric categories are culture-specific'. However, a body of empirical work explores the ways in which culture does influence lay perceptions of mental illness, the symptoms they present and their very experience of distress (see, for example, the volume edited by Marsella and White 1982).

For other authors, it is structural and political factors which have been ignored, rather than cultural ones. Thus Roland Littlewood and Maurice Lipsedge (1982) review the early history of psychiatry's search for comparative brain weights and behaviours across races, in the context of colonialism and Western dominance. They see this trend of ignoring structural factors as one which continues in many studies of the mental health of ethnic minorities, including those which emphasise the role of culture. Thus, in another publication, Roland Littlewood comments that

even the culture - bound syndromes are perhaps less determined by a particular culture alone than they are the product of a cultural response to Western dominance including the spread of biomedicine. (Littlewood 1985: 14).

It is not only within transcultural psychiatry that political factors are stressed. A book edited by David Ingleby (1981) brings together a number of different groups within 'critical psychiatry' (including the anti-psychiatrists such as R. D. Laing

and T. Szasz in the late 1960s), all of whom see mental illness as a political issue, a response to the contradictions of society. The fault of biomedicine is seen as being not just that it treats disease as a thing but that it treats people as things. (Ingleby 1981: 13).

I have already spoken of the way in which transcultural psychiatry in Britain has changed over the past ten years (pp.2f above). Those most aware of racism and its effects tend to espouse a critical approach to psychiatry and to stress structural factors. Culturalist explanations are themselves often seen as racist. Roland Littlewood's comments on a book by Philip Rack (1982) are telling. He says that

Avoidance of a critical approach to psychiatry (which is seen as an essentially neutral and culture-free reflection of the natural world) leads Philip Rack to psychologise political response (Littlewood 1983).

Nevertheless, Philip Rack's book is important as all his critics allow (Littlewood 1983; Saifullah Khan 1984). In it he outlines the widely used British psychiatric classificatory system (Rack 1982: appendix 1, pp253-61), and also some of its deficiencies, pointing out that even this system is not unitary, depending on 'an untidy set of variables, phenomenological, aetiological and even judgemental in its very definitions' (p.260). The importance of his work is that it offers an excellent way-in to many of these issues, starting from ground familiar to health care workers.

The questions which underlie this debate within transcultural psychiatry should be familiar from my discussion (above) of Arthur Kleinman's framework for the analysis of medical systems as cultural systems. Would it be sufficient if Philip Rack had taken

psychiatric classification systems as culture - bound phenomena, as particular EMs ? Or is the whole framework invalid because it fails to take account of underlying structural inequalities and political conflicts?

How do these issues relate to my data? Although I will not attempt to resolve them at a theoretical level, they have clear relevance. In chapter one I indicated my intention of drawing out both structural and cultural variables: this review demonstrates the importance of this. Despite my awareness of the different approaches within both psychiatry and transcultural psychiatry, I shall at times refer to 'psychiatry' and 'mental illness' as a medical view, to contrast with the Pathan lay view that it is my purpose to describe. When using other terms which are variously used in the literature and represent different theoretical perspectives I shall, to avoid ambiguity, follow them with a reference to an author who uses this term in the way I mean it. In practice, my concern is with the least differentiated of psychiatric disorders and with the definition of normality.

The translation of meanings across cultures crystallises many of the issues relating to the comparability of emotional states cross-culturally. It is a topic which came to have central importance in this study. It is the subject of a number of other writings (e.g. Berry 1969; Leff 1973 and 1977; Oyebode 1985; W.H.O. 1973; White and Marsella 1982). A central theme which emerges is the question of whether the difficulties of translation and the existence or not of comparable terms and meanings invalidates such attempts. Answers clearly relate to the authors' overall theoretical perspective in relation to the wider issues just discussed. My attempts to translate and use standardised

measures indeed showed up some of the assumptions on which they were based, as we shall see. It revealed similarities and differences between the biomedical and lay perspectives investigated. This is the subject of Chapter Twenty-Two, below.

6. Questions of Causality.

Causality is at the heart of the debate within psychiatry, because if mental illness is 'a response to the contradictions of our present society' (Ingleby 1981: 13) it will possibly disappear under an ideal (usually seen as truly socialist) social system. Most theorists see the situation as more complex, however, seeing mental illness as a continuum, although there are differences in whether this continuum is seen to run between biological and psychological or between biological and social variables (see Littlewood's comment (1983) on Rack's approach). I will, however, leave psychiatry momentarily to briefly consider some of the main causative factors identified in studies of health and illness generally and how these might relate to my data.

Two themes run through the literature concerning causality: the issue of the location of the causes of illness and that of responsibility for becoming ill. In respect of the former, Cecil Helman identifies four possible sites of illness aetiology in lay theories: the patient, the natural world, the social world and the supernatural world (Helman 1984: 75). Roisin Pill and Nigel Stott's interest is, however, in responsibility for illness, and they identify two groups of concepts of aetiology:

those which place the cause with the afflicted individual and those which place it outside him. In the first group, the individual is regarded as responsible for choices resulting

in sickness... according to the second group of hypotheses interpreting human sickness, the individual is considered fated. (Pill and Stott 1982: 44 -45)

It is clear from the second sentence that 'cause' in the first is used in the sense of responsibility rather than location, and this is made clear later in their paper in which the actions of the supernatural, spirits or ancestors (located outside the sufferer) are causes for which responsibility may be with the sufferer, while germs, hereditary factors etc. (located within the body, although, in the case of germs, social in origin) are causes for which the sufferer is not responsible.

In a sense which is not entirely analogous to this distinction between site and responsibility, Claudine Herzlich refers to 'endogenous' and 'exogenous' types of explanation:

On the one hand, illness is endogenous in man, and the individual carries it in embryo; the ideas of resistance to disease, heredity and predisposition are here key concepts. On the other hand, illness is thought of as exogenous: man is naturally healthy, and illness is due to the action of an evil will, a demon or sorcerer, noxious elements, emanations from the earth or microbes for example (Herzlich 1973: 19).

Amongst her respondents, she finds a bipolar classification between the individual and the way of life in which the neither one is either wholly healthy or wholly unhealthy. Responsibility is seen to lie, not in becoming ill, but in losing one's health.

Allan Young's concern is with systems of medical knowledge and whether these can be characterised by the mode of explanation dominant within them (1976). Further, he seeks to identify these with particular cultures and forms of society. The two types of

belief systems which he identifies are therefore, different again. Internalising and Externalising systems incorporate notions of both location and responsibility for cause as well as the way in which explanations are related (through narrative or through image and analogy.) Although this analysis is of interest, particularly in respect of the links made between the overall division of labour in society (a structural consideration) and the types of causal explanations employed, it is not directly relevant to my data which concerns individual responses rather than total belief systems.

Jocelyn Cornwell's work (1984) again comes closest to my own. She identifies three aspects in her respondents' causal explanations:

location of the causal agent (place); whether or not the condition could have been avoided (circumstances); and whether or not the person who has the illness is responsible for having it (blame); (Cornwell 1984: 150).

Of eight possible logical combinations, only four categories were used by her respondents - she found that 'public accounts' were preoccupied with notions of responsibility, while in 'private accounts' there was a 'chain of causality'; a series of events seen as leading to illness episodes many of which might be avoidable. These included social factors such as poor housing and unemployment over which the individual had little control, as well as individual choices and actions.

In my data, I shall look at the explanations given by women for both general health and illness and for excessive unhappiness, for episodes of mental illness and for such deviant behaviours as might be seen by psychiatrists as symptoms of mental illness. The issue of responsibility for both cause and behaviour emerges as

important. Jocelyn Cornwell's identification of social factors in causality brings me back to a study which informed my early interest in this study: George Brown and Tirril Harris's classic study of the Social Origins of Depression (1978). As indicated earlier, issues of aetiology have been seen by some as so fundamental to the definition of mental illness that they critically affect the existing psychiatric classifications and understandings. Brown and Harris review the various arguments but decide to stick with the existing psychiatric classifications of depression; they do, however, develop measures to be used for sufferers not in treatment. They develop a model in which life events and difficulties are seen as provoking agents, but they also identify four protective and vulnerability factors which affect the outcome. These are the presence or absence of a confiding relationship; whether or not the woman was employed; the early loss of mother; and the presence of three or more children under 14 years at home.

It could be argued that the social situation of my respondents is so dissimilar that these factors do not apply: we know that none worked outside the home and most had three or more young children at home. Moreover, all had recently experienced the major life event of migration. Diana Hull has reviewed the literature relating to the effects of migration on health generally finding this to be ambiguous (1979). For a consideration of the relation between migration and mental illness see Hitch (1975).

In terms of mental health, migration entails adaptation to a different environment, and this can be viewed as a major life event, whether or not it is seen as linked to the development of

illness. Whatever the differences between my respondents and those studied by George Brown and Tirril Harris, it will be of interest to look in general terms at the losses and difficulties which my respondents report, particularly any which seem akin to those identified in their Camberwell study.

Chapter Twenty. General Illness: Treatment Options.

It was easier to ask women about what they did when they or their families were ill than about health and illness in abstract, although this data did emerge. The accounts of treatment - seeking behaviour show us which services and actions were, for the women interviewed, Options in respect of illness, although, as we shall see, the forms in which they were used by respondents made them a different sort of service to that which was envisaged. The women's Options are not, therefore, the same as the range of services on offer since notions of acceptable behaviour ^{and} different Concepts of illness both limit and extend the range of 'services' in their case. This chapter is arranged according to the treatment Options mentioned by respondents. The last section of it presents data concerning complaints in respect of which the various Options were seen to have failed. Some non-Options also emerge by default: there was no reference to use of homeopathic cures, acupuncture, or private biomedical treatment. The latter was presumably excluded on financial grounds, although this was not explored and it is possible that families were not aware that this possibility exists in Britain together with the NHS. Treatment by hakims was also not sought by those interviewed; in view of the recent interest in the use of these healers by Asian communities in Britain (Aslam 1979) the reasons for this were explored, and are presented with material concerning treatment from religious healers.

1. The General Practitioner (GP).

Mark Johnson and Malcom Cross (1983) have studied use of primary health care facilities in a survey of over two thousand households (of white, Afro-Caribbean and Asian descent) in the West Midlands. In respect of GP services, two contradictory myths prevail concerning ethnic minorities: that they fail to use the services 'properly' and/or that they make 'excessive' demands. Their survey demonstrated that Asians were both more likely to have visited their GP and to have visited more frequently. However, the white - Asian differential eroded or was reversed when numbers of children were taken account of and also a tendency of white respondents to make greater use of hospital out-patient and emergency clinics. The 'excess' usage of GPs by Asians did not seem unreasonable in terms of need. Three-quarters of Asians were registered with a practice including (or made up of) Asian doctors and the authors say that their data suggests that for a large number this was a deliberate choice to minimise language difficulties.

All families of the women I interviewed were in close contact with their GPs. As Table (xiii) shows, all but one were registered with a practice of Asian GPs in the centre of the city. These doctors did not speak Pukhtu - indeed there was, at the time of study, no employee of the Health Service in Bradford who did - but they did speak Urdu. Thus the reason for their popularity as GPs for the Pathan families seemed to be that it enabled the husband to communicate with the doctor. In all but six instances, the women did not themselves go to the doctor. A seventh went sometimes. One of these seven was the single case of a woman whose doctor was female, four of them were cases where the women themselves could not speak Urdu anyway and could therefore not communicate directly with the doctor. Only two, therefore,

Table (xiii)

Use of N.H.S. Services

Respondent Number	General Practitioner		Go for self	Go for Children	Clinic Use	Health Visitor Contact
	Racial Background and sex	Is Direct Communication Possible?				
1	Asian M	Yes	No	No	Yes, child's injections	Yes
2	Asian M	No	Yes	No	Yes	Yes, + ve
3	Asian M	Yes	Yes	Yes	Yes	Yes, + ve
4	Asian M	Yes	Not usually	No	No	Not mentioned
5	Asian M	Yes	No	No	No	Yes, with interpreter
6	Asian M	No	Yes	Yes	(Yes, checks, (tests, etc.	
7	Asian M	No	Yes	Yes		
8	Asian M	Yes	No	No	Yes	Not mentioned
9	Asian M	Yes	Never	Never	No	Yes, Husband intervenes
10	Asian M	No	Yes	Yes	Yes	Yes
11	Asian M	Yes	No	No	Yes	Yes
12	Asian M	Yes	No (comes to home if necessary)	No	No	Yes, + ve
13	Asian M	Yes	No	No	No	Not mentioned
14	Asian M	Yes	No, unless a real need	No	No	Yes
15	Asian M	Yes	No (comes to home if necessary)	No	Sometimes with Husband	Yes + ve
16	Asian M	Yes	No	No	Yes	Yes
17	Asian F	Yes	Yes	Yes	Yes	Yes

themselves went to the doctor and could communicate with him directly when they got there. There is a paradox in so far as, apart from these two, it was the very women who could speak nothing but Pukhtu (and therefore could not communicate directly with the doctor) who did attend his surgery in person. The reason for this paradox lies in the coincidence of the two factors involved here - language and purdah observance. The women who spoke only Pukhtu were those from the North-West Frontier proper, not the Chhachh district of Attock. These women observed purdah strictly but less rigidly than did their Pathan sisters (not always recognised by them as true Pathans) from the areas over the river Indus. This subcultural difference was described in Chapter Ten (2.A). The group from Chhachh district is larger, fairly close knit and, in Bradford, very concerned to maintain appearances and fearful of gossip. None of them saw it as proper for the women to attend the doctor's surgery except in extreme circumstances. Thus language problems - the most frequently cited reason for difficulty in health care situations - were not the reason why women were not treated in person by their GPs. Only one woman said she did not go due to her own inability to communicate with the doctor - this was one (No.2) who went for her own problems but felt it was no help for her to be there with the children as her husband or sister spoke Urdu, which she did not. Thus they would report the problems even if she went too.

The reason why women did not go in person to the doctor was not therefore language, but observance of purdah. Only one woman claimed that purdah should be maintained from the doctor himself - one other explicitly said this was not the case and a number admitted that there would be less embarrassment with either an

English male doctor or a woman doctor (whatever her race as long as she was sympathetic). Internal examinations by a man were mentioned by some as a problem. However, most saw the difficulties not in the doctor himself but in the men who would be present in his waiting room. It was from their friends' and co-villagers' husbands that they must be hidden - and since they all used the same practice of doctors (due to their husbands' lack of spoken English) this prevented the women from going. It was a women only (zenana) place that was needed, not merely or even mainly a woman doctor, although presumably the husband was a necessary chaperone if his wife were to be seen by a male doctor and thus the only way to achieve a women-only place would be for the doctor to be female too. Such a doctor would have to be able to speak Pukhtu or have a Pukhtu-speaking interpreter available as four of the seventeen women spoke no other language and were dependent on their husbands to interpret for them, although this did leave thirteen who could have communicated with an Urdu-speaking female doctor had there been a women-only surgery time. It is interesting that the General Practice to which Mary Whitelock was attached in Woking sets aside one afternoon a week for women and children patients only (Whitelock 1984). She does not state whether men are excluded from the waiting room at this time.

The solution of the communication problem (either through provision of interpreters or by the women learning Urdu) would not therefore bring more women to the doctor's surgery. However, there was a language issue that would have solved the problem. Several women said that if they knew English, they could go to ^{an} English doctor. The purdah issue would then be resolved as they would not all be registered with the same doctor, and fellow

Pathans in the waiting room would be a rarity. There would also be less embarrassment with the doctor himself were he not an Asian. Several women expressed a wish to be seen by an English doctor as they were felt to be better.

The women's views about their doctors varied. Two took a religious view that healing is God's job anyway - one did not approve of taking a lot of medication for this reason, another said medicines could help but prayer was the most important thing. Most were grateful to their GPs. for their understanding of the fact that purdah prevented them coming in person to the surgery. There was considerable praise for the doctors involved for this reason - 'he does whatever we ask', 'he will come to the home if necessary', 'he understands that we can't come'. Three felt that their doctors were 'no good' anyway - mainly because they did not examine the patient fully or seem to pay much attention to them. 'In Pakistan you pay for it but they really go into it.' Most recognised the drawbacks of treatment by proxy and gave examples of it - some felt tired of asking their husbands to keep going for them and also that their husbands were fed up with it. Those husbands I spoke with about the research emphasised the need for their wives to learn English, so that they could take responsibility for their own health care and that of the children. The need for the husband's presence created practical problems - in terms of time off work - and there was also the feeling that this was 'women's work' even though it was located in the public domain. It would be acceptable for the women to move out to obtain health care if circumstances allowed them to do so effectively and modestly.

The services of the General Practitioner can be seen, in the

terms of my framework therefore, as an Option on the part of respondents but one which was limited by their own norms of behaviour. On the one hand there was the importance of treatment, and on the other, the importance of religious observance and maintaining correct behaviour. We will see later that Concepts of health and illness were not such as to override such limitation. It would be wrong, however, to see the arrangement of services as somehow 'given' and 'neutral' and the women's behaviour as the factor limiting Options for themselves. Services and the way in which they are arranged reflect societal assumptions concerning social structure: for example, Health Visitors are predominantly women and work 'normal' daytime hours reflecting the assumption that those with the care of young children and/or the old will be women who can be expected to be home in the daytime. Although true for my respondents, this is increasingly less true for all sections of the British population. In Pakistan, separate areas are routinely provided for men and women to wait in hospital and doctors' surgeries: this is considered a normal facet of service delivery. It should be noted, however, that the respondents themselves completely accepted the N.H.S. arrangements and preferred to modify their receipt of health care rather than their purdah observance in respect of routine health care for themselves. They were full of praise for the doctors who accepted their choice in this.

2. The Child Health Clinic.

The study by Mark Johnson and Malcom Cross (1983) suggests that the two services of the Child Health Clinic and immunisations (often, but not always carried out at these clinics) are well used

by ethnic minorities, 'and that if anything ethnic minority uptake of immunisation is as good as or better than that of working class white families living in the same areas.' Mary Whitelock's much smaller study, confined to Asian Muslims shows that reasons given for attending the Child Health Clinic were as follows:

To see the doctor:	32% of replies
For immunisation:	21% of replies
For Health Visitor advice:	14% of replies
To weigh baby:	29% of replies
To buy milk/vitamins:	4% of replies (Whitelock 1984)

In respect of my respondents, there was a greater tendency for women to go in person to the health clinic than to the doctor. Four women who did not go to the doctor went to the clinic. One said that this was because it was all ladies there anyway. The presence of a female Urdu speaking interpreter or Health Visitor was seen as an advantage. One said that she went rather than her husband because there would be a need to undress the baby - not a man's role. Even so, there were a number who did not go; in some cases the husband took the child, in others no comment was made about how immunisations were handled. Generally the Clinic was visited when an appointment card came. Two saw it as a place for check-ups, tests and injections - most associated it with injections. None saw it as a place to seek advice about infant care - one was surprised when I suggested she took a problem she had with infant feeding to the clinic. She thought an appointment was always needed, although she knew the day. One had once gone to seek advice for herself as a friend said it was for women's problems too, but had been advised to see her GP so felt it was useless. A number said there was no point in asking about a sick

child at the clinic; 'they will only send us to our own doctor anyway, better to go there first'. However, as the woman would not herself go to the GP, there did seem to be more scope for the clinic to encourage women to bring their children's problems there and then themselves act as referral agent to the GP even if the husband still had to go to obtain a prescription. In this way the mothers' difficulties would be better represented. This then, was an area where there seemed to be potential for this service to be extended to form an enlarged Option for these women. The relative responsibilities of the General Practitioner and the Community Physicians are complicated and controversial, however, rooted in the history of the N.H.S. and in the various power relations between doctors therein (Davies 1984).

3. The Health Visitor.

Both Jane Schofield (1981) and Mary Whitelock (1984) see considerable scope for the role of the Health Visitor with Asian, particularly Muslim, women and young children. My study confirmed this although respondents stressed the importance of the relationship established and of the Health Visitor's attitude to them and to their expertise. All but three spontaneously mentioned the Health Visitor and all who did so spoke warmly of her. Although they did not tend to see the Clinic as a place to go for advice, they did see it as proper to ask their Health Visitor and clearly did so. This is similar to Mary Whitelock's (1984) finding that Muslim mothers expected advice on baby care from the health visitor. The importance of this contact cannot be overemphasised, especially where the Health Visitor spoke Urdu or Punjabi as did one to some extent - or could use an interpreter.

In two instances however, women desperately needed help - one could not ask her Health Visitor because her husband was always present - the other might have done so had there been an interpreter present, had her husband happened to be out and had there not been a change of personnel which meant that it was a while since the Health Visitor had called.

The use of husbands as interpreters in the home (many were unemployed) seemed to be undesirable. Whenever it was mentioned women had been prevented from speaking of quite severe difficulties or felt unable to resist the joint pressure of husband and health worker and state their own position. Such pressure rarely resulted in advice being taken up, however. In two instances the difficulty was that the husband would not permit discussion by his wife of matters that were a great burden to her. One of these issues was abortion, the other her own depression. In two others, the husband expressed condemnation of his wife's 'village ways' and ignorance, siding with the Health Visitor in issues that made little sense to the women.

Generally, however, the women were ready to learn new ways from the Health Visitor and praised methods of child-rearing that were not familiar but seemed to work. This was apparent in their eagerness to know about infant feeding and their enthusiasm concerning toilet training. It was not the women's ignorance but their intelligence that led to their refusal to adapt or abandon certain habits. They sought to understand the reason for such changes in terms that made sense to them. Not all put forward by health workers did. The sorts of reasons that made sense tended to be personal and practical rather than scientific and abstract. Fundamental was the woman's trust in the health worker involved.

Was she a sympathetic, nice person? Was she friendly, capable of having a joke with them? Did she seem to want to help, to respect the mother's experience of childcare and of her own children? Did she try to understand and make herself understood? The importance of the personal element needs emphasising. Like health workers, the researchers were also assessed by the women on personal not professional grounds. Once the worker had established this, the difficult task of discussing controversial matters could start.

Such areas of conflict usually reflected differences in the Concepts of the lay respondents and their health workers or differences in their respective Interests. The use of surma, a paste which is frequently lead based and is applied to childrens eyes, is one example. Medical anxieties concerning this practice are reflected in the fact that a DHSS leaflet (1983) has been produced in six languages warning of the dangers. These dangers are not apparent to mothers who have been familiar with this practice and not seen it to have harmful effects and for whom cultural and religious reasons for its use (enhancing the appearance of the child and use of a holy substance) predominate. Use of alcohol or smoking cigarettes are perhaps the most analagous common English practices with some potential dangers. It is seldom pointed out that the considerable literature relating to health education in these matters has not needed to be translated into six Asian languages. Fasting during pregnancy and the apparent lack of developmental toys are similar areas of conflict which have already been discussed in Part III (Chapters Fourteen and Seventeen respectively).

4. Hospital Services.

The women's own experiences of hospital services tended to derive mainly from their own experiences of antenatal care, and of delivery, which have been discussed in Part III.

In addition to this, eight of the seventeen focus respondent mothers had experience of a child under 5 years in hospital in Britain. Thus ten of a total of 68 children in the current care of these women had been hospitalised. Most were local and mothers had visited daily. One was in Sheffield and the mother visited regularly. One of the children had died in hospital. Most expressed positive views about the treatment received - two mothers had become so upset by the child's condition and their separation from the child they stopped visiting regularly - one was advised to stop by the hospital, the other by her husband. In both cases the husband took over the role of primary visitor. These mothers saw their distress as having upset themselves and the child unnecessarily, but did not seem to feel guilty about this. There was an apparent lack of a norm of keeping a 'stiff upper lip' in such circumstances. Most were happy about the arrangements for visiting, though in some cases the care of other children at home prevented visiting as frequently or for as long as was allowed.

In this area, two examples of conflict with health workers were particularly striking. The first was the woman who wished to dress her dying baby in clothes sent by relatives from Pakistan in order to photograph the Child. This request was refused and seen as completely unreasonable by nurses. It is not possible to say whether or not it represented a danger to the baby but the manner

in which the matter was dealt with illustrated clearly the different Interests of health workers and mother. Their readiness to see her request as ridiculous was possibly also based in the expert-medical/ lay-patient relationship and in the white health worker/black parent one. This child had, in fact, recovered.

The second was an instance where a family who visited a child in hospital from a distance were encouraged to claim travel expenses by social workers on the basis that the child's father was unemployed. Although they agreed to do so, the grandfather explained to me that to do so would have been shameful and would have represented an abdication of responsibility for the child on the part of the family. Here we can see clearly a conflict between underlying Concepts of familial and state responsibility for health care and its financial consequences.

5. Religious and other 'folk' healers.

There has recently been much attention focussed on the use of alternative healers by ethnic minorities. Mohammed Aslam's (1979) work on hakims was based in Bradford and he has demonstrated that such workers practise in the city. Mary Whitelock also reports that there is a practising hakim in Woking (Whitelock 1984: 11). As shown by Table (xiv), of the focus respondents in this study, five refused completely to comment when asked about the use of either a hakim or a malwi at times of sickness. All others said they had never seen a hakim, two saying they didn't know what we meant, one unsure whether there were any in Bradford. Most said that they did not use them in Pakistan either, usually because a senior male member of the family said they were 'no good'. Only one woman said that she was not sure whether her husband had

Table (xiv)

The Use of Alternative Facilities in Sickness

Respondent Number	Hakim	Malwi		Other
1	No	No,	although sister talked re-use of tarwiz for psychiatric problems	-
2)	No) forbidden by	Not	in Pakistan for epileptic	-
3)	No) F and F-in-law	in Eng.	fits in children	-
4	-	-		-
5	No	No	only God can help if we pray to him.	-
6)	complete refusal	to respond		
7)				
8	No	No	only go to doctor	-
9	-	-		dai
10	-	-		-
11	No	Yes	Tarwiz from Malwi or Pakistan for child crying in fear at night	-
12	No	No	"people don't do this here"	-
13	No ? are there any here	No	Tarwiz is "gunah" (sinful) Faith should be in God not in Malwi or tarwiz.	-
14	No - don't know if Husband has	Yes	Tarwiz from local Malwi (a villager) or Pakistan for children crying without reason	-
15	No, nor Husband	Yes	local Malwi and visiting one in Bolton for tarwiz for child with eye swelling	-
16	No	Yes	Tarwiz for children	Masseuse
17	No, no good	No	-	-

visited a hakim, although she had not done so herself.

Of course, the women would themselves be unlikely to visit a hakim in person (although they might have had medicines brought for them) as his shop would be even fuller of other Asian men than the doctor's waiting room. Most of the women strongly asserted their use of their own doctor.

Seeking advice from a malwi was somewhat different. Two women stated strongly that faith should be put in God, not in malwis, saints and shrines or tarwiz (the holy words which are made into an amulet to be worn round the neck of the sufferer). To make tarwiz was seen by these women as sinful. However, four women did seek such amulets - all for the children, two for crying and fearfulness particularly at night, one for an eye condition for which the child was also undergoing concurrent hospital treatment, and one just 'for the children' without a specific instance stated. Yet another additional respondent discussed with a friend the use of tarwi z for psychiatric problems in adults. The local malwi had been approached by the husband for help. Two women mentioned sending to relatives in Pakistan for tarwiz made in the village and one had consulted a visiting malwi in Bolton. One case retold to me in some detail was of one ^Srespondent who would not visit a hakim, but was involved in an ongoing way with religious beliefs and practitioners, despite a certain private laxity concerning other practices (such as regular prayer). Frightened by dreams of an impending death in the family, this woman sent gifts to her father to ask a local saint (pir) in Pakistan to say prayers for herself and her family. She was convinced of the predictive nature of this occurrence. Sadly, her beliefs were later justified in the death of her four-year-old

son. It was very apparent from this account that the women had a fundamental belief in the spiritual dimension in respect of life, illness and death, and that she readily turned to Pakistan and to healers there when in distress or need. The pir consulted had been known for his healing skills.

The effect of the women's reliance on religious healers on their use of health services is a topic of some interest to health workers. It was clear from the statements of all respondents that none of these practices in any way detracted from their seeking help through their General Practitioners. There were, however, a few examples of some influence on women's persistence in pursuing a matter with their General Practitioner when religious healers had been reassuring. Most striking was the case of a woman who had consulted a malwi when in Pakistan concerning epileptic fits in her child - he had made a tarwiz and also predicted that they would cease before the age of seven. This prognosis had proved correct and was relied on by the mother in respect of a similar problem with subsequent twins born in Britain. Unfortunately the General Practitioner had been unhelpful when consulted about this through the husband (who had perhaps not stated the case very strongly) and although the woman was under severe stress dealing with these toddlers and trying to follow the doctor's advice 'not to upset them' lest this provoke a fit, the problem was not taken up very strongly, partly because her previous experience and the helpful advice from the malwi reassured her of a similar happy outcome.

In Bradford, although the hakim and malwi are the workers frequently thought of as possibly providing alternative or additional health care for ethnic minorities outside the N.H.S., they are of course men and not personally accessible to women in

purdah. There are, however, female 'experts' within the domestic domain. Those mentioned, although in each case only by one respondent, were the local midwife (dai) and the masseuse. In the latter case one woman recommended a lady with special expertise in 'rubbing' to whom the respondent subsequently went for her help with a painful shoulder which she had had treated by such a person when it had happened previously in Pakistan. In the former, a respondent referred to having once obtained some medicine from a woman with experience of such matters in order to abort the child she had been carrying. Most women, however, denied seeking the advice of older women in matters of sickness and firmly stated their total reliance on the official health service.

6. Illnesses for Which Treatment was not Sought, or where Options were Ineffective.

Many women mentioned various periodic aches and pains and headaches. Period pains were also common. Most dealt with these by taking anadin or aspirin, sometimes lying down if the children and husband permitted, but otherwise treating them as a part of normal life, rarely seeking treatment for them from their doctors. I was often told 'we do not have time to be ill'. Illness was seen to be a major event, from which flu, coughs, colds and headaches were excluded so that women would say 'I have not been ill myself at all'. There was an implication that coughs and colds, aches and pains were everyday occurrences in face of which work had to go on more or less undisturbed - to rank as an 'illness' and thus by association a cause for not doing one's work, the condition had to be more severe than this. There are

links here with Helman's description of older patients in Middlesex for whom the treatment of a cold was their own responsibility and less likely to mobilise a caring community around the patient than a fever (Helman 1978: 177) and d'Houtaud's (1978) work in which the manual workers think of health in terms of the ability to work; links too with Jocelyn Cornwell's description of the way in which public accounts stressed good health (Cornwell 1984: 127), and with Rory Williams' accounts from elderly people in Scotland (1983).

As Table (xv) shows, six of the women had long standing health complaints in respect of which treatment had not been sought or for which it appeared ineffective. This raises two issues: of treatment being precluded by the lack of an acceptable option (where treatment was not sought) and of possible underlying psychiatric disorder (where treatment was ineffective).

One woman had been reluctant to seek treatment for herself since the problem was a 'woman's one' and she feared the shame of examination by a male doctor. The others were under the treatment of their doctor - one was seen by other women to be hypochondriacal - she was always complaining of health problems and seemed to enjoy taking medicine. I suggested to a relative that unhappiness might be a reason for her behaviour, but this was denied and the woman said firmly - 'she is just like that' and elaborated on the effects of her behaviour in causing other family members to pay her some attention and to do her work (cf Cornwell's account of Nellie Davies (Cornwell 1984: 125-6)). The woman concerned frequently complained of neglect by other family members. One other found medication helped a little. The other three felt that treatment had been no help. In one case, the woman's complaints seemed to me to have a definite psychiatric

Table (xv) Longstanding Health Complaints

Respondent Number	Duration	Under Treatment	Helpful?	Nature of Complaint	Associated Event
2	3 years	Yes	No	Dizzy spells and headaches 2 or 3 times weekly. Tiredness, aches and pains.	Since migration
3	2 years	Yes	No	Blocked nose, pains in legs	None
4	Longstanding	Yes	Likes treatment but little relief	Constipation, gas, burning feet	Mother's death
11	1 year	Yes	No	Dizziness, tiredness, headaches, pains under ribs	Since death of mother and birth of baby
13	1 year	No	-	Extreme pain passing urine, too shy to go to doctor, she would be sent for examination. Bruising also	Since birth of baby
17	3 years	Yes	A little	Very bad headaches every 1½-2 months	Since 40 days after birth of other child (not most recent)

Nos. 1, 5, 6, 7, 8, 9, 10, 12, 14, 15, & 16 had no longstanding health complaints

basis being linked with both her mother's death and the birth of a child. The woman herself made these links, sometimes seeing her 'illness' as the cause of her worries and sometimes her worries as the cause of her illness. The mild tranquiliser prescribed by proxy for her seemed to me to be inadequate in dealing with what I saw as a quite severe depression. The complaints of the other two women were not so easy to understand, although the woman who claimed to have been 'ill' since migration was undoubtedly under great stress, physically run down and unhappy. Her sister complained of a blocked nose for which she sought in vain for a satisfactory explanation. She found her doctor unhelpful in his refusal to agree to an X-ray. She did not otherwise appear to be unhappy or under particular strain.

7. Womens' perceptions of Health Workers.

A very mixed picture of nurses emerges from the study generally with two extremes. At one was the nurse who cried with the mother when her baby died, the ones who loved the child hospitalised for his first ten months and who cared for him 'like a mother', and all those who took time to understand, comfort and admire and make a fuss of the women's children. Joking requests to keep a child by staff were seen as the ultimate compliment and retold to friends. At the other extreme, the nurses who laughed at them, ignored them, rebuffed them and shouted and swore at them. Contacts with health workers were long remembered, good and bad. The frequent use of family metaphors to describe good care accords both with Whitelock's findings concerning women's perceptions of the Health Visitor, a large number (75%) seeing her

as a substitute for family (although the same women also saw her in other roles in addition) and with Bikhu Parekh's observations that Indians have two categories of relationship - family and outsiders, and try where possible to explain relationships in close family terms, which then determine expectations of mutual behaviour (Parekh 1974).

These contacts with health workers might be the only contacts women had with English people. Health workers therefore bear a great responsibility for the impression that these women get of English society. The women are only too well aware of the racist attitudes of such groups as The National Front. Their personal experience in hospital can serve to convince them that these are minority views or confirm them as general. The things looked for were not intellectual or difficult. They were not such things as detailed awareness of strange practices and customs or language. Women did not even look for success in communication. They did, however, notice whether or not people tried and whether or not they seemed to care.

Two other specific experience of prejudice should be mentioned. Many women spoke of the interpreter in the hospital clinic who sought bribes of gifts from them to ensure that their views were fully and accurately conveyed to the doctor. None was prepared to make a formal complaint either individually or through me. It was clear that it was only one individual and that other interpreters encountered did their their job honestly. Some women had challenged the person concerned and condemned her behaviour. All knew that this was not acceptable practice in Britain, however much of it goes on in Pakistan. For many women it was a struggle even to get to the clinic, as I have shown; to encounter such behaviour when there was the last straw. This raises the

important issue of the power that the interpreter has.

The other experience of prejudice was on the part of some (but not all) Asian junior hospital doctors who declined to speak to women in Urdu. This raises a status issue. Many doctors from overseas struggle against great odds to achieve their qualifications. Even then, they are not fully accepted within the Health Service, often ending up in unattractive specialities such as geriatrics and psychiatry. They are often designated to work with immigrant patients - also seen by colleagues as of low status. Many of these patients are in fact of quite different cultural background to their own. When there is a matching, some use this opportunity to help the patients in their experiences of racism within the health service. Others do the opposite, passing on to their patients their own experiences of prejudice and racism, insisting on speaking English to emphasise their superiority and equality with white colleagues. Although this work is concerned with the views of the patients, who found such behaviour when they met it very hurtful, it does need to be set in the context of the doctor's own experiences.

Chapter Twenty-One. Concepts of Health and Illness.

The last chapter presented data relating to the Options for health care which came out of discussion with respondents concerning their illness behaviour. From the same discussions, it is also possible to draw accounts of health and illness which relate to the themes and issues which were identified in Chapter Nineteen from the literature concerning Concepts of health and illness.

1. Disease, Health and Illness.

Women spoke of a whole range of states in which they felt themselves to be less than normally healthy as 'illness'. Generally, darkening of colour, weakness, weight loss and tiredness as well as specific symptoms, such as headaches or other bodily aches and pains, were seen as indicators of ill health. Examples of this were a baby who was vomiting who was said to have become thin and dark in colour. The same was said of a young boy with leukaemia. A comparison was made with their previous state when both had been 'good fat babies'. One woman who was seen to have gone darker in face colour was asked if she were pregnant; another woman was tired, not gaining weight and lacking in strength. Her husband compared her condition with that of another mother at the child health clinic who had, like his wife, given birth to twins but had nevertheless regained strength and put on weight. Despite the emphasis on putting on weight as healthy, a tendency to gain excessive weight was also seen as undesirable,

although not in itself an indication of ill-health. It might however become a cause of future illness.

What was of major importance for women was not, however, how they felt, but whether or not this rendered them unable to fulfill their various obligations within the family. Many therefore claimed never to have been ill. Others used the word illness in terms of how they felt but said nevertheless that 'whether we are well or ill, we do our work'. Thus the overall indication of (serious) illness was the inability to work. There is a clear parallel here with Alphonse d'Houtaud's findings (1981).

In terms of the identification of disease by their doctors, there was some indication that doctors also assessed the seriousness of a complaint by its social effects as well as the reported symptoms. If the patient were not present it is indeed hard to assess it in any other way. Thus the person presenting the symptoms would be asked if their wife or mother were still doing their work around the house before the doctor diagnosed and prescribed for her (see also Rack 1982:110 for an example of a typical doctor - patient interaction which emphasises this definition of illness as social disfunction).

2. Illness and Normality.

Both health and illness were viewed by those interviewed as inevitable and normal states. Some might see this as a result of having been reared in a country with poor medical facilities. In Britain, with improvements in the technological possibilities of conquering disease, there has been a growing tendency for all sections of the population to see illness as alien and conquerable. However, the move to Britain had not, for those whom

I interviewed, changed their view that, even in such advantageous medical circumstances, illness was both normal and natural. Religious beliefs sustained this view. It was on a religious basis that women argued that both health and illness were given by God and were, in a sense, irrelevant. Illness was not seen as punishment by God, any more than health was a reward. Either and both are one's fate (kismat).

As in some other studies described in the literature (see Helman 1984: 84f for a discussion of work relating to the reasons for consulting a doctor or not), the factor of whether or not the 'illness' interfered with daily activities was often the basis on which the women decided whether or not to seek treatment for themselves. Just because illness was seen as inevitable, this did not mean that it was desirable or viewed with complacency. The acceptance of one's fate is often described as fatalism which has a negative connotation of apathy. This was not the case with the women interviewed. Many wished to be treated effectively for their disorders. However, the important thing is to maintain faith in God and obedience to him, whatever the circumstances. Correct behaviour in face of adversity is therefore often of more importance than the adversity itself. Thus although women wanted effective treatment for their disorders, the maintenance of pardah - an expression of their faith - was not something to be lightly discarded for this or any other purpose.

3. The Distinction between Medical and Lay Concepts.

Differences between lay and medical concepts emerge most clearly from the accounts of interactions with health workers and

the areas of conflict described. Some such areas of conflict were apparent in respect of some matters of child-rearing and aspects of behaviours in pregnancy, both of which were the subject of previous chapters (Seventeen and Fourteen, above).

The fact that women did not all go in person to their GP might be seen as reflecting underlying differences in the way illness and disease are conceptualised. This did not in fact seem to be the case. The biomedical emphasis on investigation of physical symptoms was shared by the women. Indeed, they often complained that doctors in Britain were not thorough enough in this respect, and they sought X-rays and blood tests as a way of exploring their disorders fully, being critical of doctors who did not authorise such investigations.

Thus it was not, in this respect, a conceptual conflict that primarily underlay the women's illness behaviour. This contrasts with the situation in respect of pregnancy, where concepts were dissimilar, but many of the women complied despite this. In respect of general health and illness where the symptoms did not disrupt the women's work, it was not a difference in Concepts so much as difference in Interests which seemed to inform behaviour. The women's Interests in Purdah Observance overrode their Interests in treatment on many occasions. The conflict concerned mode of service delivery rather than treatment per se. Both patients and doctors suffered in different ways from this lack of fit. Women realised that they had less adequate treatment due to the choice they made not to attend in person. For doctors, there was presumably a conflict between, on the one hand, their own training and professional standards, which maintain the importance (rooted in concepts of biomedicine) of examining the patient; and on the other their awareness of, and respect for, the women's

customs together with a wish to respond to their medical need; a combination which led these doctors to modify their usual professional practice.

Comparing my findings with others in the literature, there is some evidence of the influence of structural factors on interactions between the women and health workers. The fact that the clash between service provision and their own ideals of behaviour led them to accept a lower level of service rather than to press for change is evidence, perhaps, of their felt powerlessness in face of services. As we have seen, doctors too adapted, although the overall system did not. In this it is, however, probably significant that the doctors concerned shared the racial background and some of the cultural values of their patients, and therefore were more prepared to modify their practice to accommodate them. This is in contrast to those Asian junior hospital doctors, who often refused to make a much lesser concession by speaking Urdu with the women in antenatal clinics. White nurses were sometimes superior, at other times 'like sisters'; some were prepared to modify hospital rules and their own behaviour, others were not. The study was not set up to explore whether this tendency was more marked with black than with white patients, although a number of examples did seem related to race and cultural factors. What this study points to is the assumptions underlying the mode of service delivery; it also shows how much difference individual efforts to be friendly could make to the women's perceptions of health care. This is not to 'psychologise' structural inequalities. Rather it is to stress the importance of both personal factors and structural and political factors in respect of health care interactions.

In general, it was felt that health services in England were better than in Pakistan. Relatives might be encouraged to come for treatment here, and residents visiting Pakistan temporarily would return prematurely to deal with health problems. In respect of a subnormal child, medicines obtained in Pakistan had been found to be of lesser strength, while facilities for training were virtually non-existent. However, it was generally the medication and technology here that was superior - for example, incubators for underweight babies. There was some protest that customs, for example in relation to infant feeding and care, are quite adequate in Pakistan and not life-threatening. Moreover, considerations of health care had to be taken in the context of consideration of other family obligations. Thus there was discussion of whether young children should be taken to Pakistan to visit. The changes of diet and climate involved were recognised to be potentially dangerous for a young child, and a number of babies had had to be admitted to hospital on the family's return to Britain. However, other factors also had to be considered. Thus one family with an epileptic child had been advised against taking her on a visit to Pakistan but had gone nevertheless as the mother's father was dying. The child had suffered since treatment there was not as good as in Britain, but the mother saw her father before he died. The same family currently felt unable to visit relatives in Pakistan due to the child's condition and need for treatment here, even though they wanted to do so. There is clearly a difference between merely wanting to go and the obligation to be with a dying parent. As with mothers in this country (Graham: 1979) it was a conflict of responsibilities that might lead to a family putting one child's health in jeopardy, rather than an attitude of irresponsibility.

Several respondents compared the way injections are given in England and in Pakistan - we were told that here they throw them straight, not sideways and slowly as in Pakistan. Factors such as the use of disposable syringes were mentioned - 'oh our poor Pakistan, they don't have so much money to throw things away'. Although it was felt by many that doctors here are not as attentive as in Pakistan, there was criticism of doctors in Pakistan too - 'they give you one big injection and a bottle of medicine and only afterwards ask what is wrong'. The tale was told of a woman who drank all of the medicine in one go. Others asked what happened. Nothing, was the reply, it was half water anyway. This was greeted with roars of laughter. So too was the tale of the woman who went to the doctor and was given a prescription which she made into a tarwiz, put round her neck and returning to the doctor she said she felt fine now following his treatment. This tale seems to me to contain elements of several attitudes - laughter at the stupidity of the patient with whom they identified and at the efforts of both medical and religious healers and the ultimate irrelevance of all of them. For behind the high regard in which British medical services and doctors were undeniably held, there was a certain scepticism concerning the attempts of any intermediate agent - medical or religious - to divert the purpose of Almighty God. A scepticism too about the reality of illness which could be 'cured' in such a way.

4. Factors influencing the women's concepts.

Concepts of health and illness emerged from this study which bear a marked similarity to those described by Joan Ablon (1973).

Like the Samoans on the West Coast of America, Concepts of endurance in face of suffering could be seen to derive from factors such as religious beliefs in which fatalism was a strong element, a supportive social network (although this was less true for some of my respondents than for others) a low social position as immigrants and, in the case of my respondents, as women in a sex-segregated society. There was for both groups a lack of any sense of power to alter either circumstances or outcome. This led to a consequent lack of attempts to do so. Similar themes emerge from Jeremy Seabrook's account of Northamptonshire bootworkers in the last 50-100 years (Seabrook 1973).

The importance of good health, the reasons for this (enabling them to look after home and children: to 'work') and the fact that it is a matter of fate or of God's will, are all paralleled in work by Jenny Donovan describing the views of people of Asian and Afro-Caribbean descent living in Britain (Donovan 1983). Temperature and thinness were also found to be indicators of ill health in the Asian groups she studied.

Jocelyn Cornwell's work (1984) also provides many parallels. Particularly striking is the emphasis on correct behaviour in face of illness and on continuing to work whenever possible. As with my respondents, 'work' meant care of the children and the home and one can hear echoes of the East End women's accounts in the Pathan women's protests that they would feed their children and husbands even on their death bed. As women in the domestic domain, schedules might be modified where possible to accommodate sickness, and seeking treatment would be delayed in respect of their own health, often only justified when others were affected by the woman's ill health rather than by her own suffering.

Similarities in the results of these studies should alert us

to the danger of seeking 'cultural' explanations alone for conceptual differences. Joan Ablon's respondents were Samoans living in America, of a fundamental Christian belief. Jocelyn Cornwell's were East-Enders, not immigrants (with fixed prejudices in respect of those who were) and did not profess to be religious (although they claimed some supernatural point of reference for some of their convictions) while my respondents were Pakistani Muslim immigrants in Britain. The social situation of these people had more in common than their culture. Of course it can be rightly argued that the studies are not strictly comparable on grounds of very different methodologies. However themes emerge which are strikingly similar.

There are differences, however, and these are also illustrative. Although Jocelyn Cornwell found a belief in 'one's lot in life', she is careful to distinguish this from fatalism (p.168-9). Part of her argument is a salutary reminder of the inappropriateness of this notion or of many of its negative correlations. In respect of her own respondents, she says that

It is not helpful to describe the people in the study as fatalistic simply because many of them said that they believe in fate, if it means overlooking the premium they themselves attach to taking the initiative in relation to health problems which is part of their approach to life as a whole (Cornwell 1984: 169).

Her respondents had 'hard-earned lives' and similarly 'hard-earned health'. In public accounts of health and illness, 'good health' was a morally worthy state, and illness was discreditable (p.127).

Although her respondents had a similar attitude to mine in

respect of those they saw as malingerers (her Nellie Davies had a sister in my Kareemo Bibi) and although there was a parallel belief in the importance of correct behaviour in face of illness and in not complaining, there were differences in the extent to which a person was seen as responsible for ill health and therefore to which it was seen as discreditable. My respondents were more thoroughly fatalistic than Cornwell's. Here the religious justification for, and grounding of, their beliefs may be apparent. The Pathan women laid little or no emphasis on personal responsibility for illness. Even in the case of Kareemo Bibi, she was seen as responsible, not for her illness, but for behaving as if she were ill when she in fact was not. Both health and illness were one's fate, given by God. With Jocelyn Cornwell, I would however, query the negative correlations of the term 'fatalism'. Used in the West, this is set in a context of belief in the positive nature of individual initiative. In the different Asian context, the notion has positive connotations of acceptance and trust.

Cornwell describes the basic elements of her respondents' public accounts as

the acceptance of an unequal, hierarchial and largely immutable 'natural order of things' and the emphasis on right-mindedness, cheerfulness and positive-thinking as the one contribution the individual can make towards improving his or her own lot in life (Cornwell 1984: 170).

Much of this applies to my respondents, with a basic difference: the overall aim was not for them, to improve one's lot in life but to maintain proper relations with God and with one's fellows. Social and spiritual life were emphasised over individual aspects.

Alphonse d'Houtaud and Mark Field (forthcoming) also identify 'fatalistic' and 'voluntaristic' themes in their French study, linking these to variables of age and class. As we have seen, 'fatalism' is itself a complex notion which involves more than one dimension: it can be about who is responsible for the illness or about responsibility for behaviour in face of it, or both. We must be careful when using this notion, therefore.

5. Different Medical Perspectives.

This issue is less relevant in respect of general health and illness than in respect of mental ill-being, below. Undoubtedly those health workers met by the women will have had different viewpoints; I did not, however, set out to investigate this and therefore have to take 'the biomedical view' as given and uniform noting only those individual differences in treatment of them by health workers which were remarked on by the women, and which may or may not have reflected more fundamental differences in outlook on the part of those involved.

6. Questions of Causality.

Women would often discuss the various reasons for their own ill-health. The four sites of causation discussed in Chapter Nineteen 6 could be identified in their discussions.

In respect of factors located within the individual, heredity and disposition were often mentioned. Thus in the case of weight gain, some women were seen to have a tendency to obesity, taking after a mother or aunt. Another woman's own character was seen to

be at fault in her hypochondriasis.

The social world was also identified by women through the belief in the power of the evil-eye (nazar) through which good fortune could be destroyed by another person's jealousy of it. Thus it was seen as everyone's responsibility not to flaunt their own good health or fortune. (Compare Jeremy Seabrook's account of the power of certain individuals to 'overlook' and destroy others 1973: 47). See also belief in the power of other women's voices to dry a mother's milk (above; chapter seventeen).

The natural world was often a cause of ill health. One woman explained her hair loss in relation to change of weather, water and shampoo on migration, although others related this to a folk belief that a woman's hair falls when her baby is growing and beginning to notice things. (There may be a nutritional reason for this association in a country where babies are breast fed a long time and the mother's health deteriorates as the child requires more of her.) The weather was frequently cited as a cause of illness: this was particularly remarked on in the context of migration. I was told that: 'we get more ill here, it is not good for us here', due to the fact that women do not get out and sit in the sun. This confinement to the home was also blamed for obesity - 'we don't get any exercise, just sit around and go to each other's houses and drink tea and eat'. The suggestion that they might diet was ridiculed and I was told very firmly that 'we eat what we like'.

Food was generally seen to be good for you - I admitted to missing meals and was scolded as lack of food leads to tiredness and inability to work. There were also detailed beliefs about the effects of hot and cold foods - this belief system was not documented as part of this project, as reference was made only

occasionally to such matters, but for discussion of the understanding of this in the sub-continent generally see Henley (1980). Alcohol was referred to by one woman as a source of strength and the probable reason why a white mother of twins was healthier than she. Whether this idea is widespread I'm not sure, it certainly has little relevance for the women's own health, as consumption of alcohol is absolutely forbidden on religious grounds. Sudden changes of temperature were often seen as the reasons for illness particularly in children, and mothers took care to protect young children from such changes.

A pain in a shoulder was attributed to the way the person slept on one side, due to the presence of young children in bed. Some conditions were seen as themselves having certain effects - thus teething was connected with diarrhoea, one mother remarking that it seemed in one of her children to be associated with vomiting instead. Cancer was discussed a fair amount - no causatory factors were suggested but it was seen to be 'that sort of thing that keeps coming somewhere else' if not stopped. Thus a woman who had had a lump on her arm which was not operated would probably not now have a lump on her chest had the first one been removed; another had had a breast removed and was now all right - yet another had died following three operations to remove a lump - on the chest, in another site and finally on the leg.

The supernatural world offered an overriding and preemptive source of all things however. Ultimately it was God who was the cause of illness as of health, but any of the various factors mentioned might bring on an illness and care should be taken not to expose oneself to unnecessary risks. Factors in the causation were also seen by some to be important insofar as an illness stood

some chance of being treated if the cause were known but not otherwise, although the most orthodox would claim that prayer was the only effective treatment, since only God could heal.

In terms of responsibility for illness, most hereditary factors were not seen to be controllable. The woman who complained continually was blamed, but for her behaviour not for any supposed illnesses. This would seem to imply that while dispositional factors and heredity can lead to illness they need not lead inevitably to 'bad behaviour'. There was an element of responsibility in the theories located in the social world insofar as it was seen as a person's responsibility to behave modestly and not to arouse jealousy in others. In respect of environmental factors, the responsibility was for staying healthy rather than becoming ill. There was an implicit notion of a 'reserve of health' (Herzlich 1973) which must be maintained by proper clothing and precautions, especially in the case of children.

The preoccupation of my respondents was similar to that of Jocelyn Cornwell's, therefore. Just as the public accounts of her respondents were preoccupied by notions of responsibility, so were those of Pathan women I interviewed. Although responsibility was the important issue, it was not open to discussion or negotiation. It was moreover, responsibility for behaviour during illness rather than for becoming ill that mattered, and this was something for which every individual was held responsible to some degree, whatever the nature of their illness. Maintenance of social relations was of more importance than individual suffering, which was accepted as inevitable to some degree, depending on the will of Allah.

Chapter Twenty-Two. Assessments of Mental State.

I turn now to the data which emerged from the study concerning mental state. In the case of Concepts of general health and illness, the women's understandings became apparent through their accounts of treatment - seeking behaviours. In respect of mental or emotional ill-being, none were receiving specialist treatment and only one identified her physical disorders with unhappiness. In Chapter Twenty-three below, I will describe the Concepts of mental well-/and ill-being which emerged from their accounts overall. Some of this data is drawn from discussions concerning general life satisfactions and frustrations. The richest source of data in respect of this topic was however the discussions which arose from my use of the psychological test scales with women, and it is these that I describe in this chapter.

My aim in the assessment of mental state was to explore the extent of distress which was not identified as illness and also to shed some light on the issue of whether seclusion amongst Asain women was leading to depression (as understood in a biomedical framework) which was going untreated.

1. The Bases of Assessment: Medical and Lay EMs.

Three main methods of assessment were used: the women's own self-assessment, our assessment as research workers, and two psychological test scales. Some factors of possible aetiological significance were noted: the degree of social isolation of each woman (based on the woman's own felt isolation combined with her

reported visits or lack of them within the previous few weeks) and the long standing health complaints already described.

It was my intention by these means to arrive at assessments with two main bases; an orthodox psychiatric model and a lay Pathan Model. These would correspond to Explanatory Models as described by Arthur Kleinman (1978). I spoke in chapter nineteen of the fact that the 'medical model' is not unitary and of the consequent need to indicate what I am taking as representative of it. I therefore preface this description of the data which emerged from the assessments with some indication of the nature of the Explanatory Models which were operationalised (in the case of the test items used) and which emerged (in the case of the views of respondents).

My definition of the orthodox psychiatric model is pragmatic and tautologous. It is that system of thought which is operationalised in the tests used. In the case of the General Health Questionnaire this is described as 'psychiatric disorder'. The questionnaire is concerned with 'two major classes of phenomena: inability to continue to carry out one's normal "healthy" functions, and the appearance of new phenomena of a distressing nature' (Goldberg 1978: 5). It is a measure of the 'least differentiated level of psychiatric illness', which includes 'a tendency to develop various minor somatic symptoms, and changes in certain outwardly observance social behaviours' (p.6). Although it attempts to focus on breaks in normal function, it measures 'the most normal of all the classes' (p.6). The fact that this measure is designed to detect the least differentiated level of psychiatric illness means that the theory underlying it is consistent with those of psychiatrists from many diverse traditions (Goldberg 1978: 6).

The Langner 22 item scale poses more of a problem. Reviewing the titles of papers reporting the use of the scale, Lauren Seiler finds eight types of descriptions of what is being measured; terms used are 'psychiatric', 'psychological', 'psychopathological', 'emotional adjustment', 'emotional disturbance', 'mental health', 'mental illness' and 'stress'. Within these descriptions, authors speak of 'symptoms', 'disorders' or 'disturbance'. Lauren Seiler himself suggests that it consists of two sub-scales, measuring psychological stress and physiological malaise (Seiler 1973). Since most of these terms would fall within a model of the least differentiated level of psychiatric illness, these differentiations need not concern us much here.

There is some question as to the adequacy of current screening measures such as these for the study of non-psychotic disturbance in the community. Paul Williams and his colleagues have reviewed these measures in a paper (1980) in which they call for other models of case definition which encompass personality and social functioning as well as psychiatric symptomatology.

My use of these tests was however based upon the fact that they had been validated in a study bearing close resemblance to my own: the assessment of psychological disturbance amongst Asian immigrants in Britain (Cochrane, Hashmi and Stopes-Roe 1977). Following my study, the GHQ 30 item scale was used by Nott and Cutts (1982) in a community survey of postpartum women and found to be a useful measure of probable disturbance in this context with an adjusted threshold score to allow for the fact of certain items which are 'normal' with a young baby: disturbed sleep and restriction of movement. This raises an issue of considerable importance to which I shall return in the discussion: the

question of whether mental illness is to be understood as an absolute condition or in relation to the 'normal'. Almost every account of the use of these 'objective' measures gives evidence of 'tinkering with' the items or the scores when these do not accord with some criterion of importance in the mind of the user. I myself have done this. These tinkering reflect subtle ongoing adjustments which conceal discontinuities in the use of a measure with different groups of people. Since the General Health Questionnaire aims to detect breaks in normal functioning, this is perhaps reasonable. I will argue that it reflects a tendency (to be seen in society generally) for what is normal to be viewed as, by definition, acceptable.

Both the tests used were devised in the West: the Langner scale in America, the General Health Questionnaire in Britain; they rest on the comparison of 'normal' people in these countries with those diagnosed by psychiatrists as mentally ill. I will argue that they embody an essentially Western view of normality not shared by my Pathan respondents. Neither claims to be reliable in assessing the individual and both are intended to be self-administered. In my study, it is unfortunate that the small number of women who consented to respond to the tests means that no reasonable measure of the level of morbidity within the sample can be derived from them. (It had been my intention to use the tests with a larger number of women.) The scores are presented for each individual however, alongside the other assessments made. This is for interest only. It is indeed remarkable in view of the disparity between their intended use and their presentation in this context that the scores obtained by one individual on both scales indicates a disturbance that was borne out in both our assessment and her own.

In this study the main value of the use of these measures has not been in their yielding of rates or their assessment of individuals but in the fact that they have provided us with a basis - in the form of a number of items considered by psychiatrists here to be relevant in the assessment of mental state - for discussion of this with respondents.

The assessment of the research team combines two perspectives, one of which (my own) is in line with this orthodox psychiatric model underpinning the tests. (My background as a Psychiatric Social Worker was mentioned in Chapter One.) The other bears more similarity to the Pathan model insofar as Fatima Khan, research assistant, represents a lay Pathan viewpoint.

The Pathan model will be described in some detail later. It is important at this stage, however, to describe how the questions concerning distress were phrased in view of the fact that they were intended to reflect an Explanatory Model which had yet to be discovered. This was quite a problem. It was important to use familiar concepts. It is interesting that Arthur Kleinman (1978) points to the need for 'a new research terminology' to explore popular concepts, and cites Zola's (1972) use of 'trouble'. I have heard Dr Murray Parkes speak at a conference (Transcultural Psychiatry Conference, London 1982) of 'end of tether' behaviour. In respect of Pathan concepts, my experience in Pakistan had familiarised me with some key terms such as sadness/unhappiness/anger (one word-hafghan), worry, thought (fikr and soch). I knew of no equivalent words for stress or nervousness. In terms of the sites of possible disorder, I knew that people spoke of illnesses of the 'heart' to designate emotional disorder, or of the 'brain ' to designate disorders of

thinking or madness. Another word for madness (pagal) was familiar to me, but I wanted to avoid this term because I felt that it would be associated with bizarre and extreme behaviour rather than with more familiar disorders. I was looking for indicators of when people were unduly unhappy or worried or when they felt that unhappiness or worry had made them 'ill'. I had the opportunity to check out my own observations in respect of terminology with the two Pathan people who helped me to translate the psychological scales used; Fatima Khan and Dilshad Khan. My focus was intentionally on understanding normal behaviours and reactions and how people coped with these and how they recognised and reacted when these reactions became abnormal. My most usual approach was to ask about unhappiness (hafghan) and unhappiness - illness (hafghani bemari).

2. Results of Assessment.

A. The Existence of Illness/Disease.

Table (xvi) summarises the various assessments of individual focus respondents.

i) The Women's Self-Assessments. All the women referred to periods of unhappiness which were seen as a part of normal life. These had some direct cause and were temporary. Some also referred to temporary periods of unhappiness or restlessness which seemed without direct reason but just came from time to time. These too were temporary and considered a part of normal life. Some spoke of more severe periods of depression, thus one said she had been unhappy for three years when she first came. Another said she was unhappy for four or five months 'at first'. The period was a specific one and the cure in both cases had been

Table (xvi) Assessment of Mental State

Respondent Number	Mentally Disturbed		Test Scores		Isolation	Long-standing Medical Complaints
	Self Assessment	Research Team's Assessment	Langner	GHQ		
1	Unhappy at present following a move, otherwise not.	No	6	0	Yes	None
2	Recurring periods of unhappiness	At times	3	0-	Yes	Yes
3	No	No	3	1 ⁺	Yes	Yes
4	Sees herself as ill and unhappy	Yes	-	-	No	Yes
5	Recurring but short periods of unhappiness, mainly not	No	6	1	No	None
6	No	No	-	-	No	None
7	No	No	-	-	No	None
8*	No	No	5	6	No	None
9	Not at present, unhappy at first 3 years	No	3	0	Yes	None
10	No	No	-	-	No	None
11	Sees herself as ill and unhappy	Yes	10	12	No	Yes
12	Recurring periods of unhappiness, but well coped with	No	4	1 ⁺	No	None
13	On and off, temporarily better now	No	8	3	No	Yes
14	No	No	0	0	No	None
15	Not usually	No	0	0	Yes	None
16	Not now, was 4-5 months at first	No	0	0	No	None
17	At times, but copes well	No	7	1 ⁺	No	Yes

*Pregnant with high blood pressure at time of questioning.
⁺reflects practical temporary circumstance.

'getting used to it'. Another woman felt she was just coming out of a bad patch and had been 'better since Ramzan'. In all but two cases such periods of unhappiness did not interfere with their work. As we saw in the last chapter, the ability to continue to work was for most women a criteria in defining illness. Many of those who were most ready to speak of periods of unhappiness were indeed those we felt to be the most secure overall and the most able to deal constructively with such matters, by reliance on friends and family. These were those with scores that were between the two suggested cut-off points on the Langner scale. They were well supported by friends and/or husband and had adapted to a norm which included periods of unhappiness and took it in their stride. Two women, however, saw themselves as severely unhappy and also ill in a way that related to this.

ii) The Research Workers' Assessment. This inevitably reflected to some extent the women's own view of themselves, since a professional assessment takes as its starting point what the person themselves has to say about their own state. Thus it is not surprising to find that we considered those two women who described themselves as distressed to be the most depressed in our view too. However, other women did speak of quite severe periods of unhappiness - one said she was unhappy at present. So what else were we looking for? Like the women themselves, the issue of ability to continue to work was important. Many women spoke of unhappiness but had clean, tidy houses and children. Their own manner and appearance was also important. Fatima Khan particularly was impressed by one woman's tearfulness and the other's dishevelled appearance and 'odd' behaviour. The opinion of their neighbours was a factor - both the women whom we

considered distressed were rejected by network members although social interaction continued. They were the only two women of whom others spoke badly (and remarkably freely as we were initially strangers). This is of course a factor which is at once an indication of distress, a causative factor and an outcome of it. But insofar as it reflects the ability to successfully maintain social relations (an important part of a Pathan woman's 'job' see Part II) it can be seen as a failure to maintain her obligations. The women concerned did not see it this way, however, blaming others for their unkindness toward them. Specific classic symptomatology was also present, the one woman had a sleep problem with early morning waking and loss of appetite, the other was difficult to speak with, failing to answer questions directly and making seemingly erratic leaps from one topic to another in a way that seemed to border on speech disorder. Other women, although clearly unhappy from time to time, did not mention or exhibit such symptoms.

iii) The Test Scores. Four respondents refused to complete the tests - in two cases this was not specifically because of the nature of the scales. In these two cases contact was broken off before all areas could be covered with the respondents concerned and the test scales, which were usually done when we had known the respondents for some while and built up a relationship with them, were amongst the topics not covered. The two others continued to receive us cordially but refused to go through the questionnaires. Although a reason for this was sought, none was given.

The General Health Questionnaire was scored using the GHQ scoring method (Goldberg 1978) - thus one point was scored for each item to which a negative response was given, however strongly negative, and none for either a positive or normal answer.

A number of the positive responses were indicative more of practical temporary circumstances than of mental state - for example, in three instances the presence of a very young baby prevented the mother going out as much as usual (G.H.Q item 5). These are noted. If these are excluded, the number of respondents with no negative responses to the GHQ becomes nine. Further, respondent 8 was heavily pregnant with high blood pressure (for which she was subsequently admitted to hospital) at the time of questioning. She attributed three of her negative responses on the Langner scale and two of those on the General Health Questionnaire to her condition. These were questions relating to weakness, hot flushes, restlessness and sleep difficulties and her assessment of causality seemed reasonable. This would reduce her scores to 2 and 4 respectively on the Langner and GHQ scales. Table (xvii) shows the scores arranged in order of the score on the Langner scale with these adjustments noted and cut off points and threshold scores indicated. In respect of the Langner scale, the threshold scores used are between three and four symptoms (the most commonly used cut off point) and between nine and ten (suggested by Manis et al 1963).

With one exception it can be seen that although there is an overall congruence between the scores on the two scales, the scores on the Langner scale are higher, with six respondents (after the adjustment in the one case discussed above) scoring over the lower of the two suggested cut off points. However, Seiler and Summers (1974) have suggested that the Langner scale in fact incorporates two scales, one indicating physiological malaise and the other psychological stress. The items on the scale can be allocated to one of these two categories. When this

Table (xvii) Respondents' scores on Langner and GHQ test scales

To show congruences, adjustments and threshold scores. Also the scores on the Langner scale when divided into somatic and psychological components.

Respondent Number	Individual scores on the Langner scale	Individual scores on the Langner scale divided into		Individual scores on the GHQ 30-item scale
		<u>Somatic</u>	<u>and Psychological</u> components	
16	0	0	0	0
15	0	0	0	0
14	0	0	0	0
8	2 (adjusted score)	1	1	4 (adjusted score)
2	3	0	3	0
3	3	1	2	0 (adjusted score)
9	3	2	1	0
12	4	2	2	0 (adjusted score)
1	6	2	4	0
5	6	2	4	1
17	7	4	3	0 (adjusted score)
13	8	4	4	3
11	10	6	4	12
	* Cut off points suggested at 3/4 and 9/10			+ 4/5 threshold suggested score

is done, the scores of respondents are as shown on Table (xvii). This is of some interest here because the point is often made that Asian patients report their distress in somatic rather than psychological terms. Thus it could be that the General Health Questionnaire, using items of a psychological and behavioural rather than somatic nature fails to 'pick up' some distress amongst Asians, although early users (Goldberg and Blackwell 1970) of the 60 item GHQ found that it did alert doctors to patients presenting somatically (in this instance not Asians). However, in the present study, even when the Langner scores are broken down as Seiler and Summers suggest, none of the respondents' scores would be reduced to zero by the exclusion of somatic items - indeed, for four, the psychological symptoms predominated over physiological malaise symptoms, for three the reverse is true and for three the two types of symptom are equally balanced. Little can be concluded therefore from such a breakdown, at least where the sample is so small.

B. Causative Factors.

I turn now to a consideration of the women's accounts of causality in respect of those women seen as ill. While there was some agreement between the various assessment methods in respect of which women were identified as disturbed, there was less consensus between those involved i.e. the women themselves, their female kin and neighbourhood group members, and ourselves, in respect of the reasons for their distress. Before I consider these three sets of accounts, I will consider the factor of isolation.

i) Isolation. Isolation is considered here because of the suggestions made by some writers that isolation caused by the seclusion of women living in pardah in this country may lead to

depression. As this was one of the starting points for this study, it is important to say something about the relationship between these factors, and the effects of isolation on mental state. I have already shown (Part II above) that the women observing strictest purdah are not necessarily the most isolated. Isolation is determined not only by the degree of seclusion but also by the presence or absence in the immediate locality of a female network within which visiting is permitted and/or encouraged. I now turn to look at whether isolation leads to depression.

The five shown in Table (xvi) as considering themselves to be isolated were the only ones of the total 46 respondents who described themselves thus. (Additional respondents were, by definition, not isolated as they were those women who were met in the house of a focus respondent.) As can be seen from the Table, there was no correlation between isolation and high test scores - in fact, rather the opposite. Those women seen by themselves and the research team as mentally distressed were not isolated, and those who were isolated were not seen by themselves or us to be distressed, with one possible exception. Two made an association between isolation and distress, however, one seeing her present temporary unhappiness in a new neighbourhood as partly due to lack of company her own age, and another attributing her initial period of depression in this country to her feeling of having been shut in. The one woman who was both isolated and had recurring periods of unhappiness which we saw as quite serious was not isolated due to purdah but due to lack of kin or fellow villagers close enough to visit. She did seem to be much brighter when some family visited from another part of the country and very much

enjoyed the company provided by our visits. Thus although there may be a connection between isolation and depression, this was not marked overall. The most isolated women had, in fact, come to accept this. And the most mentally distressed women were certainly not isolated - on the contrary, they were members of active local female networks and interacted frequently with other women. They might, nevertheless, be unsupported, and in fact were.

ii) The Accounts of the Sufferers Themselves. Both had a mother who had died in Pakistan since they themselves had been in this country and both had been unable to return either to see her before death or for the burial or to mourn with their kin. Both said that thinking about this made them unhappy and that excessive thinking had affected their brain.

Both were second wives and this had given rise to other matters which they saw as underlying their unhappiness. The one was married to a much older man and was constantly anxious about his health and fearful lest he should die. This was a realistic fear based on her precarious social position that would follow his death. She had previously been widowed by a former husband, but this had been in Pakistan where she was with her own kin. Here she was amongst his family who did not care for her and made no secret of this. Her own children were too young to be much support for her in the event of his early death. Their financial situation was also very poor and his children by this previous marriage did not contribute to their income as the woman concerned saw appropriate. If so little was done for them now when he was alive, how much less would be done for them after his death?

The other woman had married a man with five children and immediately had two of her own. The work involved was enormous

and in great contrast to the life of ease she had been used to as a rather spoilt young woman at home. She herself spoke of it this way, explaining how her parents had done everything for her and her siblings. Her husband was hard on her and although she did not criticise him, she saw his expectations of her as unrealistic and was constantly under attack for her supposed neglect of the children or the house. She missed her own kin very keenly and compared her situation with that of his previous wife whose own kin lived nearby and had given her a lot of practical help. She also admitted to being 'simple' herself.

Both women came close to blaming those who had arranged these marriages for them - the brothers of one, parents of the other - but saw the decisions as having been completely reasonable. Both spoke of the reluctance with which those responsible had made them as if to absolve those they loved from their own criticism for their actions. Both saw their situation as their fate (kismet) and so beyond a certain point, accepted it totally. Neither had any other viable option.

Both saw themselves as physically ill, and said that all would be well if they were not, although one did see her illnesses as partly the result of her unhappiness. She wanted to get better at her work so that the children would not complain of her to their father and he would not be angry with her. Neither wished for any outside intervention, although one wished that the medication (a minor tranquiliser) were more effective in dealing with her 'illness'.

iii) Peer Views of Causation. Members of the two networks involved - both close knit ones - did not see the women as either unhappy or ill, but as causing their own problems. Their personalities

were blamed for their complaining ways. Both women were seen as a nuisance and/or objects of fun. Their situations were not seen by others to be unusual and so their unhappiness was not accepted in the way in which their own was within the group. While other women saw the support of friends as an important factor preventing their own breakdown in face of difficulties, they explicitly withheld such support from these women (for example by pretending to be out when they called) and then blamed the women themselves for both their own failure to cope and for bringing about their own social rejection. It has to be noted that in both cases, the women in the network, who seemed in all other respects to be responsible and concerned about others, had been very close to the previous wife. In one case this had been the other woman's own mother, in the other a close friend. Both second wives were seen as poor replacements.

Another possible reason for their rejection is that in view of the other women's own struggle to cope, they were quick to condemn any who did not succeed. Failure was too close to their own fears and so had to be rejected in order to maintain mastery themselves.

iv) An Outside View. In one of the two cases, the depression had followed the birth of a child, and I felt that this might have acted as a trigger if not given a physiological basis for the problem. The social situation of both women was sufficiently stressful that there were ample factors which may have contributed to causation, including all those described by the women themselves as well as their overt rejection by other network members. What was surprising was not in fact that they were depressed but that they had not broken down more completely. Both continued to cope with housework and children most of the time.

Although both the women themselves, and their fellow network members, gave personal reasons - such as personalities, lack of sympathy from husband - or specific situational ones - such as the number of children, death of mother etc. - for their distress, there were clearly structural reasons which made the whole set-up a 'no-win' situation for the women involved, whatever their personalities or the extenuating additional circumstances.

It would be hard for even the most sweet-tempered, sociable person to enter a social situation that was already established but completely new to her and win over all those who were initially suspicious of her, not even complaining about the difficulties of adjustment. Marriage to a widower is not a desirable prospect; there is usually some reason why a better match has not been obtained for the girl concerned. Thus the network members would expect someone slightly substandard in the marriageability stakes. By the same token a woman given in such a marriage would be unlikely to have the sweetest, most easy-going and acceptable personality needed to win people over. She would have a low opinion of herself already. And so she is caught in a vicious circle, constantly confirming everyone's expectation of her as unacceptable. It is a vicious circle compounded, in the situation of a migrant, by the lack of support from her own kin which she might have expected and got at home. Both women longed to return to their kin, and the significance of the death of their mothers in their absence was enhanced by their unhappiness here.

It is interesting that Brown and Harris (1978) show four factors to be 'vulnerability factors' in predisposing a woman to depression. These are more than four children at home, the absence of a confiding relationship, loss of mother before the age

of 11 and the lack of employment outside the home. Although the situation of Pathan women is totally different and none were employed outside the home or expected to be and most had more than four children at home, the loss of mother (not before a certain age but since migration) and the lack of a close relationship (not necessarily with the husband although for some their closest relationship was the marital one) both emerge from this study as significant social factors in relation to mental distress in respect of the women identified as ill.

C. Desire for Treatment.

Neither woman wanted help from outside. One became suspicious of us and cut off further contact - the other welcomed our company but was clearly very vulnerable. She felt that any suggestion that she was unhappy would worsen her position in her social group on whom she was totally dependent, despite their lack of sympathy towards her. She was only ready to seek help for physical symptoms which she and others could regard as an externally arising affliction. Since her husband was the one who saw the G P on her behalf, her symptoms were often inadequately reported. The Health Visitor seemed the only acceptable agent for help - being a woman who would come to the home, so I asked for a visit and encouraged the woman to seek help through her. I offered to explain the situation but the the women did not want me to. She was fearful of the outcome of involving outsiders - with reason, as it was clear that any concentration on psychological or social difficulties would worsen her position. The only hope seemed to lie in appropriate medication which might give her more strength to cope better with the unalterable inadequacies in her position.

What both really needed was an opportunity to develop

supportive relationships (such as they were missing from their own kin) outside the existing networks should members of these prove hostile, as in these cases they did. However, this is difficult because, in order to maintain purdah, visiting is only permitted 'for a reason' and within a certain prescribed group of fellow villagers etc. In this sense, purdah observance can be seen as a factor precluding other Options and supports for women and therefore an aetiological factor.

3. Discussion of the Test Items: The Translation of Meaning.

Studies using standardised measures cross-culturally 'raise questions about the "equivalence" of translated versions of symptom checklists'. (White and Marsella 82: 10)

I have already said that the main value of the administration of the Langner and General Health Questionnaires lay in the fact that being administered verbally (through necessity, see part I) they inevitably gave rise to discussion. This discussion was an opportunity to explore the meaning of the items given from the women's viewpoint. It is this that forms the basis for much of what I shall be presenting as the view of normality and deviance that emerges from the study as a whole.

It is important however to present this material first in its own right because of the questions it raises concerning the use of such measures cross-culturally. Such questions were not in any way an intention of the study, nor can they be adequately answered by it, but they emerged with great insistence from our engagement in the process of discussion of indicators of mental disturbance in this cross-cultural setting.

A. Items and Concepts that were Difficult to Translate or were Queried.

Translation issues have already been mentioned in Part I - translation is, of course, merely the first stage in the attempt to convey meaning using different words. Queries are the next stage and represent anything from not having understood a certain word through to not being able to grasp the concept even when the face meaning is clear. Sometimes elaboration of meaning resulted in understanding, sometimes not. Another sort of problem was also encountered - when the question was understood but in a different sense to that which seemed to the interviewer to have been intended. These problems are noted in respect of each question and can be found in Appendix C.

Tables (xviii) and (xix) show the two scales used and those items which presented problems in translation, together with the frequency with which each item evoked a response indicative of disturbance or was queried.

It can be seen from the tables and from the translations in Appendix C that the main translation difficulties were with 'nerves' and 'nervousness' (Questions 28 and 30, GHQ scale; and questions 10, Langner). 'Spirits' (Question 3, Langner) was similarly difficult. Translation of the former was evaded, either by the non use of the item (Question 10, Langner) or by replacing 'nervousness' with 'anger' (Question 28, GHQ) which rather altered the meaning, as did the use of 'sort of illness' (Question 30 GHQ). The term used for 'spirits' (Question 3, Langner) was more satisfactory as it combines the ideas of 'well' and 'happy' but it is not ideal as it suggests physical well-being more strongly than psychological.

Table (xviii) The Items of the Langner Scale

Item Number	Frequency of Response Indicating Disturbance	Frequency of Queries
1	3	-
2	4	1
3	2	2
4	1	-
5	2	-
6	2	-
7	4	-
8	7	-
9	0	-
10	Not asked	
11	1	-
12	1	-
13	3	-
14	7	-
15	2	-
16	0	-
17	2	-
18	1	-
19	5	-
20	1	4
21	5	-
22	2	-

Translation Notes (see also Appendix C)

Item 3 - Difficulty translating 'spirits'. Term used means 'good health', a more physical term for 'well' or 'happy'.

Item 10 - 'Nervousness' proved untranslatable.

Table (xix) The Items of the General Health Questionnaire

Item Number	Translation Notes (see also Appendix C)	Frequency of response indicating disturbance	Frequency of Queries		
			Total	Queried and not answered	Further elaboration sought before answer
1	-	1	-	-	-
2	-	1	-	-	-
3	Reversed	2 (baby and pregnancy)	1	1	-
4	Reversed because idea of "managing to keep busy" not translateable	-	-	-	-
5	-	3 (small baby always)	-	-	-
6	-	-	9	8	1
7	-	-	1	-	1
8	-	-	-	-	-
9	Element of effort removed	-	-	-	-
10	-	-	-	-	-
11	-	-	-	-	-
12	Less abstract, used idea of place and respect within family	-	-	-	-
13	-	-	3	1	2
14	-	2	-	-	-
15	-	2	2	-	2
16	-	-	1	-	1
17	-	-	2	2	-
18	Much elaborated and contextualised	-	1	1	-

Table continued

Table (xix) continued

Item Number	Translation Notes (see also Appendix C)	Frequency of response indicating disturbance	Frequency of Queries		
			Total	Queried and not answered	Further elaboration sought before answer
19	-	-	1	-	1
20	-	2	-	-	-
21	-	-	-	-	-
22	-	1	-	-	-
23	Some difficulty, use of self-doubt = loss of confidence	1	2	2	-
24	-	1	4	3	1
25	-	1	2	2	-
26	-	1	6	4	2
27	-	2	-	-	-
28	Replacement of "nervous" by anger	2	-	-	-
29	-	1	1	-	1
30	Unable to use "Nerves". Replaced by "sort of illness"	2 (1 pregnancy)	-	-	-

Ideas of 'managing to keep busy' (Question 4 GHQ, my emphasis) were not possible to translate - being busy is not seen as a particular virtue, the ideal being to complete work to be free of pressure of work (although two women did rather defiantly express the opinion that work was good). Likewise one is not 'able to feel love' (Question 9 GHQ, my emphasis) for one's family - the idea that one might be unable to do so was not comprehensible, even to the most distressed respondent. Two questions (Question 12 and Question 18, GHQ) had to be rendered less abstract - this necessitated elaboration and inevitably made them more specific. They were however well understood in these terms, although as we shall see, women felt it right that some 'things' should be 'taken hard' (Question 18, GHQ). It is not a virtue to gloss over matters which are of significance, and social slights, however minor (one of the examples suggested) are certainly significant and to be taken note of.

For practical reasons, GHQ questions 3,4, & 5 raised a few laughs and were rather inappropriate as indicators of mental disturbance. Most women had disturbed nights and very busy days due to the number of children, and in many cases, a new baby. Getting out of the house was also dictated by the presence or absence of small children. Moreover, the underlying assumption - that it is healthy to get out - does not apply to these women, some of whom had no choice in this matter. This was not therefore an indication of well-or ill-being for them.

It is interesting to look more closely at the meaning of some of the items that were frequently responded to in a way that might seem to indicate disturbance. On the Langner scale, Questions 8 & 14 came up seven times each. Question 8 - Are you the worrying

type? - People admitted to thinking (the word is the same) but usually gave the reason for the concern - a husband's absence, child's health, provision of dowries for daughters, the fate of relatives in Pakistan. Some of these were very specific concerns at that time, others more long-term. The idea of having a tendency to worry was difficult to convey, as was any idea of worrying without reason or to excess. Question 14 - bad memory. This was often a bit of a joke and seemed to be related to educational level. It was almost a virtue to have a bad memory, as if the women were questioning the value of memory here for them. Such typical jokes seem to me to be questioning the value of the prevalent mode of behaviour. There seemed amongst respondents to be an element almost of pride in having a bad memory - usually for matters such as where something had been left in the house. Respondents also scored highly on Questions 19 and 21 on the Langner scale, - 5 positive responses each. Question 19 relates to a feeling of being alone even amongst friends - the response to this was a factual one - we are alone. This was answered not in terms of feeling but of fact - and at two levels. We are alone before God and at a practical level, in terms of help with work too. No one comes to help - we are on our own in respect of our housework. Neither of these levels of response are, I think, what the question as diagnostic of disturbance had in mind. Question 21 concerns headaches which seemed a common complaint, often severe. Questions 2 and 7 which both evoked four positive responses relate to difficulty in 'getting going' and periods of restlessness. Difficulty in getting going in the morning was not for most women a problem, although four said it was, others responded very strongly to the contrary. Two of the four

saw it as a joke that they were 'a bit lazy'. It was not a cause for concern. One linked it with illness. Restlessness was a term often used to convey unhappiness, or tenseness. It was a term used by women themselves in ordinary conversation to describe periods of unhappiness. It was also linked, however, with pregnancy and physical exhaustion.

Not many items on the Langner scale were queried - number 20 ('Nothing ever turns out for me the way I want it to') was however queried four times - 'what sort of things?' I was asked. The literal translation, in face of the difficulty of translating 'turns out', was 'if ever I want something, it does not happen.' Women wanted to differentiate between physical things and life events - the former were either available or not - the latter are in God's hands and one has to accept what he gives and what he withholds.

On the General Health Questionnaire, not many items were repeatedly responded to in a way that might have indicated disturbance. It was, however, striking that the woman who was most disturbed (in her terms and ours) scored on all the questions relating to lack of confidence, hopelessness, worthlessness and feeling unable to overcome difficulties. These were some of the items most frequently queried by other women (GHQ numbers 15, 23, 24, 25 and 26), as we shall see below. The small numbers involved make any interpretation of this mere speculation. However, one might suggest that if a person is feeling extremely unhappy, these items make sense to them in a way that they do not in less extreme cases. If so, the scale would seem to be picking up the more distressed individuals rather than those suffering from the least differentiated level of disorder, in this sample where cultural understandings are so different, at least ^{at} the margin between

'normality' and 'abnormality'.

The two sets of scores in the column of queries relate to the fact that some (the first set) were queried and not answered. The additional numbers are items on which further elaboration was sought, following which a reply was given.

Top of the list is Question 6. 'Have you been managing as well as most people would in your shoes?' Typical responses were 'How do I know how anyone else would behave in my place?' 'There is no-one else in my place', 'I am my husband's only wife and have no sister-in-law living with me', or just 'what do you mean?'. In one case where the respondent was a second wife, the question was very embarrassing as it was taken to be a comparison of the woman's performance with that her predecessor. Overall, it seemed as if the habit of mental comparison of oneself with real or imaginary others was unfamiliar. Yet it is an idea that is commonly used by many English people I know - often in ordinary conversation - 'the way so and so keeps her house, manages her children, copes with everything, etc., makes me feel so inadequate' - this sort of thing. Question 26 - 'Have you been feeling hopeful about your own future?' - was queried six times. Typical comments were - it is not for us to feel hope. The future is in God's hands. How can we know what it will hold? Question 25 - 'Have you felt that life is entirely hopeless?' - was twice queried on the same grounds. On more than one occasion these questions led respondents into a lecture on the correct attitude concerning the future - always in religious terms. I was told several times that hope and despair are irrelevant, as are happiness and unhappiness - all hope is for the next life and this can be secured by acting well in this life, since all our actions

now are being judged by God. Questions 24 and 23 -thinking of yourself as worthless and losing confidence in yourself - were also queried in similar terms.

Issues of responsibilities, problems and worries were often queried - as in GHQ 13 regarding decision making. Many women protested that they had no decisions to make, as one said 'There is a decision maker' (meaning her husband). I was often asked, 'What responsibilities do we have? What decisions do we make?' This was not usually a cause for anger but for relief. Some even claimed to have no worries on this basis - 'I do my work and then I see people' or 'my sister eats and goes to the toilet, that's all, she has no worries.' Many, however, claimed to worry about concrete matters such as money, their husbands' health and safety, their children's own future and their daughters' marriages. Financial worries were for some very pressing. But overall the picture was of women who knew their worries, despairs and hopes to be totally irrelevant to the outcome of anything. God, men and elders were responsible for the future - it was up to them merely to behave correctly and modestly whatever should befall them.

B. Points of Similarity and Difference between Pathan and Psychiatric Views.

Points of similarity and of difference between Pathan and psychiatric views emerge from the discussion of these test items with respondents in this study. Many items were both well understood in translation and seen by the women to be connected with unhappiness. This was particularly marked in respect of the Langner scale. There was an acceptance of the idea that worrying can lead to illness and lack of sleep and even in one case to bad memory. Restlessness and weakness were seen as signs of illness. Moreover both scales, despite their claim to unreliability in

assessment of the individual, did identify the respondent who was felt, on all counts, to be most disturbed, as we saw in the previous section.

However, neither the social situation nor the shared ideology of respondents should be left out of account as these both influence the meaning of symptoms for individuals. Where the population of individuals to be studied - albeit in a collectivity - share an ideology and a social situation that is totally different to that of the people by whom the scales were devised and on whom they were tested, the meaning of the items cannot be assumed to be the same. By social situation I mean both the facts of motherhood (which renders disturbed sleep and excessive work normal and acceptable for a temporary period) and of purdah or seclusion, by which women do not expect either to go out freely or to be able to make significant decisions concerning their own lives. By ideology I mean the religious views so strongly put forward by respondents, most of whom were able to admit to feelings of hopelessness but for whom this was irrelevant. Such an ideology seemed, for the majority, to have a protective function - none blamed themselves for their misfortunes or sought to blame others. Thus guilt was not added to despair. In fact, despair is a term that could not be used - for the hopelessness of these women was a neutral not a negative state. This has implications for the diagnosis of patients from a comparable ideological background who do present with feelings of despair. It may be that these should be taken very seriously since they represent a departure from the prescribed cultural feelings concerning the future. This could therefore indicate either a high level of deviance insofar as the individual concerned had a vision of a

different social world and/or a high degree of disturbance (possibly consequent on this vision).

The tendencies to be specific and concrete - found in both the translation process and the interviews - are also important for a practitioner attempting to understand such people. Pathans often use parables and examples to make a point. Professional people often see such stories as childish, and abstract scientific jargon as superior. However this is not necessarily the case - abstract phrases can mean very little in real terms (as we found when we tried to make some of them more concrete) and a good parable can convey a wealth of complexity just as good novel can.

The two seemingly contradictory values of the uniqueness of the individual and the overriding importance of social life also emerge from this analysis. Belief in the uniqueness of the individual is shown in the lack of the habit of comparison with an imaginary other (as required by question 6 of the General Health Questionnaire). In a social world where each person is known well to the others and their background is also known, they are not interchangeable and cannot be imagined to be so. No set of circumstances are identical. This is an outcome of social life that is close and important. Its importance is shown in the response to item 18 in the GHQ: social relations (and hence even the slightest of rebuffs) are important. Hence the attitudes, often baffling to outsiders, of incredible sensitivity to gossip and what others might think, coupled with a general security in their own uniqueness and position. This security is hard to maintain however, where the social position is a weak one (as in the case of a second wife) and the woman's value and uniqueness is not endorsed by the immediate presence of her own kin. I have already described the vulnerability of two of the respondents in

such situations.

C. Can We Use Such Measures Cross-Culturally?

My findings in respect of whether or not such measures can be used cross-culturally appear contradictory. On the one hand, I note that the women's own assessments, my clinical judgement and the test scores were pointing to a similar picture. Elizabeth Watson has translated the General Health Questionnaire into Bengali and concludes that 'the general agreement between the three measures makes for the tentative suggestion that it is possible to compare symptoms of distress across cultures' (Watson 1984: 9) Her three measures are the same as mine: test scores, self-assessment and an 'expert' rating following interview. Like Nott and Cutts, (1982) Elizabeth Watson 'normalises' her scores by raising the threshold scores to allow for the fact that women with small babies could expect disturbed nights and little social contact or movement outside the home. She found, as I did, that questions about hopelessness seemed to have no meaning for some of those interviewed: in her case Bengali women. Like Pathans, Bengalis are Muslims. Her study has a closer focus than mine and its similar results are striking and reassuring in view of the fact that the methodology is more 'orthodox'. By this I mean that the sample was randomly selected, ratings were made where possible by the respondents themselves, scale items were not discussed during the process, and statistical methods were used to analyse the results. Although numbers within each cultural subgroup were small (23 in the case of non-English speaking Bengalis), the overall number involved was larger (101 mothers) and the inclusion of three groups representing different cultural groups gives the study added strength.

What are we to make of the fact that ratings of distress appeared to be markedly similar, yet a number of items just did not make sense in the different cultural situation? My study enables an exploration of issues of meaning which Elizabeth Watson's does not. Is mental illness essentially similar transculturally (the psychiatric universalist view as described by Elizabeth Watson 1984: 2) or essentially dissimilar transculturally (the cultural determinist view)? I find an apparent contradiction between the results of the use of the scales and my awareness, from discussion with respondents, that a number of items were not meaningful in a different conceptual system: indeed, some could not even be rendered in the other language. I find myself unable merely to dismiss these anomalies as 'problems of method' and perhaps to substitute other items (see, for example, Cochrane Hashmi and Stopes Roe 1977). As I have argued in Part II, language and relationship are as much a subject and a part of study as a tool for it.

This issue is the subject of some interest in the literature (see, for example, Berry 1969; Leff 1973 and 1977; WHO 1973; White and Marsella 1982; Oyebode 1985). Such writings support my concern with points of difference and the cultural assumptions which underlie standardised measures. Those writers who seek to develop measures which are universally applicable suggest better methods of translation, methods which attempt to build up a universal categorisation and research instrument by starting from the existing concepts within the target culture (see Oyebode 1985, Berry 1969). This depends however, on the prior demonstration of the functional equivalence of certain behaviours; it would therefore be necessary to derive instruments for each aspect of

behaviour to be studied in respect of each cross-cultural comparison intended and these would be specific to the particular cultures and aspects of behaviour involved. The usefulness of a 'universal' thus derived seems doubtful, therefore, although the emic/etic approach to cross-cultural studies (Pike 1966) at least stresses the need to shed preconceptions and not to impose culturally - derived categories as if they were culture free.

If I am right in stressing structural influences on the items as well as cultural ones, however, this problem is not one confined to minority ethnic groups. The need to exclude certain of the items as irrelevant to post - partum women (Nott and Cutts 1982) raises the whole issue of whether deprivations (of sleep, social life etc.) considered normal at a stage of life (or within a certain culture, class group etc.) should therefore be excluded as indications of ill-being when they would in other circumstances or by other groups be considered as symptomatic or reflective of it. For example, many of the 'hassles' listed by Kanner et al (1981) are routine experiences for mothers with a young baby. My study enabled me to explore both women's experiences and the way in which they themselves defined normality. It showed that they too incorporated areas of distress and suffering which were to be expected into their definitions and that this appeared, for those who were well supported, to lessen their experience of distress.

The use of scales adjusted for social reasons therefore seems in line with the way lay people themselves define situations. However, similar adjustments would need to be made to allow for cultural and religious norms of behaviour and expectations (even if these were not as thoroughly worked out as Berry (1969) advocates).

The exercise highlights the need to be clear about what the

measures used do and do not represent. If the intention is to explore the extent of distress as defined within western psychiatry and as experienced by certain English groups' then a careful translation might be adequate although even this ignores the issue of how far conceptual equivalence is possible. The measurement and understanding of distress as experienced by those concerned, is however, a different exercise. It is important to remember that such scales incorporate assumptions concerning normality which are structurally and culturally derived. These may or may not be shared by respondents. Even if they are shared, we are still left with the question of how to consider and treat the person who experiences distress and becomes 'ill' as a result of situations with which they are expected to cope because these have been redefined as normal. The new mother deprived of social contact and sleep develops symptoms and becomes ill. Two women were identified by this study as mentally ill. An immigrant may become ill having failed to 'cope' with routine experiences of racism. The issue is perhaps not whether we identify such people as ill on the basis of whatever measures, but how we consider and treat them. Their experience of deprivation is real, not a manifestation of illness; the remarkable thing is not that they have become ill but that others, similarly placed, have not (see also Oakley 1980). This accounts for my own paradoxical impression following this study: I remarked on an absence of distress relative both to what I expected and what the women told me of their experiences, yet on all measures two of the seventeen focus respondents (12%) were clearly in need of help: a high percentage.

My main interest in this study has not been in matters of

measurement but in the meaning of events and symptoms for those concerned. I turn next therefore to consider the concepts of mental well-and ill-being which emerged from discussions with respondents, including the discussions of test items.

Chapter Twenty-Three. Concepts of Mental Well-and Ill-Being.

In Chapter Nineteen, six themes were identified from the literature relating to Concepts of health and illness. These were used in Chapter Twenty-One as a framework for presentation of the Concepts of the women interviewed in respect of general health and illness. In respect of mental well-and ill-being, some of these issues have already been discussed in the last chapter relating to the assessment of mental state. In using the tests particularly, I was exploring the difference between medical and lay concepts, and the questions raised by the exercise relate to the issue of how mental illness is defined by representatives of various psychiatric traditions. The whole question of whether universally applicable measures are possible or even desirable relates directly to the issue of how mental illness is conceived. Indeed, the terms used themselves reflect different theoretical perspectives and philosophical presuppositions (White and Marsella 1982: 5).

In this chapter, therefore, I will draw together material which relates to the other themes identified: questions of causality, concepts of ill-being, factors affecting these and the relation between ill-being and normality in the women's view.

1. Disease, Health and Illness.

In presenting this data, I have found it difficult to separate the themes identified in the literature out of the women's accounts. Except in respect of the two women defined as ill, the discussions related to unhappiness and distress that was

considered normal and acceptable. The first theme, relating to the way in which illness and health are defined could therefore, for the most part, be subsumed under the second concerning illness and normality.

I tried to explore the issue of stigma in respect of mental illness but made little direct headway. Even the relating of stories of friends of mine with puerperal and other depressions elicited little response. Similarly, most women were reluctant to comment on a suicide within the Pakistani community which had occurred during the period of interviewing. I introduced this topic with most respondents with little success. Some commented that the woman's husband must be to blame - perhaps he ill-treated her - others that, no, her brain was bad. This was proved by the fact that she had been receiving psychiatric treatment. Such evidence of stigma was tantalising, but the subject was always deftly and swiftly changed. Only one woman, the one who was herself most unhappy, spoke of the incident voluntarily. Her identification with the woman involved was clear from the tears in her eyes as she spoke of the way in which she kept thinking of the young children the woman had left behind. As she spoke, she clutched her own baby to her. This was one of the few recorded examples of an 'unconscious account': in most interviews my attention was too fully taken up with keeping track of the verbal content of the interview. The example also clearly illustrated the way in which the experiences of others were incorporated into Concepts; in this case the woman said that the event had had the effect on her of spurring her on not to give into such feelings and to an awareness of her love of her own children, aroused by her pity for those of the woman who died. She consistently denied that she had suicidal thoughts herself.

Similarly, women did not see the two amongst themselves who we felt to be psychiatrically disturbed as 'ill', or even as unduly unhappy. Both women were seen as a nuisance and/or objects of fun, as has been described above.

It is clear then, that women did have a concept of 'madness' and that this was seen as both completely 'other' (the brain either was or was not bad) but also as a state into which they might themselves fall if they were not careful. Thus, death of her mother in Pakistan was for one woman reported to have led to psychiatric disorder - her brain had gone bad with thinking about her mother's death and she had been admitted to psychiatric hospital. This illustrated the way in which 'thinking' to excess was felt to be dangerous. Thoughts (sochunah) could damage the brain. These thoughts were usually of relatives in Pakistan. They were common and many women saw them as potentially disturbing, preventing sleep or interfering with concentration. Like the case of the suicide, this incident influenced other women's responses. The respondent who told me of the event also had a lot of intrusive thoughts about Pakistan but she reported that she had brooded less since being frightened by what happened to the other woman.

The majority of statements did not refer to their own unhappiness, however, but to correct behaviour in face of it. Concepts of silence and endurance emerged over and over again in descriptions of proper womanly behaviour in face of distress. A typical statement was 'I place it (unhappiness) quietly on my heart'. The terms used were concrete ones in true Pukhtu tradition: 'we are standing here', 'we pass the time'. This was not a rebellious or angry silence or sitting, however, but one

which took in and accepted all manner of adverse circumstances. It was made possible by the women's lack of any responsibility for changing these circumstances. Sitting and accepting them was all she was required to do. It might be hard - some women spoke of having 'thin hearts' meaning that they were not good at facing difficulties well. This term was used in respect of themselves and others. Men supposedly have big hearts, which is why they can absorb distress better and seldom cry as women do. Women spoke freely of different personality types, describing themselves as slow or quick to anger or take offence, as excitable or placid, eager to 'have things out' or all for a quiet life. Such individual differences were accepted and allowed for.

The emphasis was, then, as in respect of general health and illness, on behaviour rather than suffering. Protection emerged as an important theme, such that it may be seen as a major interest in respect of mental well-being. There seem to be links here with the idea of a 'reserve of health' (Herzlich 1973); of the women's ability to behave correctly as something needing nurturing and sustaining.

In respect of protection, there were a number of examples given of the value of protecting oneself or being protected from potentially stressful situations. Thus a woman with triplets was not told that she had given birth to three sons for several days after the event, at her husband's insistence. She was grateful for this. Mothers who became distressed at visiting their babies in hospital were encouraged to let their husbands take over as daily visitors rather than being told to 'control themselves'. News of one mother's baby's worsening condition was kept from her by her husband and she was proud of his consideration of her. The whole community told the story for a long while of the way in

which a family who were throwing a big party had been prevented by God from playing a tape from Pakistan before the party. Had they heard the news it brought of the death of a close relative, they would have had to cancel the event, suffering considerable losses.

Purdah too was seen as a form of protection. The women distinguished between work and worries, practical tasks and responsibilities. Even when her early childhood had been marked by the deaths of her uncle, father and brother in close succession, one woman spoke of that as a time without sadness because it was a time without responsibility. She was one of the few who felt the weight of responsibilities now since her husband had been ill and she had had to assume many responsibilities on behalf of the family in the absence of suitable substitute male kin in the locality. This problem is one that is associated with migration. Her difficulty in doing this was not helped by the way in which her assumption of many 'male roles' (such as shopping) was frowned upon by others. It is a system, like many closely defined ones, in which the deviant - however good their reasons for deviating - is not viewed with sympathy.

Most women saw themselves as having few responsibilities, few decisions to make and, on a scale of any significance, few worries. I was told that they could not affect anything and thus it mattered not at all whether they hoped or not 'I have no hope at all, it is all right', (*اومیر نشتہ خیر دے*) and again 'death is always first, therefore there's always some hope' (*مرگ اول دے اومیر نشتہ*), were two apparently unreassuring statements which to the women concerned summed up the whole situation in respect of hope for the future. Honesty and industry in the present were praised.

Life was not all lived at this level, however, and even in the women's world, anxieties crept in. Thus children gave endless cause for anxiety. One woman's husband went on pilgrimage (Haj) and she was very anxious about it and viewed her own anxiety as normal and inevitable. Guests might be welcome but they brought a lot of work to add to the common round of already onerous tasks. Work and responsibility might be distinct, but work in excess carried its own toll.

Religion was also seen as protective: it offered a framework in terms of which responsibility was with God, not the person. The only responsibility laid on her was that she should be observant and diligent in religious matters whatever befell.

2. Illness and Normality.

In general, happiness and sadness were viewed as very much a part of life. They are in fact the woman's business - all her social visiting is to do with 'ghum/shadi' i.e. sadness and happiness, as we saw in Part II. They are almost two sides of the same coin and often referred to, as in this expression, in the same breath. This contrasts with the Western separation of these states. For a Pathan, both are inevitable, both come and go. Both were seen by the women as irrelevant. Occasional bouts of homesickness and fed-upness were described and also accepted as normal. Most women thought a lot of their relatives in Pakistan and worried about them. But eventually most 'got used to it' and accepted the separation from kin and homeland with everything else. It surprised me that the move was not described as more traumatic. Although a period of unhappiness seemed to be expected 'at first' and women spoke of having themselves gone through this,

they also emphasised that they expected to leave home when they married anyway and the break was such a big one wherever one went that the distance had to be seen in this context. What was more distressing, however, was when one parent died during their absence. Death of their mother since they had migrated was a major continuing source of unhappiness for all those women who had experience of this. This seemed to render the village almost no longer really home and deprived the women even of the pleasure of imagining a visit home in the future.

I have illustrated the way in which Concepts of distress and proper behaviour incorporated perceptions of recent experiences within the group and expectations of the future. They were integrally linked to an acceptance of the respondents' current social situation as women, as mothers and as immigrants. Ideas of normality were closely linked to expectations and determined which situations were experienced as stressful. Women saw complaints concerning situations defined as normal as deviant and punished others who complained about their situation.

Before leaving this issue, let us look at the questions which emerged from the literature review in respect of illness and normality: i.e. is suffering a cause for action, under what circumstances and what sort of action? I have already spoken of the emphasis on correct behaviour in face of distress, and the women's emphasis on protection from distress, but what outlets existed for their unhappiness? Was this a cause for any action?

Some women said that talking of their unhappiness helped - but there were variations in whom they could discuss it with. For some, their husband was the only confidant permitted. Others talked with a sister or close friend. Generally such things would

not be widely spoken of, and women who complained freely were looked down on.

Other comforts were of a religious nature. Prayer was described as a comfort. So too was Haj - or pilgrimage. One woman described Mecca as such a beautiful place that she had forgotten all her troubles when she was there (including her children left at home, about whom she had worried not at all while away). Such a socially sanctioned holiday must indeed be a tremendous event for women who otherwise lead very circumscribed lives, whatever the religious benefits (which I do not in anyway wish to deny). These comforts are available (although going on Haj is expensive), as is the Holy Qu'ran, which some women read regularly. Apart from these, however, there were few social comforts since complaining was frowned upon. Close friends were valued, and the existence of a phrase 'duk-suk' to describe those troubles that could be talked over with such a friend proves that such sharing of troubles was commonplace. Certainly external events could be and were much discussed and complaint made concerning their effects. But the more important happinesses and sadnesses involved in social life had to be kept silent, particularly if they involved family members. So too did many complaints about their common unalterable situation.

For two women, as we have seen, unhappiness led to or was compounded by physical symptoms. The woman felt 'ill' and unable to work normally. She then sought treatment, not for the distress but for these symptoms. What were the chances of such action resulting in effective treatment, should others follow this course?

We have already seen in Chapter Twenty that access to the G.P. was, for most women, restricted by their own committment to

pardah observance. This would lessen the chances of psychiatric symptoms being 'picked up' routinely. It was unlikely that women would directly complain of unhappiness if this had to be done in the presence of or through their husbands. This meant, in effect, that minor psychiatric symptoms would go unnoticed and untreated, however good the specialist psychiatric services.

3. Factors Influencing the Women's Concepts.

The previous chapter traced in some detail a number of influences on the women's perceptions of the test items. It is clear that religious factors and factors relating to the women's position as mothers and as women in a sex-segregated society affected their Concepts of hope, responsibility and their expectations. A situation of powerlessness within their own society as well as in Britain seemed to lead to an emphasis on endurance and acceptance of suffering. The women's acceptance of their own powerlessness meant that they did not seek to change their circumstances. These factors led to an emphasis on protection from stressful situations which in itself endorsed their powerlessness. The similarity between my findings and those Joan Ablon (1973) are striking. Also relevant is the work of J. Ananth (1978) who suggests that the reason for low reported rates of depression in Indian women is that they do not aspire to change situations which they perceive as unalterable. Like me, he reports high levels of distress which are accepted and endured.

4. Questions of Causality and the Issue of Somatisation.

The link between social circumstances and unhappiness was readily made by all women. Mental well - being and cheerfulness were seen to result not from either the individual or their circumstances alone but from the ability to maintain equilibrium in face of difficulties. This balance was the responsibility of everyone. If failure to do so arose from very unusual social problems, there would be some sympathy, and the individual might be absolved of blame. There was some evidence that gross maltreatment (if proven) by a woman's husband might constitute such a factor. However, most felt that they shared more or less equally difficult life situations. Failure to maintain a cheerful face and to continue to work in face of God-given difficulties was therefore usually seen as the fault of the individual. This did not mean that the circumstances were seen as that person's fault; they were not. Life circumstances were sent by God and one's task was to cope with them, however good or bad.

Thus it was usually the individual who was responsible for their own mental well - being. Site of causative factors (see Cecil Helman's identification of four possible sites (Helman 1984) and the discussion of this in Chapter Nineteen above) was of little importance. These included hereditary and dispositional factors (for which in themselves the person was not responsible) as well as social and natural circumstances. All these were God - sent. As with Herzlich's respondents responsibility was more for loosing one's health than for becoming ill. Protection of oneself was an important aid in the struggle to behave well. Such comforts (many religious) as were acceptable and available would

also help. Social support was recognised to be a comfort and protection for women but this fell into two categories: the support of kin was not conditional, but a woman's own kin might be far away in the migrant situation. The support of fellow villagers might be apparently given (where this was expected) but withheld at an emotional level if the woman were not personally popular. Since this depended on her ability to behave correctly in face of adversity, such conditional support left the woman in a vicious circle, with few or no other options for help if it were withheld.

I would like to consider briefly the issue of reasons for the reported somatisation of emotional symptoms. This is suggested to be a greater tendency amongst Asian peoples (Rack 1982: 101f; Kleinman 1977; Littlewood and Lipsedge 1982: 76-77), although it is interesting that in a study in Bristol, this tendency was remarked on by all General Practitioners except Asian doctors (Steve Fenton, University of Bristol; personal communication 1985, research report forthcoming).

I consider this issue here because it is causation which determines whether a certain symptom is regarded by doctors as reflecting underlying mental disorder or organic, physical disorder. This relates not to causation of distress therefore but to whether it is distress or physical causes that lead to certain illness symptoms.

All those interviewed stressed physical rather than emotional disorder. This was however due to the fact that the latter was not seen as, of itself, disruptive of life and work. Physical complaints might, however, be disruptive in this sense. Women were expected to cope with unhappiness but not with all manner of physical ill-being (although even here they expected to work

despite most minor symptoms). Where physical disorder arose from or coexisted with mental distress it was the physical symptoms which were stressed therefore. Doubtless this was partly due to these being seen as not the individual's fault in the way in which failure to contain unhappiness might be. The stressing of physical symptoms therefore derived in part from issues of perceived responsibility, as other authors suggest when they discuss the stigma and blame attaching to mental illness (e.g. Rack 1982: 104). In many examples in the literature somatisation is seen as a psychological defence mechanism which stresses the patient's perception of him/herself as 'ill' not 'mad'. For my respondents the line was between 'ill' and 'bad' or socially deviant. Explanations which stress the metaphorical use of references to the heart and brain (such as Aslam 1979: 129 quoted by Rack 1982: 103) are also important, I am sure.

Another additional explanation arises from my data, however. It seemed that women stressed their physical disorders because these were, for them, the problem. If we take the view of depression that Roland Littlewood and Maurice Lipsedge (1982) take, viz that it is a 'biosocial event' (Littlewood 1983: 26) which leads to both bodily and psychological symptoms, then both somatisation (stressing the former) and psychologisation (stressing the latter) are reflections of this. Is it possible to see the emphasis made by people as determined, in part, by their perception of the one or other set of symptoms as both more threatening and disruptive and more amenable to alteration? The woman who, in my study, was most distressed clearly linked her physical symptoms to her unhappiness and her social situation. She saw only one of these as alterable, however. In addition, it

was her physical symptoms that were most disruptive of her housework and childcare routines.

Chapter Twenty-Four. Common Themes in Relation to Physical and Mental Disorder.

My task in this chapter is to draw together the material presented in Part IV, particularly the data relating to general health and illness, on the one hand, and mental well- and ill-being on the other, and to show how these discussions relate to my own analytic framework. Although this framework has been used throughout, it has not constituted the basis on which this data has been organised. Rather I have chosen to let a number of themes emerging from the literature guide my presentation in this instance. This is because the data on mental ill-being relates to Concepts rather than to interactions with health workers, although that concerning general health and illness relates to both. In discovering and exploring the Concepts of my Pathan respondents, I have felt the need of a series of themes such as that offered by the literature reviewed. This literature is one that concerns both interactions with health workers and Concepts. In respect of Concepts, it has helped me to explore themes within my data. In respect of health care interactions, I find my own framework, based on the interaction between any individual's Concepts, perceived Options and Interests, a more useful way of understanding health care behaviours from the actors' perspective (be the actor a lay person or a health worker) than any I have found in the literature. Although my categories of Options and Interests are discernable in the writings of other authors in various forms, I have not felt it right or helpful to rearrange their contributions according to my framework at this stage. Much of the literature relates, in any case, to Concepts and therefore

offers a useful way of exploring this aspect of my data without such modification.

1. Concepts of Pathan Respondents.

Concepts of general and of mental ill-being were markedly similar to each other in this case study. This similarity justifies my decision to consider physical and mental ill-being together: a decision that might be questioned in the light of anthropological evidence which demonstrates that not all societies view general and mental ill-being as similar: the latter may be seen as a religiously prestigious or evil state, for example. Their juxtaposition in biomedicine has not been smooth and unquestioned and is not necessarily a reflection of universal understandings.

Both general illness and mental distress and unhappiness were viewed by those interviewed as normal and inevitable; sent by God. General illness and episodes of unhappiness were part of the risk of living. The important fact was not personal/individual suffering but the maintenance of correct social and religious behaviour in face of it. Each person was seen as responsible, both for staying healthy if possible and guarding against physical and emotional risks, and, if this failed, for maintaining correct behaviour nevertheless. For the women, correct behaviour related to their work which was to care for their husbands and children and to maintain social relations within their own community. The inevitability of both happiness and unhappiness was a theme running through life: social relations were themselves concerned with condolence and congratulation, with sadness and joy, and were sufficiently important to constitute a 'reason to go out' as we

saw in Part II.

It was on the basis of this 'work' that women distinguished between acceptable and unacceptable illness; and normal and abnormal distress or unhappiness. Although many everyday symptoms and disorders were described as 'illness' (and, in a parallel way, women spoke of everyday episodes of unhappiness) serious illness was identified as that which prevented the sufferer from working. Such disorders merited attention, not because of the individual's suffering but in order that she be quickly restored to full social functioning. Failure to either endure or contain minor suffering or to recover from an accredited illness episode was seen as a failure to maintain correct behaviour.

Factors influencing Concepts of health and illness emerge clearly from this study, especially from discussion of the items of the test scales, where religious influences are very apparent as are the effects of the women's position in the social structure, as women in a pardah society and as mothers with young children. The similarities between my data and that of writers who have studied other groups should alert us to the dangers of analyses which concentrate on 'cultural' factors alone. Structural factors were clearly shown to be relevant here. One such factor is the issue of powerlessness and the women's perception of themselves as unable to change either their social circumstances or the service Options. Thus they saw themselves as the more responsible for the only factor within their control: their own behaviour. They also sought relief for those symptoms they saw as relievable which were physical disorders rather than symptoms of emotional distress.

Although the data relating to translation of the psychiatric

scales points to differences between lay and medical conceptualisations and assumptions, it also shows similarities. Chapter Thirteen concerning contraceptive behaviour showed a clear process of interaction between Pathan and medical concepts in this area, and this should stop us taking a view in which these two are seen as inevitably dissimilar or in conflict. There has been ample evidence, in this and the previous Part, of common Interests on the part of women and health workers and these lead to cooperation and moving together despite inequalities of power and the different cultural assumptions informing behaviours. The situation is complex and changing. In this process of interaction, personal as well as political factors have been shown to be important. While it is not true to take the simplistic view that all would be well if health workers and patients could understand each other better and treat each other well, neither is it true to see them as locked in inevitable misunderstanding due to structural conflicts, such that interpersonal interactions were of little importance.

2. Options.

Options for medical care have been described in respect of general illness. In chapter Twenty, I showed that these are not the same as the services on offer; they are further constrained or enlarged (to include religious healing) by what was viewed by respondents as acceptable. Options are based on certain biomedical assumptions as much as the women's own actions are based on their different ones. In this and the previous Part, I have tried to show instances where these biomedical assumptions are most apparently culturally derived and sustained. The Options for women

in respect of unhappiness are less obvious than in respect of physical disorder, but they include talking to others, sharing troubles and joys and certain religious comforts.

3. Interests.

In the case of physical illness, part of the correct behaviour was to seek treatment when work was disrupted by illness. In respect of unhappiness and distress, there was a concern to protect oneself from stressful situations and an emphasis on purdah as a form of protection for women. Women can be said to have had an Interest in treatment of their disorders in order to work as expected and in protection from both physical and mental disorders.

The women's Interests in successful treatment conflicted with their Interest in purdah observance, however. This was not because of differences in Concepts of illness within biomedicine and on the part of those interviewed, but mainly due to service organisation in which no provision was made for purdah observance. The women's reaction to this conflict was not, however, to press for change but to accept a less effective service. This reaction can be explained partly on the basis of different Concepts between healer and healed; although biomedicine was highly regarded, the women did not place such a strong emphasis on personal suffering and ill-being of the individual; they were therefore prepared to endure disorders not perceived as life threatening or socially disruptive in order to maintain purdah observance. As we have seen, this was not true in respect of childbirth and antenatal care. In that instance, despite marked conflicts in Concepts, a sufficiently high importance was attached to successful outcome because the event was perceived as life threatening. In that instance, therefore, Interests in receipt of medical care overrode

Interests in purdah observance (see Part III).

Another, possibly more important, reason for the women's lack of pressure to change service arrangements relates to their perception of themselves as powerless to change most external circumstances of their lives. This theme of powerlessness emerges again later in respect of their Concepts of mental ill-being. In this regard it relates to the powerlessness of immigrant groups in Britain and to the reluctance of those I interviewed to challenge social arrangements in a place where the women at least felt themselves to be guests.

4. The Importance of Social Relations.

An overall Interest which emerges from this Part is one which was stressed in both Part II and Part III. This is the Interest in maintaining social relations.

In face of the Concepts of the endurance and acceptance that characterised ideas of proper behaviour in cases of psychological, individual distress, reactions to social disagreements were, to an outsider, surprising. Breakdowns in social relations were not silently endured, but much publicised. Quarrels would begin over some matter of great social significance - often a failure of someone to visit when they should - for example when a new bride arrived, or when a family member died. Social relations would then be broken off, with both parties declaring themselves wronged. This might involve the curtailment of all visiting between two women who had few other contacts. It would also involve the close relations of each, who could not avoid taking sides by their decision to maintain contact with one party or the other. I asked how such situations could be resolved and was told

that the only way was usually through an intermediary close to both parties who would encourage them to make it up. I once saw such a quarrel being resolved through giving a gift when a baby was born to one of the parties - no reference was made to the quarrel and if the gift (carefully chosen and elaborate) were accepted, relations would resume. There was certainly no evidence of any 'having it out' or 'discussing the problem together'. Normal methods of quarrel resolution seem to have relevance for professionals in contact with such communities. Many of our methods of intervention may be totally inappropriate.

Two possible explanations emerge for the silent acceptance of individual suffering compared with the orchestration of instances of social breakdown.

The strong norms of proper behaviour in face of individual distress can be understood as a simple reflection of a cultural emphasis on the collectivity rather than the individual. Such explanations are offered in the papers contained in the collection edited by Marsella and White (1982). Alternatively, a more complex explanation might suggest that the women's endurance is socially sanctioned and prescribed as a means of maintaining a social system which is oppressive of them; their distress and unhappiness is potentially disruptive if it questions the social order. Quarrels are, on the other hand, already socially disruptive and therefore press for resolution. Individual suffering, especially on the part of women, is not disruptive as long as it can be endured and contained by the sufferer.

Whichever explanation is chosen, the emphasis is on social relations rather than individual experience. Women are not always the victims in the social system; they did not in fact see

themselves in this way. The danger of an account which focusses on unhappiness is that it does not relate the joys and satisfactions which were as much a part of the women's experiences as the negative ones described. The idealisation of one social system over another is, in my view, not justified (certainly on the basis of my data). Whatever one's ideals of personal freedom of choice or equality of opportunity, the women's view of their own situation was not that it was oppressive; rather, they stressed the way in which it protected them. In respect of the importance of social relations, women were well aware that in the long term it was these, however inadequate, that determined their individual happiness and well-being. Thus they were not set over against women's happiness, but were themselves a part of it.

5. Normality.

The tendency to include a whole range of adverse circumstances and experiences as acceptable and 'normal' has emerged clearly from this study. I have shown also, however, that this is a tendency common to medical writers as well as lay groups in our culture and society as well as amongst the women studied.

I would argue that expectations and notions of 'normality' enter into peoples experience of life circumstances as stressful or not. This works at two levels, probably lowering a person's actual experience of unhappiness (since the meaning of an event is an important element in this) as well as resulting in various well-developed mechanisms to 'cope' with familiar and expected deprivation.

'Experts' also exclude from their statistics that suffering which is considered normal. Thus I adjusted the scores of

respondents to disallow negative responses due to the presence of a young baby, Nott and Cutts (1982) do likewise. Some of these adjustments 'creep into' the scales themselves; for example, Cox et al (1984) speak of designing a test that 'makes sense' to potential respondents. This does not include items which would be automatically precluded by their social situation. Social situational factors, once defined as 'normal' become one of the 'givens' of a situation rather than a stress factor themselves.

6. A Relative View of Physical and Mental Ill-Being.

The foregoing discussion of the extent to which measures of mental illness and lay Concepts both incorporate assumptions concerning normality supports the view that mental illness is a relative rather than an absolute construct (see Ingleby 1981; Szasz 1970) at both a macro-and micro-level. At the level of society, it concerns the relation between abnormal and normal behaviour and experiences. For the individual, it is about the relation between the person and his/her way of life: it is about the way people 'cope' with life circumstances rather than either difficulties which are external to the individual or deficiencies in the person involved alone. This view of illness emerged from Claudine Herzlich's work (1973) and is apparent in the accounts of my respondents. Despite the emphasis on Fate, they saw each person as responsible for maintaining health and happiness, where possible, in face of God-sent circumstances and (when illness or unhappiness could not be avoided) for behaving correctly in face of these inevitable adversities.

Chapter Twenty-Five. Overall Conclusions.

Three levels of conclusion are to be discerned in this work and will be drawn out in this chapter. First of these is the level of practical questioning. The impetus and funding for the study related to issues of practice in the field of transcultural psychiatry. I was interested to discover if secluded Asian women (particularly mothers) in Britain were depressed; if so, what social factors (including their seclusion and their role as mothers) contributed to this; and what action they took in face of it (including the seeking of NHS treatment or reasons for not seeking it). These questions will be answered in this chapter in respect of those women studied. At this level, such answers are individualistic and specific - they are about the individual experiences and behaviour of those involved.

The second level focusses, not on individual experience and behaviour alone, but on the links between society and the individual - on collective meanings and determinants of action. In this research, I found that even in order to discover answers at the practical level, I had to go beyond the deceptively simple initial practical questions to look, not just at the problems that individuals were facing, but at the source of these problems in the collectivity.

Thus, in seeking to answer the initial questions, and in 'unpacking them', I found that they related to various literatures; not only that of transcultural psychiatry. Within each of these literatures, there are a number of central issues in respect of which the data I have presented offers explanations and insights, drawn from an understanding of the lives of the group of women studied. These issues all concern links between

aspects of society and the experiences of individuals within them. For example, the link between the seclusion of women and mental state; or the way culture, gender and race effect the definition of normality and the experience of deprivation and distress. In looking at health care interactions, I was seeking for social determinants of outcome, and I came to see social research (including transcultural assessments of mental state) as a social process also, influenced by social and cultural factors in the way it is defined and conducted.

This second level - concerning the link between society and ^{the} individual (whether in respect of research, health care interactions or definitions and experience of illness) - has preoccupied the account throughout. The major areas to which the work was seen as offering a distinctive contribution were identified in Chapter One. Conclusions to each Part have documented the new knowledge in each area that has emerged. This Chapter will draw these conclusions together, partly in order to briefly reemphasise them at this point and partly in order to identify commonalities which may not have been so apparent when they were considered separately. This is necessary because I have stated that the Parts of this work each make both a distinct substantive contribution in respect of the issues addressed therein, and also a cumulative contribution in relation to the overall subject of health and illness behaviours and Concepts.

The third level of conclusion is theoretical. In exploring the diverse issues raised by the work, I have been led, by the data, to a framework within which the women's behaviours in respect of receipt of health care could be understood from their own perspective. Although arising from the work, I have used this

framework in my presentation of the data, thus demonstrating its value. The framework is not one which has been suggested by any other writer, although it draws on understandings that are apparent in the literature. I shall pay some attention to this framework itself in this chapter, showing ^{both} how it emerged from the data and how it offers a useful way of understanding the behaviours studied, thus fulfilling my intention, stated in Chapter One, of inviting the reader to reflect with me on the adequacy of the framework and the theoretical understandings to which the work leads. A number of theoretical emphases have emerged from the work and these too are drawn out here. As stated at the outset, the nature of Concepts was to be a critical issue: the term is used variously by other writers. My data leads me to certain conclusions in respect of the nature of Concepts. The theoretical contribution of this work concerns Concepts of health and illness behaviours. This contribution lies in the use of a detailed case study approach to the theoretical issues involved, allowing issues of process, change and context to be clearly apparent.

It is my contention that this work offers distinctive contributions at each of these three levels, contributions which could only have emerged from a study of this kind. Conclusions at the first practical level relate only to the group individuals studied; at the second they show ways of approaching the various issues identified and demonstrate emphases which derive from the particular group but show similarities with others (as described in the literature); and at the third the conclusions have theoretical and thus wider implications. I consider the conclusions of the work at each level in turn.

1. The Initial Questions relating to Practice.

Of the seventeen women studied in depth, only two seemed to be depressed in both their own terms and those of psychiatry. Despite this apparently high rate (from which little can be concluded, however, because of the small numbers involved), the impression gained was of a lower rate of depression in the group of women as a whole (including all forty-six women - focus and additional respondents: see Chapter Four) than might have been expected both by an outsider and in view of the women's own accounts of their lives. The reason suggested for this was that women included a great deal of personal unhappiness and hardship in their expectations of life and their own definitions of normality: this worked to render such experiences less traumatic in many cases and also to lead women to continue to work and to behave correctly despite them.

Questions of aetiology can be answered from two directions: Firstly in respect of those women identified as ill. Neither of these women was socially isolated; both interacted frequently with other women and were members of large, close - knit networks. Despite formal status, both lacked informal status in the groups, however, and were personally unsupported. In both cases the death of their own mother (in Pakistan) since the woman's own migration to Britain, seemed significant. Both were second wives. One had seven children to care for including her own two babies. Due to purdah observance, neither had any options for social interaction outside the ascribed group of women within which they were subject to ridicule and censure.

Secondly, we can consider the effects of the suggested

aetiological factors in the group as a whole. No simple link could be made between seclusion and mental state. The women who were most isolated were not those who were most distressed; both the implications of seclusion for individuals and its meaning for them had to be understood. Here I note only the negative correlation found between degree of seclusion and mental distress. The issue is further discussed in more general terms below. Experiences as mothers were hard but again not in themselves a stress factor for most women: the context of total acceptance of the role seemed important. Conflicts with health workers concerning methods of child rearing (a suggested aetiological factor) did not seem to give rise to distress amongst respondents. Migration affected the women's lives in a number of ways but was, in itself, accepted as their fate.

Factors which seemed to be of aetiological importance were two. Firstly, the degree of social supportedness of women (either a close marital relationship, or membership of a supportive women's network or even the supportedness that derives from membership of an ideological community as a proud observer of purdah, physically isolated by virtue of unalterable circumstances but maintaining correct and honourable social and religious behaviour nevertheless). The second factor was any circumstance(s) which emphasised the women's separation from their own kin in Pakistan. Death of the woman's mother was especially traumatic, but other circumstances were evident too: one woman had not received letters for some time; others had been unable to attend weddings of sisters. On the positive side, visits to and from Pakistan had a positive influence, as did regular receipt of letters, papers and news. This is, of course, related to migration. It was not the migration in itself, however, that seemed

significant but the way in which this altered the meaning of subsequent events, events which were of themselves independent of migration.

Looking at the initial questions relating to treatment, we find that both of the women seen to be ill were in receipt of treatment from their GPs. The first had numerous medications for her somatic complaints; the second did not see her doctor in person and it seemed probable that her symptoms were not accurately or adequately reported, although the prescription of a minor tranquiliser did indicate that the doctor was aware of the emotional nature of her physical complaints but had (in my view) under-estimated this. Both women emphasised their physical disorders; in one instance this seemed to be because it was these that prevented her from working and maintaining social relations. In respect of the group overall, there was little chance of minor psychiatric symptoms being detected by their doctor because half the sample did not see him in person but were treated by proxy.

There was no evidence that distress was dealt with by seeking help from other healers, but there was evidence of different Concepts and of a different emphasis: on correct behaviour rather than individual suffering. This led to an understatement of personal distress except where this interfered with the women's 'work'. There was no evidence that previous contacts with health workers or doctors led women not to seek help for their distress through these channels although there was evidence that unhappiness was not, of itself, seen as a reason to seek any sort of remedy from any source except strength from God to cope with it.

2. Collective Influences on Individual Experience and Behaviour.

In each of the major areas of study which are involved in answering the initial practical questions a number of key issues have been identified. These issues all concern collective influences on individual experience and behaviour, and it is in exploring these issues that this work offers a distinctive contribution to these various fields of study and that results of this work can be linked to those of other researchers.

The first issue is that of research methods. How is it possible to investigate and understand other people's behaviour in a systematic way? What difference does it make when the cultures of researchers and researched are different? Can we show how this changes the techniques to be used and why it does so? From this study overall, as documented in Part I, I concluded that the use of certain research techniques and methods in a cross-cultural setting shows up some of the assumptions which underlie them. In this instance, I came to feel that the interview method was individualistic and not entirely appropriate to the group studied, in which collectivity was emphasised. I found translation and use of psychiatric test scales to be a problematic exercise, and felt that the scales used reflected assumptions peculiar to Western industrialised society and culture - again not entirely appropriate. In both cases, the process of the work was itself illustrative. It was by close attention to this process (rather than by discarding it as a 'problem of method') that I learned most both about the respondents' Concepts and about research assumptions. My work convinced me of the importance of the context of research (historical, geographical and academic) and of its interactive nature and the importance of the relationship

between researcher(s) and respondents. My work both challenges and supports the use of standardised psychiatric test scales cross-culturally depending on the researcher's purpose. While they might be used to demonstrate the presence or absence of the particular sorts of manifestations of distress identified as important by Western biomedics, they do not lead us to understand how distress is experienced, understood and coped with by other peoples and may fail to pick up considerable unhappiness when this is not manifested in analogous ways.

I suggest that my detailed account of the research process in Part I offers a distinctive contribution to discussions of methodology by its illustration of the way in which methods are changed during a piece of research and of what can be learned from this if these changes are themselves included as data for analysis.'

In exploring the relationship between seclusion (an aspect of social structure) and mental state (a psychological experience of individuals), I concluded in Part II ^{that} it was important to understand the implications of the social structure for individuals (this might vary) and its meaning for them (which had to be set in the context of acceptance of purdah by the women). It seemed that it was not women's non-interaction with others that demanded explanation, but their actual patterns of social interaction. This led me to see communal values other than purdah observance as important; particularly the maintenance of social relations. In a context which included an emphasis on the collectivity and on the maintenance of social relations, purdah was not necessarily seen by women as oppressive, although some did experience the extent of their seclusion as such. Many emphasised

positive aspects, such as the protection it afforded them. As we shall see, it was not related in a simple way to mental state.

This Part of the thesis yielded understandings relating to three key concepts in the overall analysis: the women's work, their experiences of seclusion, and their experiences of psychosocial isolation. Its contribution lies in the way in which it relates aspects of overall social structure to individual experience; starting from overall cultural and structural definitions of the women's own self concepts. Such an account of the lives of Pathan women in Britain is not available in the literature: the role of the wish to receive health care in modifying purdah observance (a theme taken up in the next Part, too) adds a distinctive dimension to the analysis.

Part III concerned the women as mothers, and concentrated on two aspects: the effects of mothering on their own health, and their interactions with maternity and child health services and workers. Data in respect of the former area relates to a literature concerning women and health. I found that although the experiences of my respondents had much in common with those of other groups of mothers, and were often hard, these were set within a total acceptance of, and pride in, their role as mothers. Its deleterious effects on their own health were acknowledged but accepted. There was little evidence of conflict between their own Interests as women and the Interests of their children except in respect of aspects of religious observance (e.g. fasting in pregnancy, leaving children to go on pilgrimage).

Concepts were found to be at variance both with those of biomedicine and of other lay groups. Pregnancy was understated; child and adult worlds less differentiated and the importance of socially acceptable behaviour stressed over individual achieve-

ment. An emphasis on collectivity emerged at many points: in the women's own view of themselves in relation to others rather than in individual terms; in the informal placement of children within the family and in the values seen as important in socialisation of the child.

Women's behaviours in respect of health care were examined most fully in this Part. In so doing, I was looking to respond to some of the issues in the literature concerning ethnic minority groups and health services, through understanding the experiences of this particular group in detail. Were such conflicts as existed due to different Concepts on the part of patients and health workers?' How far were conflicts due to culturally derived beliefs on the part of the women and how far to deficiencies and assumptions in the services, including institutional racism? Did the data suggest personal solutions (reeducation of workers and patients in order to facilitate mutual understanding) or political ones? What role did expectations play? How far were there 'two sides', locked in opposition? Did the women's own Concepts predispose them to accept services on offer and these services put them off, or was it the other way round?

My analysis and conclusions offer an important contribution to these debates. It contributes a description and analysis of the Concepts and behaviours of a group of people in respect of whom no such description exists. This is a group whose views are of interest because they can be expected to (and were indeed shown to) differ from those of other lay and medical groups. Similarities between their experiences and those of other groups of women are the more telling; conflicts with health workers can be expected more in the case of this than of other Asian groups.

Coincidence of Interests was, therefore, the more striking.

My conclusions were that the interactions between members of ethnic minority groups and health workers were complex and changing and that past interactions between them played a part in this process of change. Even where Concepts and assumptions differed, Interests might coincide. It was aspects of each 'side' that both led to take-up of services and was a disincentive to it. The Options from the women's point of view were not the same as the services on offer. Simplistic explanations relating to different Concepts or to racist structures were not adequate. It was clear that both the interpersonal and the political level were important. I also showed that the women's Concepts were both culturally and structurally derived so that their experiences had much in common with those of other groups of women where social situations were similar.

Understanding of women's Concepts in those areas helps us to see why some forms of health care constituted a reason to go out, while others did not, and also shows how expectations define what is seen to be normal - a conclusion that emerges in the next Part also.

In Part IV the focus was on Concepts and illness behaviours as in Part III, but the emphasis shifted towards understanding Concepts. Themes were identified from the literature and these provided a way of presenting data relating to both general and mental ill-being. Concepts were similar in respect of each; social behaviour was emphasised over individual suffering in relation both causation and to illness behaviour. Health and illness, happiness and unhappiness were all seen as inevitable and God-given; serious illness was defined by the inability to work. Some attention was paid to different medical, particularly

psychiatric, perspectives; the use of test scales showed up assumptions underlying Concepts on both sides as well as the way in which normality is defined and redefined both within medicine and by lay groups. I identified similarities between the Concepts which emerged from this study and those of other groups described in the literature and concluded that it was structural similarities between groups concerned which accounted for this since they were culturally very dissimilar. Structural factors emerged from the data yielded by translation of the test items also: these items demonstrated how it is that such very precise indicators of ill-being are changed when those concerned are in a social situation which reflects a different social structure. This is as true for mothers with young children in our own society as for secluded women in Pathan society. I concluded from Part IV that respondents had a relational view of what was important in respect of both physical and mental ill-being: although life circumstances (including sickness) were absolute and God-given, what was important was individual behaviour in face of such circumstances. Especially in the case of women, personal suffering had to be endured and contained in the light of wider spiritual and social Interests. These are of course Concepts which derive from a social structure which is male dominated. While an analyst has to acknowledge this as oppressive of women, it was not viewed as such by those involved.

There are clearly some common . . . emphases which emerged overall. The importance of social relations and of the collectivity emerged from all sections. So did an awareness of the importance of understanding Concepts and behaviours in the context of the values to which the person subscribes if the aim is

to understand the meaning of data. This was as relevant to understanding the results of research as to understanding the implications of purdah observance or of mothering. Change, process and interaction were also common to all Parts.

Conclusions from each Part of this thesis stand alone and make substantial contributions to a number of different areas of literature, as I have tried to show. It is, however, in combination that they offer a unique contribution by demonstrating the extent to which these aspects are interrelated. For example, the complexity of the relationship between purdah observance and mental state can only be understood from Parts II, III, and IV together. From Part IV, we see how the women have Interests in protection from responsibility and that this directly effects the extent to which they see themselves as able to cope or not. Purdah is, for them, a system which clearly defines what women are expected to do, and limits their responsibilities to the extent that many claimed to make no decisions, and to have much work but no responsibilities. Purdah also has to be understood, as Part II showed, within an emphasis on the collectivity rather than the individual. However, we also saw that it delimits the sources of social support so that, where these fail, there are few alternatives. It may also be the basis on which women do not go in person to their doctors (see Part IV), although this would not be the case were services differently structured. Purdah observance therefore has both positive and negative implications for women's mental health. Thus one of the three initial practical questions can only be fully answered in sociological terms (rather than in respect of individuals) on the basis of the understandings and conclusions which result from the study as a whole. Another example is the issue of the ability to work as the basis for the

definition of health (from Part IV). Understandings of the nature of women's work are important if we are to realise what this means - these understandings come from Parts II and III. I conclude therefore that health Concepts and illness behaviours are rooted in the whole lives of individuals and groups and can only be fully understood in this context. This conclusion is not itself new but is demonstrated in Jocelyn Cornwell's recent study (1984). My work confirms her conclusion which was drawn from a study of a group of women whose lives appeared, on the surface at least, to be very different to those of my respondents.

3. Theoretical Conclusions.

A. The Nature of Concepts.

I have concluded, on the basis of this study that Concepts are both structurally and culturally derived. This was shown both in the comparisons of my respondents' Concepts with those of other groups, where similarities which emerged could only be accounted for on the basis of structural parallels between the groups; and in the detailed analysis of the process of discussion of test items where issues of religious belief, cultural emphases and assumptions, and structural position all emerged with clarity.

I also observed a process of change in women's Concepts which incorporated understandings deriving from past experiences, including experiences of interactions with health workers. Concepts then, are not fixed. There was evidence of change due to interaction with medical views. It is not possible from this data to say how far these changes were one - way. I did not study the Concepts of the health workers. It is likely, however, that

changes were primarily one way, which is consistent with the arguments of those who see a process of medicalisation. This was not, however, complete. Women retained emphases on their own world-view despite attacks on it.

I also discovered that different sorts of Concepts can coexist within accounts - what I have described as the women's overall ideological views and their experiential views. Moreover, it was evident that respondents chose to emphasise certain aspects of their experience and world view to me that would not have been emphasised to others. The account I give therefore derives from their perceptions of me: as a woman, a mother, a Pukhtu - speaker and a member of the dominant white society, possibly linked to health services. Concepts are not 'things'; they are communications.

B. The Framework.

I began from an awareness that Concepts (somewhat loosely understood) would be an influence on behaviour. I assumed also that the services available would affect what women did or did not do. I came to see, however, that services were differently used by women or not used by them and concluded it was more appropriate, in seeking to explain illness behaviours from the actors' perspective, to speak not of the services, but of Options for treatment. These would include those services seen as acceptable or appropriate and, perhaps, other possibilities for help. I also concluded that another factor was of importance since women made apparently irrational choices unless account was taken of their Interests in one form of action over another. I have used this tripartite framework in my presentation, and found it helpful. It is not suggested as a tightly knit theoretical model but as a practical means by which people's behaviours may be

understood. It does, in my view, force one to take serious account of their own perspective insofar as each of the factors takes this as a starting point.

C. My Aims and Theoretical Perspective.

In assessing this study and the framework used within it, it is important to be aware of what it does, and does not, try to do. My concern throughout has been to understand everyday behaviours and situations rather than overall social processes. I am aware that many would wish to set the data concerning Concepts within an analysis which sees these as deriving from the women's position in a Patriarchal male-dominated society which is so thoroughly oppressive of women that an acceptance of their own oppression has become incorporated into their own world-view. In respect of health care interactions, a similar analysis could be made which sees the women as victims of racist structures and modes of service delivery. Critics will undoubtedly see this study overall as contributing to the social system which oppresses black groups in Britain, with its focus on a minority group and its funding by institutions seen as racist. However, my analysis itself challenges a view of the women and health workers as in inevitable conflict due to differences of power, since each have Interests which, at times, coincide even when they are differently derived. Women who valued medicalised childbirth, on the basis of their Interests in a healthy outcome at all costs, welcomed the efforts of doctors to increase the technological aids used in delivery, even if these were part of an armoury which devalued women as persons and their ability to bear children unaided. While such differences in orientation may eventually result in conflict, in the immediate situation the Interests coincided.

Personally, I do have some sympathy with political criticisms of work such as this, and would question whether it is helpful for white researchers to continue to focus on minority groups, however sensitively. The study suggests other focusses of attention which would be illuminating - on the Concepts of health workers interacting with the women, for instance. As described in Part I, my own perceptions and awareness of a political dimension have been changed by the study itself. I have tried to acknowledge and document this process together with the data and to let my analysis reflect it insofar as the limitations of my data and original focus of attention allow. Whatever one's views of studies which focus on minority groups, there seem to be an increasing number of these being undertaken by Health Authorities in recent and current years. This study shows up some difficulties and highlights a number of issues relevant to this exercise.

In this context, I would however assert the importance of studies which treat seriously the world-view of those studied, whether the respondents be 'liberated' or racially conscious or not. It is not only politically aware Asian women who need to 'find a voice'. Other groups have a voice too. I have tried to represent the voice of my Pathan respondents. My focus of attention has been everyday experiences and behaviours, rather than overall social processes. I have not seen the women as irresponsible or as victims (either of their own social situation and structures or within British society), but as rational actors. My framework is one which seeks to understand and draw out this rationality. I would challenge any theoretical perspective which seeks to undermine or devalue the women's world-view on the basis that it is explicable as the result of societal conflicts or

structures. The respondents' own theoretical assumptions were that male and female are complementary, not in conflict, and that racial barriers are not such as to preclude meaningful interaction, either in health care or in the research process.

Bibliography.

- Ablon, J. (1973) Reactions of Samoan Burn Patients and Families to Severe Burns, Social Science and Medicine, 7, pp.167-178.
- Abraham, Rachel (1982) Some Observations on Gujarati Diet and Pregnancy, Health Visitor, 55, pp.421-426.
- Ahmed, Akbar, S. (1973) Mataloona: Pukhtu Proverbs. Peshawar: Pakistan Academy for Rural Development.
- Ahmed, Akbar S. (1976) Millenium and Charisma among Pathans. London: Routledge Kegan Paul.
- Ahmed, Akbar S. (1980) Pukhtun Economy and Society. London: Routledge Kegan Paul.
- Ahmed, Sharma (1984) Cultural Racism in work with Women and Girls, in Conference Report of the Transcultural Psychiatry Society (U.K.), Conference on Women: Cultural Perspectives. 6th - 8th April.
- Althusser, L. (1971) Ideology and Ideological State Apparatuses in Lenin and Philosophy and other Essays: New Left Books.
- Ananth, J. (1978) Psychopathology in Indian Females. Social Science and Medicine, 12B, pp.177-8.
- Anwar, M. (1979) The Myth of Return. London: Heinemann.
- Arney, W.R. (1983) Power and the Profession of Obstetrics. Chicago and London: University of Chicago Press.
- Aslam, M. (1979) 'The Practice of Asian Medicine in the United Kingdom'. Thesis for Ph.D. Dept. of Pharmacy, University of Nottingham (Unpublished).
- Badinter, E. (1981) The Myth of Motherhood. An historical View of the Maternal Instinct. London: Souvenir Press.

- Ballard, R. (1976) Ethnicity: theory and experience
(a review article) New Community V. No.3. pp.196-202.
- Ballard, R. (1979) Ethnic Minorities and the Social Services, in Verity Saifullah Khan (ed.) Minority Families in Britain, London: Macmillan.
- Ballard, R. (1982) South Asian Families, Chapter 8, in R. N.Rapoport et al (eds.) Families in Britain, London: Routledge Kegan Paul.
- Ballard, R. and Ballard, C. (1977). 'The Sikhs: The Development of South Asian Settlements in Britain' in J. L. Watson (ed.) Between Two Cultures: Migrants and Minorities in Britain. Oxford: Blackwell.
- Ballard, R. & Holden, B. (1975a) 'Racial Discrimination: no room at the top', New Society, 17th April pp.133-135.
- Ballard, R.E. and Holden, B.M. (1975b) The Employment of Coloured Graduates in Britain. New Community IV, No.3, Autumn pp.323-336.
- Barth, Fredrik (1959) Political Leadership Among Swat Pathans. London: Athlone Press.
- Barth, Fredrik (1969) 'Pathan Identity and its Maintenance', in Barth, F. (ed.), Ethnic Groups and Boundaries: The Social Organisation of Culture Difference, London: Allen and Unwin.
- Bavington, J. T. (1984) 'A Frontier Mental Health Venture', Paper prepared for the Fifth International Psychiatric Conference of the Pakistan Psychiatric Society. 13-16th December 1984. Unpublished.
- Beard, Patricia (1982) Contraception in Ethnic Minority Groups in Bedford, Health Visitor 55, pp.417-421.

- Bennett, T. et al (eds.) (1981) Culture, Ideology and Social Process. London: Batsford Academic and Educational, in association with the Open University Press.
- Benny, M. & Hughes, E.C. (1956). 'Of Sociology and the Interview', American Journal of Sociology 62, pp.137-142. Reprinted in Bulmer (ed.) (1977).p.233f (See below.)
- Berry, J. W. (1969) On Cross - cultural comparability International Journal of Psychology, 4, pp.119-128.
- Bhatti, M. (1976) Language Difficulties and Social Isolation: (the case of South Asian women in Britain). New Community V. 1-2, Summer, pp.115-117.
- Bilton, T. et al (1981) Introductory Sociology. Basingstoke: Macmillan.
- Black, John (1985) Series of four articles on the subject of Child Health in Ethnic Minorities/ Paediatrics among Ethnic Minorities, British Medical Journal, 290, 23rd February, 2nd, 9th-16th March.
- Blaxter, M. & Patterson, E. (1982) Mothers and Daughters, A three generational study of health attitudes and behaviours. London: Heinmann.
- Brent C.H.C. (1981). Black People and the Health Service. London: Brent C.H.C.
- Brighton Islamic Centre (undated) Choice of Food - Halal or Haram.
- Brown, G. W. and Harris, T. (1978) Social Origins of Depression, London: Tavistock Publications.

- Bulmer, Martin (ed.) (1977) Sociological Research Methods, London: Macmillan.
- Burgess, Robert, G. (1984) In the Field; An Introduction to Field Research, London: Allen and Unwin.
- Buswell, Christine (1980) Working report of research to Child Health Project group. University of Warwick, 26th November.
- Caroe, O. (1958) The Pathans. Oxford: Oxford University Press.
- Carpenter, L. and Brockington, I. (1980) A study of Mental Illness in Asians, West Indians and Africans Living in Manchester. The British Journal of Psychiatry, 137, p.201.
- City of Bradford Metropolitan Council (1982) Census 1981, A series of Bulletins.
- Clare, A. (1976) Psychiatry in Dissent. London: Tavistock.
- Clarke, M. & Clayton, D. G. (1983) Quality of Obstetric Care Provided for Asian Immigrants in Leicestershire, British Medical Journal, 286, pp.621-3.
- Cochrane, R. (1977) Mental Illness in Immigrants to England and Wales. An analysis of mental hospital admissions, Social Psychiatry, 12, pp.23-25.
- Cochrane, R., Hashmi, F. & Stopes-Roe, M. (1977) Measuring Psychological Disturbance in Asian Immigrants to Britain, Social Science and Medicine, 11, pp.157-64.
- Commission for Racial Equality (1976) Mental Health among Minority Ethnic Groups. Research Summaries and Bibliography. London: Commission for Racial Equality.

- Cornwell, Jocelyn (1984) Hard Earned Lives. Accounts of Health and Illness from East London. London: Tavistock.
- Cox, J.L., Trotter, J.M. and Sagovsky, R. (1984) The Detection of Postnatal Depression in the Community; a preliminary report of the development of the Edinburgh Postnatal Depression scale. Unpublished paper, Dept. of Psychiatry, University of Edinburgh.
- Crawford, R. (1977) You are dangerous to your health: The Ideology and Politics of Victim Blaming. International Journal of Health Services, 7, pp.663-680.
- Currer, A. (1978) Report on the Community Mental Health Scheme (1976-1977) Unpublished.
- Currer, C. (1983a) The Mental Health of Pathan Mothers in Bradford: a case study of migrant Asian women. Final report to D.H.S.S. June. Unpublished.
- Currer, C. (1983b) Pathan Mothers in Bradford. Shortened version of the findings, November. Unpublished, University of Warwick.
- Currer, C. (1984a) Pathan Women in Bradford - Factors affecting Mental Health with particular reference to the effects of Racism. The International Journal of Social Psychiatry. 30th Anniversary Double Issue. 30/1 and 2. Spring, pp.72-76.
- Currer, C. (1984b) 'Lay Concepts of Illness and Depression, and their relation to illness behaviour, amongst Pathan mothers in an English city: in B. Tax (ed.) Proceedings of Workshop on Lay Culture and Illness Behaviour, July 2-4 1984, Department of Social Medicine, Nijmegen, Holland: Mimeo.

- Currer, C. (forthcoming) Concepts of Mental Well - and Ill - being: The case of Pathan Mothers in Britain, Chapter 9 in Currer, C. and Stacey, M. (eds.) Concepts of Health, Illness and Disease; A Comparative Perspective. Leamington Spa: Berg Publishers.
- Dahya, Badr (1974) The Nature of Pakistani Ethnicity in Industrial Cities in Britain, in Cohen, A. (ed.) Urban Ethnicity, London: Tavistock.
- Dahya, B. (1981) Gender Roles and Ethnic Relations; Comment in New Community, 9, pp.111-2.
- Dally, Ann (1982) Inventing Motherhood, London: Burnett Books.
- Das, Veena (1976) Indian Women: Work, Power and Status, pp. 129-45 in B.R.Nanda (ed) Indian Women from Purdah to Modernity. Delhi.
- Davies, C. (1984) General Practitioners and the pull of prevention, Sociology of Health and Illness Vol.6 3 Nov, pp.267-289.
- Deutscher, Irwin (1968) Asking Questions Cross-Culturally: Some Problems of Linguistic Comparability. pp.318-341 in Becker et al (eds.) Institutions and the Person, Chicago: Aldine.
- Deutscher, I. (1969-70) Asking Questions (and Listening to Answers): a Review of some Sociological Precedents and Problems, Sociological Focus, 3 No.2 pp.13-32. Reprinted in Bulmer (1977) op.cit.
- D.H.S.S. (1983) Surma - is your child at Risk? H.M.S.O.

- Donovan, Jenny (1983) Black People's Health: A different way forward? Radical Community Medicine, 16. Winter, pp.20-29.
- Eisenberg, L. (1977) Disease and illness: Distinctions between professional and popular ideas of sickness, Culture, Medicine and Psychiatry, 1: pp.9-23.
- Eister, A. (1984) 'Social Structure' in J. Gould & W.L. Kolb A Dictionary of the Social Sciences, London: Tavistock.
- Ehrenreich, B. & English, D. (1979) For Her Own Good: 150 years of the experts advice to women. London: Pluto Press.
- Fabrega, H. (1973) Disease and Social Behaviour, Cambridge, Massachusetts: M.I.T. Press.
- Fenton, Steve (1985) Personal Communication concerning research on interactions between black people and health workers in Bristol. Research report forthcoming. University of Bristol.
- Field, D. (1976) The Social Definition of Illness, Chapter 10 in Tuckett, D. (ed.) Introduction to Medical Sociology, London: Tavistock.
- Frankenberg, R. (1979) Methodology: Social or Individual, Paper given at BSA/SSRC Methodology conference.
- Gavron, Hannah (1966) The Captive Wife, Harmondsworth: Penguin.
- Gellner, E.A. (1964) 'Concept' in J. Gould & W.L. Kolb A Dictionary of the Social Sciences, London: Tavistock.
- Gideon, Helen (1962) A Baby is Born in the Punjab, American Anthropologist, 64, pp.1220-1234.

- Goldberg, D. and Blackwell, B. (1970) 'Psychiatric Illness in General Practice. A Detailed Study using a New Method of Case Identification'. British Medical Journal, 23rd May, pp.439-443.
- Goldberg, D.P., Cooper, B., Eastwood, M.R., Kedward, H.B. and Shepherd, M. (1970) A standardised psychiatric interview for use in community surveys. British Journal of Preventive and Social Medicine, 24, pp.18-23.
- Goldberg, D. (1978) Manual of the General Health Questionnaire N.F.E.R. - Nelson Publishing Co.
- Gould, J. & Kolb, W.L. (1964) A Dictionary of the Social Sciences, London: Tavistock.
- Gould, J. (1964) 'Ideology' in J. Gould and W.L. Kolb, A Dictionary of the Social Sciences, London: Tavistock.
- Graham, H. (1979) Prevention and Health: every mother's business: a comment on child health policies in the 1970's. In Harris, C. (ed.) Sociology of the Family: New Directions for Britain. Sociological Review Monograph No.28, University of Keele.
- Graham, H. (1982) Coping: or how mothers are seen and not heard, in Friedman, S. and Sarah, E. (eds) On the Problem of Men. London: The Women's Press.
- Graham, H. & Oakley, A. (1981) Competing Ideologies of Reproduction: Medical and Maternal Perspectives on Pregnancy, in Helen Roberts (ed.) Women, Health and Reproduction, London: Routledge Kegan Paul.
- Griffiths, K. (1983) Child-rearing Practices in West Indian, Indian and Pakistani Communities, New Community, 10, 3, pp.393-409.

- Hall, S. (1981) Cultural Studies: two paradigms; in Tony Bennett et al (eds.) Culture, Ideology and Social Process. London: Batsford Academic and Educational, in association with The Open University Press.
- Harrison, C. (1982) Life Styles, Well-Being and Stress, Human Biology, 54, pp.193-202.
- The Health Care Foundation in association with the Royal Society of Medicine (1978) Pregnancy and Baby Care A-Z, London: Scott-Clark.
- Helman, C.G. (1978) 'Feed a Cold, Starve a Fever' - Folk models of infection in an English suburban community, and their relation to medical treatment, Culture, Medicine and Psychiatry, 2, pp.107-137.
- Helman, Cecil (1984) Culture, Health and Illness, Wright. PSG, Bristol.
- Herzlich, Claudine (1973) Translated Douglas Graham, Health & Illness, a Social Psychological Analysis. London & New York: Academic Press.
- Hiller, E.T. (1947) Social Relations and Social Structures. New York: Harper & Sons.
- Hitch, P.J. (1975) 'Migration and Mental Illness in a Northern City.' Thesis for Ph.D. University of Bradford, (unpublished).
- Homans, H. (1982) Pregnancy and Birth as Rites of Passage for Two Groups of Women in Britain: in C.P. MacCormack (ed.) Ethnography of Fertility and Birth, London: Academic Press.
- Honigman, J. (1957) 'Women in West Pakistan.' in Stanley Maron (ed.) Pakistan: Society and Culture, New Haven: Human Relations Area File.

- d'Houtaud, A. (1981) Nouvelles recherches sur les représentations de la santé, Review Internationale d'Education pour la Santé, 24, 3 pp.3-22.
- d'Houtaud, A. and Field, M. (1984) The Image of Health: variations in perception by social class in a French population, Sociology of Health & Illness, 6, No.1 pp.30-60.
- d'Houtaud, A and Field, M. (forthcoming) 'New Research on the Image of Health', Chapter 12 in C. Curren and M. Stacey (eds) Concepts of Health, Illness and Disease: A Comparative Perspective. Leamington Spa: Berg.
- Hughes, Joan (1980) Working report of research to Child Health Project Group, University of Warwick, 13th May 1980.
- Hull, Diana (1979) Migration, Adaptation and Illness: A Review, Social Science & Medicine, 13A pp.25-36.
- Illich, I. (1976) Limits to Medicine. London: Calders & Boyars Ltd.
- Illsley, R. (1982) Personal communication proposing a meeting to discuss methods of social characterisation and differentiation in research concerning Asian women and reproduction, and subsequent discussions at Northwick Park Hospital, Harrow, 21st May 1982.
- Ingleby, D. (1981) Introduction, and understanding 'Mental Illness', in Ingleby, D. (ed.) Critical Psychiatry, The Politics of Mental Health. Harmondsworth, Penguin.

- Jackson, K. (1976) 'How to Organise a Toy Bus', in The Needs of Asian Mothers and Under-Fives, Report of a one-day Seminar, 25/3/76. Community Relations Commission.
- Jacobson, D. (1977) The Women of North and Central India: Goddesses and Wives, in D. Jacobson and S. Wadley Women in India: Two Perspectives. Columbia: Asia Books.
- Johnson, M. and Cross, M. (1983) Race and Primary Health Care in the West Midlands. In Radical Community Medicine, 16. pp.47-50.
- Jeffery, P. (1976) Migrants and Refugees, Muslim and Christian Pakistani Families in Bristol. Cambridge: Cambridge University Press.
- Jeffery, P. (1979) Frogs in a Well, Indian Women in Purdah. Zed Press.
- Jeffery, Patricia et al (1984) Childbirth and Collaboration among women in Bijnor District, Uttar Pradesh, Journal of Social Studies, 25, July, pp.15-35 (Dhaka, Bangladesh).
- Jeffery, R. et al (1984) Only Cord Cutters? Midwifery and Childbirth in Rural North India. Social Action, 34, July-Sept. pp.229-250.
- Jones, E. (1963) The Courtesy Bias in South-East Asian Surveys, International Social Science Journal, 15, 1.
- Kanner, A., Coyne, J., Schaefer, C. and Lazarus, R. (1981) Comparison of Two Modes of Stress Measurement: Daily Hassles and Uplifts versus Major Life Events. Journal of Behavioural Medicine, 4, 1.

- Karpf, A. (1985) The hospital pain killers, The Guardian, 13th March.
- Keesing, R.M. (1981) Cultural Anthropology, New York: Holt, Rinehart & Winston.
- Kiev, Ari (1972) Transcultural Psychiatry, Harmondsworth: Penguin.
- Kitzinger, S. (1978) Women as Mothers. Glasgow: Fontana/Collins.
- Kleinman, A.M. (1977) Depression, Somatization and the 'new cross-cultural psychiatry'. Social Science & Medicine, 11, p.3.
- Kleinman, A. (1978) Concepts and a model for the comparison of medical systems as cultural systems, Social Science & Medicine, 12, pp.85-93.
- Kluckhohn, Clyde (1984) 'Culture' in J. Gould and W.L. Kolb, A Dictionary of the Social Sciences. London: Tavistock.
- Knight, L. (1978) Protect their minds too, Mind Out, 31, pp. 12-14.
- Langner, T.S. (1962) A twenty-two item Screening Score of Psychiatric Symptoms indicating impairment. Journal of Health and Social Behaviour, 3, p.269.
- Leff, J.P. (1973) Culture and the differentiation of emotional states, British Journal of Psychiatry, 123, pp.299-306.
- Leff, J.P. (1977) International variations in the diagnosis of psychiatric illness. British Journal of Psychiatry, 131, pp.329-338.

- Lemert, E.M. (1958) An exploratory study of mental disorders in a rural problem area, Rur. Sociol,13, p.48.
- Lerner, D. (1984) The Passing of Traditional Society; Modernising The Middle East. The Free Press.
- Lewando-Hundt (1984) The Excercise of Power by Bedouin Women in the Negev, pp.82-124 in The Changing Bedouin, Emmanuel Marx and Avshalom Shmueli (eds.) London & New Brunswick: Transaction Books.
- Lewis, G. (1975) Knowledge of Illness in a Sepik Society. London: The Athlone Press.
- Littlewood, R. (1983) Book Review in Bulletin of the Transcultural Psychiatry Society (U.K.), 6, pp.24-28.
- Littlewood, R. (1985) The Migration of Culture-bound Syndromes. Bulletin of the Transcultural Psychiatry Society, (U.K.),7, pp.12-15.
- Littlewood, R. and Lipsedge, M. (1982) Aliens and Alienists, Ethnic Minorities and Psychiatry, Harmondsworth: Penguin Books.
- Locker, D. (1981) Symptoms and Illness; the cognitive organisation of disorder, London & New York: Tavistock.
- Lumb, K.M., Congden, P.J. and Lealman, G.T. (1981) A comparative Review of Asian and British-born Maternity patients in Bradford, 1974-78, Journal of Epidemiology and Community Health, 35, pp.106-109.
- Manis et al (1963) 'Validating a Mental Health Scale' American Sociological Review, 28, (February) pp.108-116.

- Marsella, A.J. and White, G.M. (eds.) (1982) Cultural Conceptions of Mental Health and Therapy. D. Reidel.
- McDermott, M.Y. and Ahsan, M.M. (1980) The Muslim Guide. Leicester: The Islamic Foundation.
- Mehta, R. (1976) From Purdah to Modernity, in B.R. Nanda (ed.) Indian Women. New Delhi: Vikas.
- Mennell, S. (1974) Sociological Theory: Uses and Unities. Sunbury on Thames: Nelson.
- Mitchell, R. (1965) Survey Materials Collected in the Developing Countries: Sampling, Measurement and Interviewing Obstacles to Intra- and International Comparisons. International Social Science Journal, 17, (4): 678.
- Nott, P. and Cutts, S. (1982) Validation of the 30-item General Health Questionnaire in post partum women, Psychological Medicine, 12, pp.409-413.
- Oakley, A. (1975) 'The Trap of Medicalised Motherhood'. New Society, vol.34 p.639.
- Oakley, A. (1976) 'Wisewoman and Medicine man: Changes in the management of Childbirth' in J. Mitchell and A. Oakley (eds.) The Rights and Wrongs of Women. Harmondsworth: Penguin Books.
- Oakley, A. (1979) Becoming a Mother, Oxford: Martin Robertson.
- Oakley, A. (1980) Women Confined: Towards a Sociology of Childbirth. Oxford: Martin Robertson.

- Oakley, A. (1981) Interviewing Women; a Contradiction in Terms, in Roberts, H. (ed.) Doing Feminist Research, London: Routledge Kegan Paul.
- Oyebode, Femi (1985) A Critical Examination of the PSE Translation into Yoruba, Bulletin of the Transcultural Psychiatry Society (U.K.), 7, May pp.16-19.
- Pakistan F.P.A. (Undated). Birth right: Islamic Viewpoints On Family Planning, Special Number publication of the Family Planning Association of Pakistan, Undated report - late 1960's/early 1970's.
- Papanek, H. (1973) Purdah: Separate Worlds and Symbolic Shelter, Comparative studies in Society and History, 15, pp. 289-325.
- Papanek, H. (1979) Family Status Production: the 'work' and 'non-work' of Women. Signs: Journal of Women in Culture and Society, Vol. 4, No.4. pp.775-781.
- Parekh, B. (1974) The Spectre of Self-Consciousness, in Parekh, B. (ed.) Colour, Culture and Consciousness. London: Allen and Unwin.
- Parkin, D. (1974) Congregational and Interpersonal Ideologies in Political Ethnicity, in Cohen, A. (ed.) Urban Ethnicity A.S.A. Monograph 12, Tavistock.
- Parkin, M. (1983) 'Bradford Parents Present £1.2.m Muslim Schools Plan', The Guardian 19/2/83.
- Pearson, M. (1983) The Politics of Ethnic Minority Health Studies, Radical Community Medicine, 16, Winter, pp.34-44.
- Phillips, H.P. (1959-60) Problems of Translation and Meaning in Field Work, Human Organisation, 18, (4):190.

- Pierce, G. (1982) Revealed: a British Community Living in Terror, The Guardian, Monday, June 21st. p.11:
- Pike, K.L. (1966) Etic and Emic stand points for the description of behaviour, in Communication & Culture, (ed.) A. Smith. pp.152-166, Holt, Rhinehart & Winston.
- Pill, R. and Stott, N. (1982) Concepts of Illness Causation and Responsibility: some preliminary data from a sample of working class mothers, Social Science & Medicine, 16, pp.43-52.
- Pollock, K. (1984) Mind and Matter, A Study of Conceptions of Health and Illness among three groups of English Families with particular reference to multiple sclerosis, schizophrenia and 'nervous breakdown', Ph.D. Thesis submitted to the University of Cambridge, Unpublished.
- Rack, P. (1982) Race, Culture and Mental Disorder, London: Tavistock Publications.
- Ray, C., Lindop, J. and Gibson, S. (1982) The Concept of Coping. Psychological Medicine, 12, pp.385-395.
- Rex, J. and Moore, R. (1967) Race, Community and Conflict: a study of Sparkbrook. O.U.P. for the Institute of Race Relations.
- Richardson, C. (1976) A Geography of Bradford. Bradford: University of Bradford.
- Saifullah Khan, Verity (1974) 'Pakistani Villages in a British City', Ph.D Thesis, Bradford University, Unpublished.
- Saifullah Khan, V. (1976) Purdah in the British situation, in Barker, D. and Allen, S. (eds.) Dependence and Exploitation in Work and Marriage. London: Longmans.

- Saifullah Khan, V. (ed) (1979) Minority Families in Britain; Support and Stress London: Macmillan.
- Saifullah Khan, V. (1984) Book Review, in Sociology of Health and Illness, 6, 2: pp.249-250.
- Sashidharan, S. (1985) Editor's Notes, Bulletin of the Transcultural Psychiatric Society (U.K.) No. 7, p.1.
- Scarman, L.G. (1981) The Brixton Disorders 10-12 April 1981: report of an enquiry by the Rt. Hon. the Lord Scarman. London: HMSO, Cmnd 8427.
- Schofield, J. (1981) Behind the veil: The Mental Health of Asian Women in Britian. Health Visitor 54, April, May, June.
- Schools Language Survey, (1983) Summary of the First Report of Findings, Bradford Metropolitan District, (unpublished report).
- Seabrook, J. (1973) The Unprivileged: A Hundred Years of Family Life and Tradition in a Working Class Street, Harmondsworth: Penguin Books.
- Seiler, Lauren (1973) The 22 Item Scale Used in Field Studies of Mental Illness: A Question of Method; A Question of Substance and a Question of Theory. Journal of Health and Social Behaviour. 14, pp. 252-264.
- Seiler, L. and Summers, G. (1974) 'Towards an Interpretation of Items Used in Field Studies of Mental Illness', in Social Science and Medicine, Vol. 8 pp.459-467.
- Sharma, U. (1971) Rampal and his family: The story of an Immigrant, Collins.

- Sharma, U. (1977) Migration from an Indian Village;
An Anthropological Approach, Sociologia Ruralis,
Journal of the European Society for Rural Sociology
Vol. XVII No.4
- Sharma, U. (1978) Segregation and its Consequences
in India: rural women in Himachal Pradesh, in
Patricia Caplan & Janet Bujra (eds.) Women United,
Women Divided. London: Tavistock.
- Sharma, U. (1979) Trust and Understanding: Presenting
the Results of Participant Observation, Unpublished
paper prepared for SSRC workshop on Participant
Observation, Birmingham.
- Sharma, Ursula (1980) Purdah and Public Space. Ch.9
in Alfred de Souza (ed.) Women in Contemporary India
and South Asia. Manohar.
- Shorter Oxford English Dictionary. (3rd Edition reprinted
and corrected 1965) London: Oxford University Press.
- Singer, André and the Editors of Time-Life Books (1982)
Guardians of the North-West Frontier: The Pathans.
Amsterdam: Time-Life Books.
- Singer, K. (1977) A Comment, Social Science and Medicine,
11, pp.11-12.
- Stacey, M. (1984) Who are the Health Workers? Patients
and other Unpaid Workers in Health Care. Economic
and Industrial Democracy Vol.5; pp.157-184.

Stacey, M. (forthcoming) 'Concepts of Health and Illness and the Division of Labour in Health Care', in Curren, C. and Stacey, M. (eds) Concepts of Health, Illness and Disease a Comparative Perspective, Leamington Spa: Berg.

Stern, V. (1976) 'The Work of the C.R.C. on Under-Fives' in The Needs of Asian Mothers and UnderFives, Report of the One-Day Seminar. 25/3/76, Community Relations Commission.

Szasz, T. (1960) 'The Myth of Mental Illness' American Anthropologist, 15, pp.113-8.

Tapper, R. (undated) 'Possession, Insanity and Responsibility in Northern Afghanistan', Unpublished discussion paper from research conducted in 1971-1972.

Tax, B. (ed.) (1984) Proceedings of a Workshop on Lay Culture and Illness Behaviour, Nijmegen: University of Nijmegen, Mimeo.

Thomas, A. (1978) 'Discussion on Arthur Kleinman's Paper', Social Science and Medicine, 12, : 95.

Thompson, C. (1981) A sense of 'sharm': its implications for the position of women in Central India. South Asia Research. No.2.

Townsend, P. and Davidson, N. (1982) Inequalities in Health. The Black Report. Harmondsworth: Penguin Books.

Training in Health and Race (1984), Health and Race Report, Quarterly newsletter of Training in Health and Race, Summer.

Veitch, A. (1983) Cutting death rate among Asian babies, The Guardian, 24th February,

- Wadel, C. (1979) *The Hidden Work of Everyday Life*, in Wallman, S. (ed.) Social Anthropology of Work. New York: Academic Press.
- Watson, E. (1984) Cross - cultural measurement of Psychological symptoms. Unpublished paper presented at the 28th Annual Scientific meeting of the Society for Social Medicine 19-21st September.
- Whichelow, M.J. (1979) Breast Feeding - Keeping up the milk Supply, Health Visitor, 52, No.6.
- White, G. and Marsella, A. (1982) 'Introduction: Cultural Conceptions in Mental Health Research and Practice', in Marsella, A. and White, G. (eds.) Cultural Conceptions of Mental Health and Therapy. Reidel.
- Whitelock, M. (1984) An Investigation into the Expectations Pakistani Women in Working have of the Health Visitor, Unpublished Project Report, June 1984.
- W.H.O. (1973) The International Pilot Study of Schizophrenia Vol.1 Geneva. W.H.O.
- Williams, Paul et al (1980) Case Definition and Case Identification in Psychiatric Epidemiology: Review and Assessment. Psychological Medicine. 10, pp.101-104.
- Williams, Fory (1983) Concepts of Health: 'An Analysis of Lay Logic, Sociology, 17, pp.183-205.
- Wilson, A. (1978) Finding a Voice, London: Virago Press.
- Winkler, Fedelma (1983) Advocacy in Health: Racial Minorities and Maternity Services, Radical Community Medicine, 16, Winter, pp.51-54.

- Winnicott, D.W. (1964) The Child, The Family and the Outside World, Harmondsworth: Penguin Books.
- Young, A. (1976) Internalizing and externalizing medical belief systems: an Ethiopian example, Social Science and Medicine, 10, 3/4 pp.147-156.
- Zaklama, M.S. (1984) The Asian Community in Leicester and the Family Planning Services, Biology and Society, 1. 2.
- Zola, I.K. (1972) Studying the decision to see a doctor, In Lipowski, Z. J. (ed) Advances in Psychosomatic Medicine, 8, p.216.

Glossary.

It has been my general policy to use Arabic script when quoting Pukhtu words and phrases, with an English translation. There have, however, been exceptions to this, which have been made for one of two reasons.

1. Some words are commonly heard or used in English in untranslated form. These I have spelt out in Roman script.
2. Some words I have felt to be important to the flow of the work in their Pukhtu form - I have therefore offered the reader a Roman script version in order that s/he might be able to 'say' the words as s/he reads, despite an inability to articulate the Arabic script.

The glossary lists such terms used which may be unfamiliar. Explanatory notes are offered in the case of terms of central importance.

1. Terms of Central Importance.

Pathan. I have throughout referred to the women studied as Pathans, rather than Pukhtuns. This usage follows a number of major authors (Caroe 1958, Barth 1959, 1969, Ahmed 1976, Singer 1982). As Akbar ^{Ahmed} says, 'Pathan is the popular name for Pukhtuns; they refer to themselves as Pukhtun' (1976:143). In a later work, however, Ahmed agrees with reviewers who have criticised his earlier use of the term, saying that 'the word Pathan does not exist among Pukhtu speakers and Pukhtuns; it is an Anglo - Indian corruption' (1980: 368). He chooses therefore to use the 'correct' term (Pukhtun).

Despite sympathy with his argument, I have retained the word Pathan because of differences between my study and his. My study is of Pathans in Britain. While I would not argue that they therefore lose the right to be considered in their own terms by virtue of migration, the issue of mutual understanding and of health care interactions is central to the work. My useage is to help those readers who are ready to differentiate between groups of Pakistani settlers in Britain and wish to link my findings with those in the more popular literatures. Pathan is a commonly used term and will be more generally understood. I feel that this would have been more important to my respondents than other issues.

Pathans are a tribal people who live in what are now the countries of Afghanistan and North-West Pakistan. Many have settled in towns and villages in those areas, although large areas of land are still designated 'tribal areas' and outside direct Governmental control. They claim descent from a common ancestor who was converted to Islam by the Prophet Mohammed himself. The most complete account of the history of the Pathans is that by Sir Olaf Caroe (1958).

Pukhtu. The language of the Pathans which embodies their code of Pukhtunwali.

There are various ways of writing this term in Roman script, some of which reflect different regional dialects, and some different phonetic conventions. I have followed Ahmed (1980) here, retaining the 'kh' spelling which is characteristic of the dominant dialect in the language.

Purdah, the social system by which women are secluded from men and from public life. This system is variously defined, discussed and described by a number of writers (e.g. Papanek 1973, Saifullah Khan 1976, Jeffrey 1979, Sharma 1980) and others referred to in the text.

2. Places.

North-West Frontier: One of the four Provinces of Pakistan; the home of many Pathans. (N.W.F.P.).

Punjab: an area in the Indian subcontinent which was divided in 1947. There is now an Indian and a Pakistani Punjab.

Swat: District in the North-West Frontier of Pakistan (formerly a kingdom).

Attock: }
Campbellpur: } Two names (the former more recent; the latter dating from British times) for a District in Punjab Province of Pakistan which is just over the border (formed by the Attock river) from the North-West Frontier.

A number of people claiming Pathan descent have settled in villages near to the border.

Chhachh: The name for the areas of Attock district close to the border where some Pathans (Chhachhis) have settled.

Peshawar: Provincial capital of N.W.F.P.

Mardan: a town in N.W.F.P.

Waisa: a village in Attock District from which large numbers of Pathan (Chhachhi) people have emigrated to Britain.

3. Languages.

Urdu: The national language of Pakistan.

Hinco: A regional language used in the N.W.F.P. and adjoining areas.

Pukhtu: (op.cit). The provincial language of N.W.F.P. as well as the language of the Pathans.

4. Other words and phrases used in the text.

In Alphabetical order. This list is offered as an aid to the reader ^{of this work} only. It is to be used in conjunction with the text, where the context of a term will be important to its meaning, and where some additional explanations and, in certain cases, explorations of a concept are offered. I do not claim to be a linguist and apologise to any reader who finds this mixture of Pukhtu, Urdu, Arabic, Persian (and indeed, Anglicised corruptions of any of the former) offensive. Where possible, I have followed authorities and traditions, but this has not always been possible.

awaz	lit. voice.
burqa	Veil; total covering for purdah-observing women when moving in public.
cameez	tunic worn by men and women. Part of Pakistani national dress.
dai	untrained midwife.
dupatta	scarf - part of woman's Pakistani national dress; symbol of modesty.
duk-suk	(duk = lit. full) troubles or worries that might be discussed with a friend.
Eid	one of the two major Islamic festivals: 'Id al - Fitr' and 'Id al - Adha' (McDermott and Ahsan 1980).
ghairat	honour (see also izzat).
ghum-shadi	lit. - sadness and happiness. Life's 'joys and sorrows'.
hafghan	sadness, unhappiness, anger (of all degrees).
haj	religious pilgrimage to Mecca.
hakim	a traditional healer who has undergone a training programme recognised in the Indian sub continent.
halal	permitted e.g. halal food is food that has been ritually killed.
halwa	a food made of butter fat and sugar.
huq	lit. right, due.
izzat	honour (see also ghairat).
jirga	tribal gathering of elders.

kismat	fate (understood in the context of Islamic faith in the will of Allah).
malwi	a Muslim teacher or leader.
masharan	elders.
mataloona	Pukhtu proverbs.
nazar	lit. sight; the 'eye'.
pagal	mad.
pir	a saint' or holy man.
Qur'an	'lit. reading. The last Divine Revelation of Allah' (McDermott and Ashan 1980). The Holy book of Islam.
Ramzan	(or Ramadan) The Muslims' sacred month of fasting.
sawab	holy, pure.
sayyid	a holy person or family.
shalwar	baggy trousers, forming part of Pakistani national dress for both sexes.
sharm	shame, shyness, embarrassment, A complex concept.
soch	thought, (pl. sochunah) usually deep thought.
surma	a black substance (Kohl) applied to the eyes of babies and children.

tarwiz an amulet, usually containing holy
 words, worn around the neck.

umedwara lit. hopeful. Expectant, pregnant.

zenana women; usually used to refer to
 a place reserved for women.

APPENDIX A

Statement of my own Assumptions and Values.

Appendix A.

Statement of my own Assumptions and Values.

A number of works discuss and dismiss the suggestion that research is, or can ever be, completely objective and value - free (see for example Ingleby 1981). I accept this totally: it was in fact confirmed within the present study which itself convinced me of the cultural assumptions underlying a number of research methodologies. It is important therefore that I state my own position in respect of four central areas: religion; purdah (this is the issue of the subordination of women); racism; and depression (this is the issue of the meaning of mental illness). I should stress that the discussions which follow are not exhaustive: they are not offered primarily as critiques of alternative positions or as a full justification of my own. They represent a point in the development of my thinking which will, I trust, continue to change and develop. I am myself aware of confusions and contradictions in what I believe which will be even more apparent to an outsider. The purpose of their inclusion relates solely to the need to make explicit assumptions that have influenced this work and its presentation.

1. Religion: A Christian describing Muslims

This is not the place to discuss the affinities and differences between Christian and Muslim beliefs. I merely state my position as a committed Christian, as I stated it to respondents. Far from being horrified that a non - Muslim was attempting to interpret their beliefs, most saw it as preferable

that I had my own faith than that I had none. Many, moreover, feel some affinity with the Christian tradition - we are at least 'people of the book'. They could better grapple with a different, albeit mistaken, faith than with what they saw as the faithlessness and hence the moral decadence prevalent in the West, although some linked this with Christianity. Inevitably my own faith has influenced this analysis; the next section particularly reveals some points at which I see it as being of relevance. I hope that it has not prevented an accurate presentation of the views of respondents within their own religious tradition. It is certainly a tradition for which I have a genuine respect.

2. Purdah: the social position of women.

I do not find myself angry concerning purdah nor do I view the purpose of my work as being to expose its iniquities. Some have expressed surprise at this. My first line of defense would be that neither the women I knew in Pakistan nor my respondents in Britain who observed purdah were outspokenly critical of it nor did they appear angered by it or to experience its observance as an imposition. There were discussions concerning how strictly it should be observed/enforced and some criticism over this, which is presented in the main text. On the other hand, a recent visit to Pakistan (December 1984) brought me in touch with Pathan women who were critical of purdah as a social institution. I understand that such criticism is growing and increasingly expressed and I have considerable sympathy with it. Recent legislation in Pakistan makes overt and further institutionalises attitudes concerning women's inferiority. Reaction to this by women in Pakistan is inevitable.

Yet the defence that I share the perspective of my respondents is not sufficient. An ethnographer can describe a people and their views without adopting them and, indeed, must remain somewhat detached from what s/he observes and describes if s/he is to put it into an overall framework. It is perhaps the awareness of their views however, which makes me echo what Verity Saifullah Khan has to say in the context of her discussion of purdah in the British situation.

There is a disturbing arrogance and 'cultural' imperialism underlying many of the most valid aims of the womens movement. The movement is based on concepts such as individuality and independence, which are essentially Western concepts. It applies little time and energy to delve below the submissiveness, conformity, dependence, exploitation and lack of individuality which it characterises as fundamental to the Asian, and many other ways of life. In our society the state of the old and the mentally ill indicate but two examples of our need to learn from the altruism, and the notion of duty which are equally fundamental elements of Asian culture.

To the Asian, the Westerner's stress on independence and individuality appears immoral, selfish and irresponsible, although it may well foster innovation and creativity. Freedom is not identified with self-assertion, and emancipation must surely be attainable without Westernisation. It is arguable, I think, that Asians do not see the status of men and women as comparable, and thus not in competition or conflict ... Each have their own 'equal' status, but their statuses are different, with their own unique characteristics and resources. Comparison and

competition make little sense. (Saifulllah Khan 1976 :241).

Although I personally do believe that the status of men and women is comparable such that equal opportunities to participate in both domestic life (currently often culturally denied to men) and public life (currently often culturally and structurally denied to women) are important, I share the view expressed that independence and individuality are not goals which are paramount.

Although I believe in the necessity of political change to achieve equality of opportunities, both in respect of sex and of class, I see political change as a means to an end rather than an end in itself. Moreover my view of the end has more to do with powerlessness than with power, more to do with service than with rights and more to do with interdependence than with independence. (I like to think that these views not only reflect and derive from my Christian belief, but that I hold to that belief because, to date, it best incorporates what I believe to be true from experience). I am aware that many who are committed to political struggle would agree that it is a means and some might even agree with me about the nature of the end in view. They would argue further however that social justice is a prerequisite: that those who suffer deprivation, whether materially or in terms of opportunities cannot think about ends; that salvation (whether religiously conceived or in terms of self-fulfilment and actualisation) is impossible within an unjust structure. At the extreme this argument is, in practice, true for the majority of people although there are many who bear witness to the possibility of personal fulfillment within unjust situations, including Christ himself. This may however be where Christian and humanist perspectives differ, for I do not see social justice as a

prerequisite to individual salvation, important as it is. It seems to me to be wrong to argue, as many Marxists and Feminists do, that anyone who experiences fulfillment within a situation of social inequality is suffering from 'false consciousness'. On the contrary, it is my view that some (not all) situations of powerlessness (even those not consciously chosen) offer a greater opportunity for personal development in terms of relationships with other people than do many (perhaps all) situations of power.

My view of my own strengths and potential is that they lie in the area of the personal, not of the political. I do not see my own preference for personal action as 'opting-out'. It is often the case that the personal becomes political and many, perhaps most, political activists derive their commitment and interest from personal struggles. I can only say that for me this has not yet happened. I feel closer in many respects to the Pathan mothers I interviewed, including their acceptance of a dependent social position, than I do to a large number of feminists. This account of Purdah is not therefore a critical attack on an unjust social institution although I accept that purdah is potentially oppressive. For such an analysis, the reader will have to turn to a writer with other assumptions and theoretical leanings.

3. Racism

Whereas I share with those I shall be describing a common situation as a woman, in respect of the issue of race, I belong to the more powerful group while they are of the other side - I am a white person describing the experiences of black people. In respect of the issue of race therefore I tread more warily. I am

aware of the current view in many black circles that white cannot and should not speak of or for black, and of the criticism of white liberal attitudes concerning issues of culture and, less often, race.

Awareness of these views and their validity represents a change in my thinking that has occurred during the project ~~to be~~ described.

From a simplistic and (many would argue), fairly typical liberal notion that more and better understanding of the culture and customs of members of minority ethnic groups would lead to better treatment of them within, for example, the health service, I have come to an awareness of the nature and pervasiveness of racism, such that the situation is a radically different one to that which I originally thought I understood. I find Bhikhu Parekh's analysis helpful:

Combating racism, then, involves not simply ending discrimination or eradicating prejudice but something totally different; it involves securing from the white community a full recognition of the humanity of the black man who, although deficient in this respect as all human beings, white and black, are, is still a human being with dignity and pride and entitled to proper respect and regard. Racism therefore cannot be combated in ways that social psychologists have proposed for eradicating prejudices ...

... the answer to it obviously does not lie in ... hoping to eradicate the white man's 'prejudices' by giving him more information on the black man's cultural and personal background, ... While all these and other methods may succeed in establishing better relations between isolated members of different races, the problem of racism is too profound to be

tackled by such simple-minded a-historical and a-political approaches.

(Parekh 1974: 239 & 241).

Neither the research project nor this thesis attempt primarily to combat racism. Racist features of the health service and of British society are discussed as they arise and the experiences and concepts of the women described have to be understood as influenced by the racist nature of their situation. As argued in Chapter One of the text, I would suggest that my approach and framework leave room for a political analysis, although I do not take inevitable conflict as a starting point. I accept (and have tried to indicate ways in which this is so) that my analysis is different to that which would be made by any other researcher, and that the factor of race is likely to be of particular importance in this respect. I have yet to be convinced however, that either sex or race are such fundamental variables that either overrides other more subtle affinities between people.

4. Depression: the Meaning of Mental Illness.

I came to this work with a view of Depression as a discernable syndrome with specific recognisable and universal symptoms. This was also a psychodynamic approach emphasising the possibility of healing through psychotherapy rather than the more physical treatments e.g. ECT or pharmaceuticals, which I viewed as giving merely symptomatic relief. However, my experience of working with Pathan patients in Pakistan reinforced both my view that depression exists in other cultures and places in more or less the same form and that it was/is susceptible to treatment by psychodynamic and group dynamic methods.

The present work has led me to question these starting

assumptions both in respect of the universality of some of the characteristics of depression and in respect of the advisability of using psychodynamic or group dynamic methods in situations where social relations are vital to individual well-being rather than vice versa (as in the West). The text illustrates both some of my initial assumptions (as embodied in Methodology) and my conclusions in respect of this central issue.

APPENDIX B

RESEARCH ASSISTANT:

JOB DESCRIPTION AND CRITERIA FOR SELECTION

RESEARCH ASSISTANT JOB DESCRIPTION"The Mental Health of Pathan Women in Bradford: a case study of migrant Asian Women"

This research project is funded by the DHSS to run for a period of 29 months from 1st June 1980. The project is under the direction of Margaret Stacey, Professor of Sociology at Warwick University and is being conducted (on a part-time basis) by Ms. Caroline Currer of the same department, with supervision, in the field, by Dr. John Bavington of Lynfield Mount Hospital, Bradford, in relation to psychiatric aspects of the work.

A Research Assistant will be required to start as soon as possible and to work, on a part-time basis for the duration of the project. The scale is that of Data Analyst (Clerical Grade 4, £4,200 p.a. pro rata i.e. £2,100 half time). This person must be a woman, a Pathan and fluent in both English and Pukhtu, with sufficient educational background to appreciate the aims of the study and the need for careful and accurate methodology. Ideally, she should have a first degree in a social science subject but it is difficult to say at this stage whether a person qualified in this sense will be available and others are encouraged to apply.

The research assistant's tasks will be to facilitate introduction into Pathan households, to act as a check in the research worker's understanding of language and concepts during interviews and later during transcribing and analysis of interviews, and to make practical arrangements that enable the research worker, who will only be in the locality on days when fieldwork is in progress, to use her time in the field to the maximum effect. Although employed for a total period of 22 months on a part-time basis, she will need to be flexible enough to alter her times to fit the progress of the work, possibly working more during the fieldwork period and then less during the period of analysis and writing up. She will also be expected to travel to Warwick University for discussions with the other personnel as needed during the course of the work. (not necessarily)

Further details of the role envisaged and discussion with the other personnel involved are expected to be necessary before an application is made by anyone interested. In the first instance Ms. Currer will be happy to meet anyone who considers herself able to undertake this work, to explore the possibility with her. In view of the tasks involved the relationship between these 2 workers will be crucial and is a factor to be considered in the appointment of research assistant. An ability on the part of the applicant to maintain an objective attitude in respect of members of her own community will also be necessary together with a sympathetic understanding of the difficulties of the immigrant situation.

N.B. Please read together with the further notes "Research Assistant: Criteria for selection".

October 1980

Research Assistant - Criteria for selection

Summary of notes made (August 1980) on the relative importance of the conflicting requirements.

Ref. Project Description (esp. paras iii.9.3 and iii.9.5)
Research Assistant Job Description

This appendix to the job description is necessitated because discussion and further thought have made it clear that the ideal expressed in the original description is unlikely to be obtainable and that my requirements are in contradiction with each other in several respects.

The Research Assistant must be a woman (preferably a mother) and of Pathan origin, able to speak fluent Pukhtu.

1. I see the role of the Research Assistant in:

- a) facilitating response
- b) being sensitive to the meaning of the communication at all levels (verbal and non verbal)
- c) being able to communicate this understanding to C.C. (at the time of interviewing and later during transcribing of interviews - this can be in a mixture of Pushto and English if necessary) - as of critical importance.

2. Also of critical importance is the issue of confidentiality. While this cannot be understood in the same way in an Asian context as a British one, the nature of the data to be collected is sensitive and considerations of "izzat" are bound to enter into the willingness of respondents to communicate at all and this will be influenced by the way in which respondents perceive their relationship with those receiving the information - particularly with the Research Assistant who as a Pathan will have a greater or lesser overlap of social network with their own.

I see these 2 considerations as in conflict - (1) points to a person similar in background and social status to that of the respondents; (2) to someone physically and/or socially removed.

3. Practical considerations cannot be ignored. For a Pathan woman to take a job at all is unusual in a traditional home, particularly one that involves contact with outside agencies and travel. There is a further conflict here. The Research Assistant will be able to make a greater practical contribution the more independent, mobile and fluent in English that she is. While I am prepared to accept a minimal contribution in these respects (despite the additional burden this puts on myself) in view of the importance of the role described above (1); the fact that even the taking of a job is itself unusual seems to suggest that anyone applying will be less traditional however little practical assistance I am willing to settle for.

cont'd...

Overall, a culturally 'marginal woman' seems the most likely to consider this job and would be best suited to it in respect of considerations (2) and (3) although perhaps less suited in respect of (1b) which is the most important.

I should probably be looking outside Bradford therefore, possibly for someone married to a non-Muslim or who has been educated in Britain and is fairly independent of the Pathan community. It may be that I have to consider an unmarried girl (although again an unusual degree of independence would be necessary for this to be permitted. I can, however, act as chaperone to some extent, including while at Warwick.)

CC/SCW
22/10/80

APPENDIX C

The Psychiatric Test Scales and Translations.

The General Health Questionnaire 30 item scale,
The Langner 22 item scale.

Fukhtu translations of both scales.

Literal English back-translations of the
Fukhtu, with comprehension notes in
respect of each item.

GENERAL HEALTH QUESTIONNAIRE

GHQ-30

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1	– been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2	– lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	– been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
4	– been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
5	– been getting out of the house as much as usual?	More so than usual	Same as usual	Less than usual	Much less than usual
6	– been managing as well as most people would in your shoes?	More so than usual	Same as usual	Rather less than usual	Much less than usual
7	– been feeling on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
8	– been satisfied with the way you've carried out your task?	Better than usual	About as usual	Less well than usual	Much less well
9	– been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
10	– been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
11	– spent much time chatting with people?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	– felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
13	– felt capable of making decisions about things?	More so than usual	Same as usual	Less useful than usual	Much less useful

PLEASE TURN OVER

HAVE YOU RECENTLY:

14	— felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
15	— felt that you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
16	— been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
17	— been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
18	— been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
19	— been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
20	— been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
21	— found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
22	— been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
23	— been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
24	— been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
25	— felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
26	— been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful
27	— been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
28	— been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
29	— felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
30	— found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual

LANGNER SCALE (from Amer.J.Psych.)

(As used by Cochrane Hashrri and Stopes Roe in "Measuring Psychological Disturbance in Asian Immigrants to Britain" Social Science & Medicine Vol.II)

1. I feel weak all over much of the time.
 - a. Yes
 - b. No
 - c. Don't know
 - d. No answer

2. I have had periods of days, weeks, or months when I couldn't take care of things because I couldn't "get going".
 - a. Yes
 - b. No
 - c. Don't know
 - d. No answer

3. In general, would you say that most of the time you are in high (very good) spirits, good spirits, low spirits, or very low spirits?
 - a. High
 - b. Good
 - c. Low*
 - d. Very low*
 - e. Don't know
 - f. No answer

4. Every so often I suddenly feel hot all over.
 - a. Yes*
 - b. No
 - c. Don't know
 - d. No answer

5. Have you ever been bothered by your heart beating hard? Would you say: often, sometimes, or never?
 - a. Often*
 - b. Sometimes
 - c. Never
 - d. Don't know
 - e. No answer

6. Would you say your appetite is poor, fair, good, or too good?
 - a. Poor*
 - b. Fair
 - c. Good
 - d. Too good
 - e. Don't know
 - f. No answer

7. I have periods of such great restlessness that I cannot sit long in a chair (cannot sit still very long).
 - a. Yes*
 - b. No
 - c. Don't know
 - d. No answer

8. Are you the worrying type (a worrier)?
- a. Yes* b. No c. Don't know d. No answer
9. Have you every been bothered by shortness of breath when you were not exercising or working hard? Would you say: often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
- e. No answer
10. Are you ever bothered by nervousness (irritable, fidgety, tense)?
Would you say: often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
- e. No answer
11. Have you ever had any fainting spells (lost consciousness)?
Would you say: never, a few times, or more than a few times?
- a. Never b. A few times c. More than a few times d. Don't know
- e. No answer
12. Do you ever have any trouble in getting to sleep or staying asleep?
Would you say: often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
- e. No answer
13. I am bothered by acid (sour) stomach several times a week.
- a. Yes* b. No c. Don't know d. No answer
14. My memory seems to be all right (good).
- a. Yes b. No* c. Don't know d. No answer
15. Have you ever been bothered by "cold sweats"? Would you say:
often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
- e. No answer

16. Do your hands ever tremble enough to bother you? Would you say:
often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
e. No answer
17. There seems to be a fullness (clogging) in my head or nose
much of the time.
- a. Yes* b. No c. Don't know d. No answer
18. I have personal worries that get me down physically (make me
physically ill).
- a. Yes* b. No c. Don't know d. No answer
19. Do you feel somewhat apart even among friends (apart, isolated, along)?
- a. Yes* b. No c. Don't know d. No answer
20. Nothing every turns out for me the way I want it to (turns out,
happens, comes about, i.e. my wishes aren't fulfilled).
- a. Yes* b. No c. Don't know d. No answer
21. Are you ever troubled with headaches or pains in the head? Would
you say often, sometimes, or never?
- a. Often* b. Sometimes c. Never d. Don't know
e. No answer
22. You sometimes can't help wondering if anything is worthwhile anymore.
- a. Yes* b. No c. Don't know d. No answer

* Response is pathognomonic

General Health Questionnaire (G.H.Q.) 30 Item Scale.

Fukhtu translation.

1 نه چھ کوم کار کوے نو په هغه کبش خیال
ساتلے نشے یا نور ته سوچونه کوے

عام طور نه ډیر کم	عام طور نه کم	عام طور په نشان	عام طور نه ښه
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2 کله ډیر فکر نه ستا خوب خراب شوه دے

عام طور نه ډیر زیات	عام طور نه زیات	عام طور په نشان	بالکل نه
------------------------	--------------------	--------------------	----------

3 ستا به خوب کبش آرام وي

عام طور نه ډیر کم	عام طور نه کم	عام طور په نشان	هو
----------------------	------------------	--------------------	----

4 داسے ته وخت وي چه ستا ډ پارا
ته کار نه وی یا بیگانه یے

عام طور ډیر زیات وخت	عام طور نه زیات وخت	عام طور په نشان	نه
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5 نه عام طور په شان کور نه بهارے

عام طور نه ډیر کم	عام طور نه کم	عام طور په نشان	عام طور نه زیات
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6 دا خیال ډوي چه کله نور فلق ستا
په کاهے وو نو هغوي به ستا به شان
هر ته کوي

ستتا نه زیات ښه	ستتا نه زیات ښه	ستتا به شنان	ستتا نه کم ښه
--------------------	--------------------	-----------------	------------------

7. دا خیال دوی چه عام طور زه مرنه
قافی بنه کوم

عام طور نه دیر کم	عام طور نه کم بنه کم	عام طور به اشان	عام طور نه زیات بنه
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8. تاته نه کار کول کبش تسلی وی

عام طور نه دیر کم	عام طور نه کم	عام طور به اشان	عام طور نه زیات
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9. ستا په زره کبش د خیلو د پارا مینه شته

عام طور کم نه دیر کم	عام طور نه کم	عام طور به اشان	عام طور نه زیات
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10. نورو خلقو سره گوزاره کول شتاد
پارا اسان دے

عام طور نه دیر کم	عام طور نه کم	عام طور به اشان	عام طور نه زیات
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11. نورو خلقو سره زیات وخت
مکب شب لکولے

عام طور نه دیر زیات	عام طور نه زیات بیر	عام طور به اشان	بالکل نه
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12. ستا په خیال کبش ستاسو خپل تبرداره
کبش ستاسو رخت یا خپل کله شته

عام طور نه دیر کم	عام طور نه کم	عام طور به اشان	عام طور نه زیات
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13 خیلے فیسلے کولے ننتے

عام طور نہ ادیر گم	عام طور نہ اگم	عام طور پہ اشنان	عام طور نہ زیات
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14 تا تہ داسے وی چه همیشه تا بانر بوج
وی

عام طور نہ دیر زیات	عام طور نہ ازیات	عام طور پہ اشنان	بالکل نہ
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15 تا تہ دا خیال وی چه تکلیفونہ ما بانر
دومرہ زیات دی چه هیچ نہ شم کولے

عام طور نہ ادیر زیات	عام طور نہ ازیات	عام طور پہ اشنان	بالکل نہ
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16 تا تہ ہر تہ گران وی یا تکلیفونہ
پہ کنس وی

عام طور نہ دیر زیات	عام طور نہ زیات	عام طور پہ اشنان	بالکل نہ
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17. ستا پہ روزانے کارونہ کنس خوشحالی
ننتے

عام طور نہ ادیر گم	عام طور نہ اگم	عام طور پہ اشنان	عام طور نہ ازیات
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۱۸ چه تا بانرِ تَه پُل وُشي يا تا ته شوک
 تَه مامولي خراب واپي نو تَه د
 هُفغ په تارک دیر خوچ کوے یا دیر
 هُفغان کوے

عام طور نه دیر زیات	عام طور نه ازیا ت	عام طور په نشان	بالکل نه
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۱۹ داسے کلہ نشوے دے چه بے وجه
 به یریر یا کبر او نشوے

عام طور نه دیر زیات	عام طور نه زیات	عام طور په نشان	بالکل نه
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۲۰ تکلیفونه تَه دے مَخ کوے نشوے

عام طور نه دیر کم	عام طور نه کم	عام طور په نشان	عام طور نه زیات بند
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۲۱ داسے کلہ وی چه ستا بانر به مگر
 تَه ستا په سر بانر بوج وی

عام طور نه دیر زیات	عام طور نه زیات	عام طور په نشان	بالکل نه
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۲۲ کلہ تا تَه داسے وی چه شو نشالی
 دے نه وی او هُفغان دے وی

عام طور نه دیر زیات	عام طور نه ازیا ت	عام طور په نشان	بالکل نه
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23 داسے تہہ وُفت راغلے یے چہ کوم
وُفت تہہ خیل ٹان بانرِ نشک وی
چہ تہہ کولے نہ شم

عام طور نہ دیر زیات	عام طور نہ ازیات	عام طور پہ اشان	بالکل نہ
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24 دا خیال دے کلہ وی پہ خیل ٹان
بانرِ بروسہ نہ وہ

عام طور نہ ادیر زیات	عام طور نہ ازیات	عام طور پہ اشان	بالکل نہ
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25 دا خیال دے کلہ وی پہ جونر کنیں
اُمیر نہ وی

عام طور نہ دیر زیات	عام طور نہ ازیات	عام طور پہ اشان	بالکل نہ
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26 ستا خیل اینرہ دُ پارا تہہ اُمیر شتہ

عام طور نہ ادیر کم	عام طور نہ اکم	عام طور پہ اشان	عام طور نہ ازیات
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27 عام طور تہہ کافی خوشحال یے

عام طور نہ ادیر کم	عام طور نہ کم	عام طور پہ اشان	عام طور نہ ازیات
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28 داسے دے چہ کلہ دیر تنگ نشے
یا غوسہ منترہ یے

عام طور نہ دیر زیات	عام طور نہ زیات	عام طور پہ اشان	بالکل نہ
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29 دا خیال دے کلہ وی پہ جونر اُسے
آباس دے

عام طور نہ دیر زیات	عام طور نہ زیات	عام طور پہ اشان	بالکل نہ
------------------------	--------------------	--------------------	----------

30. کلہ تہ وقت راغلے دے چہ مہینہ
نہ نشے کولے تگہ پہ بیمار پہ
نشانتے وے

عام طور نہ دیر زیات	عام طور نہ زیات	عام طور پہ اشان	بالکل نہ
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General Health Questionnaire Copyright Declaration

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جی سی ۱۹۸۱ نیر

1. ٺٺا ٺول بڙن ڊير وٺت ڪٽھورے
شانتے وي

هو	نه	پتھ نشتھ	جواب نشتھ
----	----	----------	-----------

2. زنه وٺت داسے دے ڇھ ورڻھو ڊ پارا
يا مياشتو ڊ پارا ڪار هم نه شتم ڪولے
ٺٺھ ڇھ ما ته شورو ڪول ڪران وٺ

هو	نه	پتھ نشتھ	جواب نشتھ
----	----	----------	-----------

3. عام طور ته به وائے ڇھ زيات وٺت
ته ڇھ ڊير بنه طبيت ڪنن يے بنه
طبيت خراب طبيت ڊير خراب طبيت

ڊير بنه	بنه	خراب	ڊير خراب
---------	-----	------	----------

4. ڪله نه ڪله ٺٺا ٺول بڙن ڪرم شئي

هو	نه	پتھ نشتھ	جواب نشتھ
----	----	----------	-----------

5. ڪله تاته داسے شتوے دے ڇھ سنا
زله تيخ ڊبيري

هميشه	ڪله ڪله	هيچرے هم نه	پتھ نشتھ
جواب نشتھ			

6. تہ بہ تہ واٹے چہ ز خراک دیارا
ستا زمرہ کیبری زیات کیبری نہ کیبری
بالکل نہ کیبری

بالکل نہ کیبری	نہ کیبری	کیبری	زیات کیبری
پتہ نشہ		جواب نشہ	

7. کلہ کلہ زہ رومرہ تنگ شم چہ
زہ گورسئی کبش زیات نہ شم کببناستے

ہو	نہ	پتہ نشہ	جواب نشہ
----	----	---------	----------

8. تہ ریات فکر ولہ یے

ہو	نہ	پتہ نشہ	جواب نشہ
----	----	---------	----------

9. چیرے تا تہ زاسے شوے دی چہ ستا
صا لائیرہ شی کلہ چہ کار نہ کوے یا
ایکسرایر نہ کوے

ہمیشہ	کلہ کلہ	ہیچرے ہم نہ
پتہ نشہ		جواب نشہ

No Translation .

10.

11. تا بانر کلہ داسے چکہ راغلے دے
چہ کوم سرہ تہ بیہوشہ سوے

ہیچرے ہم نہ	کلہ کلہ	دے نہ زیات
پتہ نشہ		جواب نشہ

12. تاتہ کلا مُسبِت وى اوردۂ کيرو کيش
يا اوردۂ کيرو وخت کيش

هميشه	کله	کله	هيچرے هم نه
پتہ نيشته	جواب نيشته		

13. هفتے کيش کله کله ستا کيرۂ کيش
کيس وي

هو	نه	پتہ نيشته	جواب نيشته
----	----	-----------	------------

14. کما ياراش تپک دے

هو	نه	پتہ نيشته	جواب نيشته
----	----	-----------	------------

15. تاتہ کله سارۂ خويله راعلے وے
تہ به وائے

هميشه	کله	کله	هيچرے هم نه
پتہ نيشته	جواب نيشته		

16. داسے کله نشوے دي په نشتا لاسونه
دير خوا سيري دومره په تاتہ
تکليف وي تہ به وائے

هميشه	کله	کله	هيچرے هم نه
پتہ نيشته	جواب نيشته		

17. داسے زيات وخت انگاري لگه په
کما صا يا پوزۂ بئر وي

هو	نه	پتہ نيشته	جواب نيشته
----	----	-----------	------------

18 ڄڻ ته خپل فڪرونه نشتنه ڪوم ڇه
ما بيمار وڃي

هو	نه	ڀتہ نِشتہ	جواب نِشتہ
----	----	-----------	------------

19 تاتہ دا خيال راڻي ڇه هم خپلو ڪين
يوائے يم

هو	نه	ڀتہ نِشتہ	جواب نِشتہ
----	----	-----------	------------

20 ڇه ڪله ره ڏٺا غوارم نو اسے ڪله
هم نه ڪيري - دا خيال راڻي

هو	نه	ڀتہ نِشتہ	جواب نِشتہ
----	----	-----------	------------

21 تاتہ ڪله داسے تڪليف ڏوي ڇه
سر ڏي ڇوڙ پيري

هميشه	ڪله ڪله	ڀتہ نِشتہ	جواب نِشتہ
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22 تاتہ ڪله دا خيال راڻي ڇه ڏٺا
ڪين هم متلب نِشتہ

هو	نه	ڀتہ نِشتہ	جواب نِشتہ
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Literal English Retranslation of the items of the Pukhtu version
of the General Health Questionnaire with comprehension notes for each item

1. When you work, can you keep your thoughts on your work or do you think of other things?

Well understood. It is a common idea that "thoughts" can destroy both concentration and health.

2. Has your sleep been destroyed (lit. made bad) from a lot of worry?

Well understood. Worries are seen to have the power to destroy sleep.

3. Are you rested in your sleep?

Well understood, although note the question had to be turned round. All had disturbed nights due to a young baby.

4. Is there ever a time when you do not have any work or you are idle?

Well understood but note that again the question had to be turned round and that the idea of "managing" to keep busy was not possible to translate.

Respondents laughed at this item - keeping busy is no problem with an average of four young children.

5. Do you go out of the house as much as usual?

Well understood, but "going out" has a different meaning.

6. Do you think that, if someone else were in your place, then they would do everything as you do?

Clumsy, hard to grasp. I was asked "how do we know how someone else would behave in our place?",

7. Do you think that, in general "I do everything well enough"?

Well understood, but lack of anyone specific to compare with - all have different circumstances.

8. Do you gain satisfaction from your work?

Well understood.

9. Is there love in your heart for your own (people)?

Well understood, but hard to admit to not feeling this.

10. Is it easy for you to pass the time with/get along with other people?

Well understood.

11. Do you spend a lot of time chatting with other people?

Well understood, though this was not always in her power to determine.

12. Do you think you have a place in your family, and their respect?

This paraphrase was well understood. Exact sense did not make sense in Pushto.

13. Can you make your own decisions?

Not well understood - women saw themselves as having no decisions to make.

14. Does it seem to you as if there is always a load on you?

Well understood, associated with unhappiness and loneliness.

15. Do you think that "the difficulties on me are so great that I cannot do anything"?

Well understood.

16. Is everything hard to you, or containing difficulties?

Well understood, some laughed at idea that they might have difficulties.

17. Is there happiness in your daily work?

Well understood, some laughed at idea that they might enjoy life.

18. If something minor happens to you, or someone says something that is mildly insulting (bad), then do you think a lot about that or get unhappy about it?

Very hard to translate - note the elaboration necessary. Even when put this way and understood, it was considered entirely natural that such incidents should be very upsetting indeed.

19. Have you ever become fearful or afraid for no reason?

Well understood.

20. Can you face your difficulties?

Well understood - even the idiom of turning the face towards problems translates directly giving the same sense.

21. Is it as if everything is a load on your head?

Well understood.

22. Is it the case that you have only sadness and no happiness?

Well understood.

23. Has there been a time when you doubt yourself feeling "I can do nothing"?

Well understood usually.

24. Have you ever thought that you had no value?

Sometimes queried - one specific term was unfamiliar.

25. Do you ever think that there is no hope in life?

Well understood, but religion precludes such feelings.

26. Is there hope for your own future?

Well understood, but in Islam there is always hope.

27. In general, are you happy enough?

Well understood.

28. Have you ever got very uptight or angry recently?

Well understood, women especially spoke of feeling angry with the children.

29. Do you ever think that life is just pointless?

Well understood.

30. Has there ever been a time when you could not do anything because you were sort of ill?

"Nerves" was untranslatable. "Sort of ill" was not comparable since by definition if you are ill you cannot work and if not you can.

Literal English retranslation of the items of the Pukhtu version
of the Langner 22 item scale with comprehension notes for each item

1. My whole body is sort of weak a lot of the time.
 Weakness is a sign of illhealth, also meaning thin. One linked it with having problems.
2. These days it is as if I cannot work for periods of days, weeks or months because it is difficult for me to start.
 Well understood, one linked it with illness.
3. Generally, would you say you are in very good health, good health, bad health or very bad health.
 Generally well understood - the word used for "spirits" is wider than the English, covering bodily as well as mental health.
4. From time to time my whole body becomes hot.
 Generally well understood, linked with work and pregnancy.
5. Has it every happened to you that your heart beats fast?
 Generally well understood, one linked this with fear.
6. What would you say - that you have a good appetite for food, no appetite or absolutely none?
 Generally well understood.
7. Sometimes I get so restless that I cannot sit in a chair for long.
 Generally well understood - the term for restlessness is commonly used for agitation of all sorts. Some associated it with pregnancy and physical restlessness.
8. Are you a great worrier?
 It was hard to convey an abstract tendency to worry even though the term used was well understood. There were many examples of concrete worries.
9. Has it ever happened to you that you have become short of breath at a time when you were not working or exercising?
 Generally well understood.
10. No translation possible.
11. Have you ever become dizzy to the extent of loosing consciousness?
 Well understood. Two linked this with unhappiness.

12. Do you have any difficulty in sleeping or at the time of going to sleep?

Well understood. The demands of children prevented sleep as did worries or "thoughts".

13. During the week, do you sometimes get gas/wind in your stomach?

Well understood but is a little different from a sour stomach as in original.

14. My memory is good.

One saw a bad memory as a consequence of worrying. Others saw had memory as an acceptable joke.

15. Have you ever had cold sweats?

Well understood.

16. Has it ever happened that your hands have trembled enough to trouble you.

Well understood.

17. It often seems as if my head or nose is blocked.

Well understood, but most linked this with having a cold.

18. I have my own worries which make me ill.

Some acceptance that worries can lead to illness, although most claimed to have no worries.

19. Have you ever had the thought that "even among my own people, I am alone".

Often taken to mean "single handed" - alone in a practical rather than psychological sense. Also often taken religiously - we are alone before God. Thus, well understood but differently from the way intended.

20. Whenever I want something, then it just doesn't happen - do you ever get this idea?

Understood, but very literally - some claimed that whatever they want, comes to be. Others that we have to accept that it will not. God is responsible.

21. Have you ever been troubled by headaches?

Well understood.

22. Have you ever had the thought that there is no point/meaning in anything?

Well understood, but the idea that life may not be worthwhile caused little anxiety. It is merely to be accepted as it comes.

APPENDIX D

REVISED
RESEARCH INSTRUMENTS
AND RECORDING SYSTEMS

Individual Interview Guidelines

Group Interview Guidelines

Individual Record Sheets

Group Record Sheets

List of Initial Contacts with notes

List of Group Contacts with notes

List of Respondents with notes

Individual Record Sheet

Respondent Number:

Name:

Husband's name:

Address:

Telephone No.

Children with ages

Single family or joint household:

Shared with:

Own village of origin:

Husband's village of origin:

Is husband a relative?

which?

Length of time in Britain - self
- husbandOther family in walking distance
in Bradford
in England

who?

who?

who?

Others from village in walking distance?
in Bradford?
in England?

Husband in work?

Sort of employment?

Languages spoken by woman?

by husband?

(tick main one used at home)

School:

Type of housing:

Clinic:

G.P.:

Health Visitor:

Individual Record Sheet (cont'd.)

Respondent number:

Points arising from interviews

Date

Points to follow up or of note

Checklist of topics to cover
with individual respondents

<u>Topics</u>	<u>Covered</u>	<u>Date</u>
Explanation - woman - husband		
<u>A. Childbirth in England</u>		
1. Last Birth experience		
2. Contraception and timing of family		
3. Discussion of pregnancy and confirmation		
4. Self care in pregnancy		
5. Hospital stay		
6. Social experience of birth and religious customs		
<u>B. Rearing Young Children in England</u>		
1. General - Being a Mother		
2. Concerns and concrete practices		
3. Reference groups and support systems		
4. Aspirations		
<u>C. Being a Pathan Woman in Bradford - stresses and supports</u>		
1. Purdah		
2. Family organisation		
i) present household		
Domestic division of labour		
a) in respect of children		
b) other domestic		
c) social		
ii) wider family		
3. Events and Festivals		
4. Religious observance		
5. Use of English		
6. Dress		
<u>D. Illness and Treatment</u>		
1. Use of alternative facilities in the area		
2. Use of NHS facilities		
3. Seeking treatment (specific)		
a) Own illness		
b) Child's illness		
c) Hospitalisation		
<u>E. Experience of stress</u>		
1. Present Psychological disturbance		
2. Own specific experience of disturbed or distressed mood		
3. Specific history of severe disturbance		
Termination		

Individual Interviews with Pathan Mothers 2A. Childbirth in England1. Last Birth experience

Encouragement to talk about most recent birth experience in specific terms, comparing with previous NWFP births or with imagined situation there if wanting to.

2. Contraception and timing of family

Depending which number in the family this most recent child is:

Do you feel you have enough children now?
Why/not? Are you trying to prevent another?
What are you using? What are your husband's ideas about this?

(If it has not emerged in group discussion) - what do you think about these things? What is best for the mother?
Who should decide what to do?

3. Discussion of pregnancy and confirmation

Who did you tell first when you thought you were pregnant?
When did you tell your relatives in Pakistan?
When did you go to the doctor?
Did you go or did someone go for you, or with you - who translated - was this awkward?

4. Self care in pregnancy

Who advised you about how to look after yourself the first time you were pregnant?
This time, did you go to antenatal classes?
How did you get there?
Who went with you? Who translated?
~~Were~~ the visits helpful?
What happened, did you understand why?
Did the advice make sense? How far did you follow it?
Who was the most helpful person for you?

5. Hospital stay

Can you tell me about the delivery -
was anyone with you?
did you have anaesthetic?
how long was labour? were there any problems?
did you know what was going on?

What about after the birth? Were you in a room with Pakistani women or English women?
Did anyone else speak Punjabi?
Was anything specially difficult or that you specially liked?
How did you feel about it all?

A. Childbirth in England cont'd.

6. Social experience of birth and religious customs

Did a lot of people come and see you - in hospital?
- at home?

Did you have extra help when you got home - who from?

Did you get very tired?

Did you have a party when his/her head was shaved, or
when he was circumcised?

Individual Interviews with Pathan Mothers 2.B. Rearing Young Children in England1. General - Being a Mother

Do you enjoy having young children?
 What are the best aspects of it, and the worst for you?
 What time do you go to bed?
 What time do you get up?
 How do you feel by the end of the day, most days?
 Do you have any/much time apart from the children?
 Would you want it?
 Who helps you with the children most?

2. Concerns and concrete practices

Do you have any special worries about any of the children at the moment?

In respect of the youngest child:

- Did/does he/she wear nappies?
 What age did he/she stop using them?
 What do your children like to play at/with?
 What time do they go to bed?
 Does he/she sleep alone or with you?
 Does your husband do much with them?
 What does he do?
 What did he do yesterday?
 Did you breastfeed your children?
 For how long or why not?
 Why did you stop?
 What solid foods did you start with?
 Do you notice a difference between the boys and the girls;
 do you treat them differently?

How do your children go to school - who with? (if applicable)

3. Reference groups and support systems

Whose advice do you ask if you are worried about the children?
 Do you miss your mother to ask about the children?
 Do you discuss problems concerning the children with your husband, or with other women - who?
 Have you ever been to the clinic to ask for advice?
 What was the problem?
 When did the health visitor come last?
 Does she seem at ease when she is here?
 What does she talk about?
 How do you understand her?

4. Aspirations

What do you hope for for your child(ren)?
 What aspects of the future worry you most?

Individual Interviews with Pathan Mothers 2.C. Being a Pathan Woman in Bradford - stresses and supports1. Purdah

Do you wear a burqa to go out?

a chaddar

a coat

Do you ever go out on foot or always in a car?

Do you feel strange on the street here in a burqa?

Do you ever feel lonely and isolated because you can't go out freely?

Last week - when did you go out?

- where to?

- what for?

- who with?

- how car/taxi, foot, bus?

Was this typical?

Would you prefer to get out more?

Why don't you - own feeling?

- pressure from husband?

- pressure from family?

- pressure from community?

Are the Pathans here generally fairly strict about these things do you find?

Do people come and see you?

Last week - when did you have a visit?

- who was it?

- from where?

- how long did they stay?

- what did they come for?

How would all this be different in _____ (name of village)?

2. Family organisationi) - present household

Background:

Tell me a bit about yourself?

Where do you come from?

How old are you, how many brothers and sisters have you, older or younger?

Where are they now?

Have you ever had a job?

Did you go to school in Pakistan?

When did you come here?

Did it take a long time to fix up?

Had you ever been here before?

What did you think about coming?

When did you get married?

Where?

Is your husband a relative?

Who arranged it all?

So you've been married _____ years now.

C. Being a Pathan woman in Bradford - stresses and supports cont'd.

2. Family organisation cont'd.

Domestic division of labour - a) in respect of children

Does your husband look after them while you're busy or out?
Does he feed them, change them, bath them?
What does he do with them?
Does anyone else regularly help with them?

- b) other domestic

Who does what - pays bills, gas, electric, phone, water?
- shopping - household, for own clothes?
- collects benefits?
- income tax returns?
- goes to doctor - for woman?
- for children?
- arranges transport?
- home maintenance, dripping tap, frozen pipes?
- car maintenance (if applicable)?
- housework?

- c) social

If someone is ill or has a death in the family, who goes?
What determines this?
Do you go out as a family at all?
How often?
Who goes?
Where to?
Do you visit out of Bradford together?
Why (not)?
Is transport a problem?

If husband is at home - what does he do all day?
Is your relationship here with him different to a husband wife
relationship in Pakistan?
In what ways?
Does this make life easier or harder for you?

ii) - wider family

Where do your parents live now?
Where do your husband's parents live now?
So you don't often see your mother (or so it is not hard
for you to see your mother)?
When did you last see your mother?
Would you like to see her more often?
Would she like to see you more often?
How does this change your relationship?
What would your mother do for you if she were nearer?
What would you do for her?

How often do you see your mother-in-law?
When did you last see her?
Would you like to see her more often?
Would she like to see you more often?
How does this change your relationship?
Are these changes good or bad, do you think?
Do they make life easier or harder for you?

C. Being a Pathan woman in Bradford - stresses and supports cont'd.

2. Family organisation cont'd.

ii) wider family cont'd.

Are there other members of your family you are very close to?

Who?

Where do they live?

When did you last see them?

What do you miss most about them?

Is there anyone here who does for and with you what they would if you were closer?

Who?

Do you feel lonely at all?

What other family members would you see a lot of?

Is it easier or harder to be far away?

In what ways?

Are there other family or village members you see more of because they are near?

Who?

Where do they live?

How often do you visit?

3. Events and Festivals

Tell me about the last time there was a wedding in your close family?

Who was it?

Where was it?

Could you attend?

What did you give?

Was this difficult?

Was this typical?

Have you attended a Pathan wedding here?

Whose?

What was it like?

What about Eid?

What did you do last Eid?

Who did you visit?

Who visited you?

Was it a happy time?

Were the children excited?

Did you feel very far from home?

Did you send cards and gifts - in England?

- in Pakistan?

How easy is it to keep fast in England?

How many days did you keep last year?

Did you have any left?

What happens at iffair time - is there much visiting?

Is it very different here to Pakistan?

Did you wish you were there?

When was the last time that a close member of your family died?

Who?

Where?

Could you go to give condolence?

What did you do instead? (If unable to go)

Did you feel very cut off? (if unable to go)

C. Being a Pathan woman in Bradford - stresses and supports cont'd.

4. Religious observance

Do you pray regularly?
Do you keep fast?

5. Use of English

When was the last time you needed to use English?
What was the occasion?
Would you like to learn it? Why especially?
Have you had a teacher or been to classes?
Why did you stop?

6. Dress

Who bought the cloth you're wearing?
Who made the suit?
Was this what usually happens?
Do you ever wear Western dress?
Why (not)?
Do you get any chance to wear your jewelry?

Individual Interviews with Pathan Mothers 2.D. Illness and Treatment1. Use of alternative facilities in the area

Have you ever been to a hagim in Bradford?
 When?
 What for?
 What happened?
 Have you consulted a malwi about sickness here?
 When?
 What for?
 What happened?

In the last month, have you been to either a hagim or malwi for advice?
 Has your husband been on your behalf?

2. Use of NHS facilities

In the last month, have you been to your G.P. or has your husband or someone else been?

- How often?
 What for?
 With what result?
 How did you get there?
 Who translated?

3. Seeking treatment (specific)

a) Own illness:

When was the last time you were ill yourself?
 Can you tell me about it?
 What was wrong?
 How did you feel?
 Could you carry on with your jobs?
 Who helped with the home (if not)?
 What did they do?
 What did you do - bed?
 - medication?
 What treatment did you try first?
 Whose idea was this?
 Did it help?
 What else did you do?
 Did you ask friends for advice, family?
 Is there anyone in your community with a lot of experience
 of illness - friend?
 - family?
 - 'expert'?

Who
 Did you go to them?
 What sort of help did they give?
 Did it help?
 Did you see your G.P. at all?
 Did he come or did you go there?
 How did you get there?
 Who went with you?

D. Illness and Treatment cont'd.

3. Seeking treatment (specific) cont'd.

Who did you see?
Did they understand Pukhtu?
Who translated for you?
Did you feel that the doctor/nurse, understood what was wrong?
Did they try?
Did you feel they wanted to help?
What did they do? - say?
Did you understand what was happening?
What advice did they give?
Did the treatment work?

Was it easy or hard for you?
In what ways?

Did you return?
Why (not)?
Did you try other remedies after?

It is not easy if a mother of small children is ill. Generally
do other women help out? Is it possible here?
What did your friends do for you last time?
Was this typical?
What did your husband do?

b) Child's illness:

When was the last time your child was ill?
Can you tell me about it?
What was wrong?
What did you think was wrong first?
What did you do?
Do you have a relative or friend who knows more about illness
etc. than you do?
Did you ask them?
Did you give any home treatments?
Who is there in your community who understands these things?
Did you ask their advice?
What did they advise you?
Did you call a doctor?
What made you do so? After how long was this?
Did he come to you or did you go to the clinic?

c) Hospitalisation:

Have any of the children in your family ever been in hospital here?
Who?
How old were they?
What was wrong?
When was it?
Can you tell me about it?
How long was it for?
Which hospital?
Was it possible for you to visit?
How long did you stay?
How did you feel about this?
Were they able to communicate with the staff?
Was it a frightening experience - for the child - for you?
What is your main memory of it now?
What is his/her main memory of it now? (Explore)

Individual Interviews with Pathan Mothers 2.E. Experience of stress1. Present Psychological disturbance

GHQ 30 item scale
Langner 22 item scale

2. Own specific experience of disturbed or distressed mood

Do you sometimes feel very low in spirits or restless or unsettled?

Tell me how it feels, in your own words?

(Suggestions, do not use - do you get aches and pains?
- feel tired or restless?
- cry a lot, feel things are unreal?
- want to be alone, cannot bear to be alone?)

What Pushto word do you use to describe feeling this way?

When was the last time you felt this way?

- Was there any reason you could see for it?

How long did it last?

What did you do about it?

Does telling someone how you feel help?

Does talking about your troubles help?

Who do you talk to when you are feeling like this?

3. Specific history of severe disturbance

Has it ever go so bad that you/someone you know well have had to

- go to bed, couldn't cope?

- seek outside help?

- take medicine?

(Self/other)

When was this?

Can you tell me about what happened?

Had anything happened in your/their life which had
disturbed you/them?

Why do you think you/they felt that way at that time?

What did you/they do about it?

What did your/their husband - say?
- do?

Did you ask advice?

From whom?

Why them?

Was this helpful?

Who is there in your own community who has special understanding
of these things?

Did you/they go to them?

Why (not)?

Did you/they go to the doctor?

Why (not)?

E. Experience of stress cont'd.

3. Specific history of severe disturbance cont'd.

What did he - say?

- do?

Were you/they able to explain what seemed to be wrong or
did someone speak for you/them?

Did you/they feel that the problem was understood?

What did your/their friends and family think of the situation?

Was there much loss of izzat in having to admit difficulties?

Did you/they receive treatment?

What sort - talking?

- medicalisation?

- hospitalisation - where?

Did you feel that this was the best thing to happen?

How long was it before you/they felt better?

What do you think was the most helpful part of what happened?

What was the worst part?

Group Record Sheet

Group Letter:

First Visit

Date:

Address:

Persons Present:

(underline houseowner
and/or key member)

Topics Covered:

Subsequent Visits

<u>Date</u>	<u>Location</u>	<u>Present</u>	<u>Topics covered</u>
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Group Record Sheet (cont'd.)

Group Letter:

Points arising from interviews

Date

Points to follow up or of note

Checklist of topics to cover
with groups

<u>Topics</u>	<u>Covered</u>	<u>Date</u>
<p>Explanation - women -> men</p> <p><u>A. Childbirth in England</u></p> <ol style="list-style-type: none"> 1. Birth experience here c/f in N.W.F.P. 2. Contraception and Timing of Family 3. Norms re. discussion of pregnancy 4. Self care in pregnancy 5. Hospital Stay 6. Social experience of birth and religious customs <p><u>B. Rearing Young Children in England</u></p> <ol style="list-style-type: none"> 1. General - Being a Mother 2. Child Rearing here c/f in Pakistan 3. Concerns and concrete practices 4. Reference Group and Support systems 5. Comparisons with British childrearing 6. Aspirations <p><u>C. Being a Pathan Woman in Bradford - stresses and supports</u></p> <ol style="list-style-type: none"> 1. Purdah 2. Family organisation 3. Events and Festivals 4. Religious observance 5. Use of English 6. Dress <p><u>D. Illness and Treatment</u></p> <ol style="list-style-type: none"> 1. General alternative facilities in the area 2. NHS facilities 3. Seeking treatment 4. Support in times of sickness <p><u>E. Experience of stress</u></p> <ol style="list-style-type: none"> 1. Recognition 2. Causation 3. Response 4. Acknowledged distress in other(s) and outcomes 5. Comparing stress situations <p>Termination</p>		

Group Discussion with Pathan Mothers 2.A. Childbirth in England

Many of you have had a baby born here and some of you have had children born in Pakistan too.

1. Birth experience here c/f in N.W.F.P.

If you were at home, where would you have a baby - at home or in hospital. What would happen and who would be there. What are the special customs connected with it?

Which way of doing things do you think is better? Why?

Some English women prefer to have babies at home and this is sometimes possible if the home is suitable and it is not the first baby.

Would you want to do this?

Why (not)?

What is different about how you live here compared with Pakistan that you prefer a hospital delivery here?

2. Contraception and Timing of family

I waited 5 years after I was married before I had a baby. You usually have a family soon. Why is that?

What about contraception (pāl) - which methods do you think are best? Why?

How do you find out about all these things and decide what is best? Are there religious guidelines? How do you know what they are?

What do you think is best for the mother - a lot of children or a few? Who should decide?

3. Norms re. discussion of pregnancy

When I am expecting a baby one of the first things I do is tell my parents and my parents-in-law. But you don't, do you?

Who can you talk to about it?

How do other people find out?

How has migration changed this?

4. Self care in pregnancy

Are there special customs associated with pregnancy? What about going out? Things to eat/not eat, do/not do? Hot and cold foods? Who advises about all this?

Do you go to the ante-natal classes arranged here?

Is it difficult to go? Does anyone there speak Pushto?

Do you understand the advice given - does it make sense to you? How far do you follow it?

Who do you think is the best person to advise someone having their first baby - relatives, friends, professionals?

A. Childbirth in England cont'd.

5. Hospital Stay

When I had a baby in Pakistan, the nurses laughed at me because I didn't understand them and my ways were different.

How is it for you here in hospital?

What happens at delivery time - is there anyone with you who knows English?

Do you understand what happens?

Is it all right to have anaesthetic - are you able to ask for it?

Many English women have their husbands with them. What do you think of this idea?

At home in the village your female relatives would be there - are they present at the birth? Does it feel strange here to be alone?

What about after the birth? Are you able to understand the hospital routine and get what you want? Are any of the hospital rules especially difficult for a Muslim woman? What about the ideas of not washing for 40 days - do women still keep to that?

- Do the hospital staff get cross with you when you can't understand - do people laugh?

6. Social experience of birth and religious customs

What happens when you take the baby home?

How much help do you get e.g. with the other children and housework?

At home you would get more, wouldn't you?

Do you get very tired?

Do people try to visit when you have a new baby - in hospital - at home? Is it important to do this?

Do they bring gifts?

What are the religious customs? Do they involve a party? ('azan, sūnat, head shaving)

Group Discussion with Pathan Mothers 2.B. Rearing Young Children in England1. General - Being a Mother

Is the time with young children a good time for a woman?
 What do you like about having young children?
 What do you not like about having young children?

2. Child Rearing here c/f in Pakistan

What are the main differences between bringing children up here and in Pakistan?
 What are these differences due to?
 How does this affect the mother? What things are easier for her here and what things are harder? Why?
 How much do mothers here help each other with their children?
 What prevents them doing more together?

3. Concerns and concrete practices

- What do you think are the most important things for young children?
 What things do you worry about most in respect of your children?

Many of the everyday things here are different to what you're used to in Pakistan e.g.

- a) Use of nappies - I couldn't buy them when I was in Peshawar - do mothers there potty train their children? Do you do it here?
- b) What games do the children play most? There seem to be more special toys here too - do your children have a lot more than you did as a child.
- c) I noticed that children in Pakistan don't have a set bedtime like ours do? Do yours here?
- d) How much do your husbands help here with the children?
 Is this more than it would be at home - do they ever change the nappies?
- e) What about feeding? Many Muslim women say it is the child's right (hug) to drink its mother's milk. Is this right?
 Is this in the Qu'ran shahi? But I've seen a lot of women here bottle feeding. Why is this?
 Is it true that you don't seem to have as much milk here?
 Why do you think this is?
 Someone said it might be because of "awaz" - hearing the voices of other women with new babies in hospital. Is this a common idea?
- f) What foods do you usually give next - are there some traditional Pakistani foods for young babies?
 How early do they like curry and strong foods?
- g) A lot of English women say that girls are more naughty than boys. What do you think? Why is this?
 Do you treat boys and girls differently?

B. Rearing Young Children in England cont'd.

4. Reference Group and Support systems

Who do you think is the best person to discuss your children with and to ask for advice if you are worried?

Would this be different if you were at home e.g. would you ask your own mother more? What do you do here?

Who helps you most with the children?

Do you go to the clinic for advice over problems of handling i.e. when the children are not ill but when you are not sure what to do?

Can you understand what the health visitor is saying when she visits you?

What do you think she comes for?

What does she do when she comes? Why?

Do you think she is a good person to advise you about your children? Why/not?

5. Comparisons with British childrearing

- When I was in Pakistan, I used to think that your children were all so well behaved.

Here some Pakistani woman said that English children were better behaved.

What do you think?

Are there any differences overall?

What do you think they are, and why?

6. Aspirations

When you think about the future for your children, what sorts of things do you hope for? What are you afraid of?

Do you think they will become more like English people?

Does this worry you? In what ways?

Group Discussion with Pathan Mothers 2.C. Being a Pathan Woman in Bradford - stresses and supports

We've talked a bit about the things involved in being a mother. But your life is not just concerned with your children. Today I'd like to think about some of the other things. Being a wife must be different here to in Pakistan. So must other occasions and duties as members of a family. Then there are a woman's own concerns.

1. Purdah

When English women see you, they can't understand how you can accept living in purdah, not going out without a veil. Can you tell me why its good and why you do it this way?

What does it involve?

How strictly is purdah observed here?

Is keeping purdah in England very different from keeping it in Pakistan? In what ways?

Do people laugh at you wearing a burqa?

2. Family organisation

You seem to have a fairly fixed idea of whose job it is to do what - husband does some things, wife another, one sister one thing, the other another. Is this true?

What sorts of things are a husband's job?

What sorts of things are a wife's job?

What about visiting other people for "afsos" or "khushhali" - are there rules about who should go?

Are all these patterns of things different here to in Pakistan? Why are they?

What responsibilities does a woman usually have to her parents and her husband's parents?

How are these changed by living in England?

Are these changes good or bad, do you think?

Do they make life easier or harder for you?

Do you think your husband's concerns and worries e.g. re unemployment, affect you more here than they would in Pakistan?

In what ways are the responsibilities of a wife different here to in Pakistan?

3. Events and Festivals

Weddings and funerals are big family occasions in Pakistan, aren't they? I suppose many of you have been unable to attend such events since being here.

How do you cope with these things - sending gifts - condolences - going back?

Do most people return home to be married? What about Pathan weddings in England? They must be very different occasions. In what ways?

And what happens when someone dies here?

Other festivals of course are more regular. How is Eid celebrated amongst Pathans in Britain? Does it feel very different? Can you buy the things you need? How easy or difficult is it to keep the fast - no sirens at itfari time!! and others are not celebrating at Eid?

Often it is at such times that people feel most cut off from their own homeland - is it this way for you?

C. Being a Pathan woman in Bradford - stresses and supports cont'd.

4. Religious observance

Where is the nearest mosque?

Is there a Pathan Malwi?

Do most people say their prayers regularly and keep fast?

Many women have said I should become a Muslim - what is special about it?

5. Use of English

Is it ever a problem that you can't speak English?

When?

What would be the best solution do you think - to employ interpreters, or for the workers to learn Pukhtu or for you to learn English?

Do you feel you would like to speak English?

Do your husbands want you to learn to speak English - why?

How often do you use English?

6. Dress

Who makes your suits?

- Is good cloth available? Are there any tailors?

- Are there many opportunities here to wear your jewelry?

- Do you copy Pakistani fashions or are there different ones here?

Group Discussion with Pathan Mothers 2.D. Illness and Treatment1. General alternative facilities in the area

Are there hagims working here as they do in Pakistan?
 Do people use them - what for especially?
 In Pakistan, a lot of people go to a malwi for help
 in time of sickness, do they do that here?
 I've heard that sometimes special healers come over from
 Pakistan, do women go to see them much?

2. NHS facilities

Who is your doctor?
 Where is his surgery?

3. Seeking treatment

If you or one of the children is ill what happens - who is consulted &
 - others in area? *first?*
 - alternative facilities?
 - NHS doctor etc.?

Who goes to the doctor - can you go yourselves, if not, is this
 - due to purdah?
 - because of lack of English?

Are the doctors treatments usually helpful?
 Why (not)?
 What are the main problems for you in getting what you want?
 What would improve things for you?

4. Support in times of sickness

When someone is ill or in hospital, especially a woman, it
 can make for difficulties at home.
 Do you help each other out?
 What do you do - look after children, go along, give advice,
 explain what to expect or discuss what happened?
 Is there anything you all find hard to understand in
 connection with the health service?
 If one of you has a headache or minor complaint, will the
 others come and do her work, if not, why not?
 Will husband do more?

.. Group Discussion with Pathan Mothers 2.

E. Experience of stress

1. Recognition

Most people have times when they feel very unhappy, that they cannot carry on.

This happens to you too, doesn't it?

Do you feel happy most of the time?

Why (not)?

Do you think that it is easy for Pathan women to feel happy here?

Do you think that unhappiness can make people ill?

Does this often happen?

Do you think that such illness is the concern of doctors or of someone else?

Who?

How do you know yourselves when you are upset?

How can you tell when your friends are?

- look different - in what ways?

- performance (or non -performance) of role - which bits go first?

- alteration of mood - vulnerability - distance?

What Pukhtu words do you use to talk about feeling like this?

2. Causation

What sort of things make your women most unhappy?

Is becoming ill from extreme unhappiness to do with outside circumstances or is it usually due to individual, personal factors, do you think?

3. Response

If one of you becomes very unhappy, what is the proper thing to do?

- talk to husband?

- talk to female family/friends?

- seek outside help - what sort, from whom?

- return home?

Is there a great loss of izzat if you admit to having difficulties or if you become unable to do your work?

How does this affect who you will talk to about it?

4. Acknowledged distress in other(s) and outcomes

Do you know anyone - (especially women) who has started to behave strangely, become unable to cope with life here?

What has happened?

What Pukhtu words do you use to talk about this sort of thing?

What sorts of help were offered by different sources?

Which sort of help is most effective and in what circumstances?

What are the disadvantages of National Health Service treatment?

The advantages?

Do you know of anyone who has been in a mental hospital here e.g. Lynfield Mount? What difficulties are there for a Pathan woman if she is in this situation?

E. Experience of stress cont'd.

5. Comparing stress situations

What is the most difficult time of life for a woman do you think?
Do you think it is harder for Pathan women to be happy here than
it is for other women?
Why (not)?

List of Initial Contacts

An initial contact is the person to whom I am introduced by an outsider. Some initial contacts are themselves respondents, some are not, but all of them introduce me to others known to them - usually groups of people amongst whom there will be one or two respondents.

An outsider is a professional who is in close contact with Pathan people and who I approach to ask for an introduction into the community.

Selection of outsiders is done by myself on a fairly arbitrary basis. They are people who seem interested in this research and its aims and who offer help. They also seem to have strong positive links with the Pathan people they know. Moreover, I want to be introduced to sections of the Pathan community in separate parts of the city to achieve some sort of spread of contact over the known areas of Pathan settlement, and have selected the outsiders accordingly.

Selection of initial contacts is done by the outsiders on the basis of how well they feel they know the initial contact and how sympathetic they anticipate their response to a request to participate is likely to be. I prefer to explain myself the aims of the work when I make the initial contact, but sometimes the outsider concerned prefers to do this before taking me to meet them.

Further introductions take place - either to the rest of a group of women of which the initial contact is a member, in which case little or no further selections are apparently involved; - or to women known to the initial contact but from whose group he is excluded. This has happened only where the initial contact was a man when I was actively taken to several groups of relatives and neighbours. In the case of a female initial contact further introductions are suggested during the course of discussion later and new introductions made without further recourse to an outsider and a new initial contact.

6th May, 1981.

List of Initial Contacts

<u>Name</u>	<u>Contact point/address</u>	<u>Name of outsider introduced by</u>	<u>Groups contacted</u>
1.			
2.			
3.			
4.			
5.			
6.			

List of Groups

These groups are the configurations of people into which I enter when I state an interest in meeting women with young children. They contain some women who do have young children (if they also speak Pukhtu I designate these respondents) and others who do not. Although I myself speak Pukhtu and expressly say that I want to meet Pathan women, these groups sometimes naturally include non Pukhtu speakers also.

The make up of the groups vary - sometimes they are sisters sharing a house, sometimes friends or relatives who regularly meet together in one house or another, sometimes they are less stable groupings of women who do not often visit but chance to be together. Certainly in the initial stages, the presence of other familiar people in the groups seems to serve as a defence against the threat of an outsider who in turn also offers amusement which other groups members may as well share, so a group may be called together even when the respondent chances to be found alone.

The social relations within the group and to outsiders become clearer with increasing length of contact with the group.

In some ways the groups seem to serve as the individual's protection and way of deciding whether or not to co-operate - this was more or less overt in one case. While we suggest that the husbands of respondents can and should be asked for permission for us to speak with their wives, the women's own co-operation is seemingly partly dependent on peer group reaction. This seems to be especially so where women do not wish to ask their husbands permission. It is not therefore possible, even were it desirable, to insist on seeing women alone and refuse to stay and make a relationship with the group. It has therefore seemed sensible, and most in accordance with the way the women naturally view their lives to conduct much of my interviewing in the group setting. Since much of my interest is in group norms of behaviour in times of illness, childbirth and in rearing young children, this is not inappropriate. Concepts of health and illness are likely to be shared and may in fact be more likely to emerge from group discussion.

Those parts of my questionnaire which relate to specific individual experience I have therefore separated off to be asked at a time when the respondent is alone (either by accident or design).

Some of these groups are more static in membership than others. For purposes of fieldwork, I designate a group as a new group when the majority of its membership is different.

I designate a group by its usual place of meeting and a letter. This letter represent the usual membership of that group - which is found detailed in the group record sheet, together with changes of membership.

As the groups are natural configurations, I cannot necessarily complete my schedule of questioning with them all and cover all topics with all groups.

List of Groups

<u>Group Letter</u>	<u>Usual location/ address</u>	<u>Name of house owner/ key member</u>	<u>Normal number of members</u>	<u>Complete</u>
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2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

List of respondents

A respondent is a Pukhtu speaking woman who has children under 5 years at the time of interview.

The purpose of this list is to identify and locate respondents for the purposes of fieldwork.

The "name" may therefore be any identification used by the woman. It is the response to "what can I call you?".

The "contact point" is not necessarily her address, though it may well be. It is the response to "how/where can I contact you?".

Contact will probably have been made in the presence of a group and much of the contact with the respondent will continue to occur in the group setting. However, individual discussion with each respondent will either occur naturally and/or be sought.

Thus, further details will be found on the relevant:

- a. individual record sheet
- b. group record sheet

providing that the details are such that have either come up in interviews or been necessary to ask specifically.

6th May, 1981.

List of respondents

<u>Name</u>	<u>Contact point/address</u>	<u>Group letter(s)</u>	<u>Completed</u>
1.			
2.			
3.			
4.			
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