CULTURAL VALUES, SOCIAL SUPPORT AND SELF-ESTEEM AS PREDICTORS OF DEPRESSION IN A LIBYAN CONTEXT

A thesis submitted for the degree of Doctor of Philosophy

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October 2013

Acknowledgment

I would like to express my deepest grateful and appreciation to all whom helped me complete these studies. I would like to express my sincere gratitude and special thanks to my supervisors: Prof. Michael Wright for commendable support, valuable guidance, advice, and encouragement, through my entire research journey; I am thankful to Dr. Stanley Gaines for guidance, and valuable feedback throughout the statistical analysis. I would like to thank Dr. Nusrat Husain and Dr. Andrew Parton for valuable feedback and corrections, my thanks go to Dr. Timothy Milewa for providing methodological guides in the qualitative study. I would like to express my deepest appreciation to Dr. Linda Williams for methodological guidance and for comments on study 2. Also, I would like to thank Dr. Cheeta and Dr. Bridget Dibb for their great support. I am very grateful to the all the study participants for sharing with me their valuable time and experiences, and the staff of Tripoli hospital. I would like to thank Libyan bureau for its funding, I am grateful to have love and support from my family and friends in the UK and Libya.

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Abstract

The typical clinical presentation of depression is defined primarily from a Western perspective and may have limited cross cultural applicability. Yet, these descriptions characterise practice and diagnosis in Libya. Therefore, a study was conducted to identify symptoms of depression and cultural factors in Libya. Following a pilot study with 83 British non-clinical participants, a study was carried out in Libya using standardised questionnaires, with depression (BDI-II) as the dependent variable, sex as fixed factor, and individualism (IND), collectivism (COL), familism (FAM), social support (MSPSS) and self-esteem (RSE) as covariates. The sample comprised 169 Libyan non-clinical participants all scales were back translated for Arabic versions, and sufficient reliability and validity conditions were achieved. ANCOVA showed a significant effect on depression of gender (females > males) after controlling for all covariates. Self-esteem was an independent negative predictor of depression. Secondly, a qualitative study was conducted to gain insights into the experience and perceptions of depression in a Libyan clinical sample. Fifteen female and seven male out-patients were interviewed and iterative thematic content analysis was used to identify key emphases on an inductive basis. Six super-ordinate themes encompassed: symptoms; recognition of depression; treatment choices; stigma; sources of support; and perceived causes of depression. Social withdrawal, feelings of guilt, loss of the "old" self, loss of weight, sleeping disturbance and somatic symptoms were the reported symptoms. Religion was cited the most effective coping strategy. Formal psychiatric interventions were accepted but taking antidepressants was not favored. Little distinction was made between serious mental illness and less serious conditions. Explanations for depression encompassed familial relationships, professional roles and other cultural factors. There were notable gender differences regarding social support, expected behaviour and the posited causes of depression, which reflect the differentiated male and female roles in Libyan society.

Chapter 1

General Background

Mental health is fundamentally important for people around the world, and according to the World Health Organisation's constitution (WHO, 1946) "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" so mental health does not indicate just the absence of mental illness. In other words, people can become unhealthy because of social problems, psychological factors, life events, or economic factors. Maintaining mental health is essential for an individual to be socially effective in different dimensions of life, thus mental illnesses significantly affect an individual's condition, and may include functional impairments; loss of ability to work or study; and breakdown of personal relationships.

Mood disorders can affect people's psychological health. Individuals with depressed mood tend to report sadness, loss of pleasure, loss of interest, loss of interest in sex, fatigue, worthlessness, indecisiveness, crying, self -dislike, pessimism, irritability, inability to sleep well, to eat, to concentrate, and feeling too exhausted to achieve anything. Individuals with depressive disorders show increased suicide ideas and a substantial risk of death if suicide is attempted (DSM-IV-TR, 2000). The major categories of mood disorder are; Major Depressive Disorders, Dysthymic Disorder, and Bipolar I Disorder (DSM-IV-TR, 2000).

Depression is described as "the common cold" of psychopathology because it is the most frequent mental health problem (Goodwin, 2008). Because depression can vary in severity, the measure of prevalence will depend on the diagnostic criterion adopted. According to DSM 1V:

"*Studies of Major Depression Disorder have reported a wide range of values for the proportion of the adult population with the disorder. The lifetime risk for Major Depression Disorder in community samples has varied from 10% to 25% for women and from 5% to 12% for men. The point prevalence of MDD in adults in community samples has varied from 5% to 9% for women and*

from 2% to 3% for men. The prevalence rates for MDD appear to be unrelated to ethnicity, education, income, or marital status" (DSM-IV-TR, 2000, P. 372).

Established literature has generally suggested that women have higher rates of lifetime depression than men (DSM.IV.TR, 2000; Weissman et al., 1996; Angst et al., 2002; Moskvina et al., 2008). A possible reason for this is that women are more likely than men to experience specific severe stressful life events such as sexual, physical, and psychological abuse (Nolen-Hoeksema, 2001).

In a study by Simon, Goldberg, Van Koff and Üstün, (2002), differences in national prevalence of depression were measured across 15 centres and 14 countries in primary care patients. Centres included: Ankara, Turkey; Athens, Greece; Bangalore, India; Berlin, Germany; Groningen, Netherlands; Ibadan, Nigeria; Mainz, Germany; Manchester, UK; Nagasaki, Japan; Paris, France; Rio de Janeiro, Brazil; Santiago, Chile; Seattle, USA; Shanghai, China; and Verona, Italy. Using the Composite International Diagnostic Interview (CIDI) to assess depression, three levels were identified, a low-prevalence group (Nagasaki, Shanghai), a medium-prevalence group (Ibadan, Verona, Berlin, Seattle, Athens, Bangalore, Mainz, Ankara, Paris, Groningen, Manchester), and a high-prevalence group (Rio de Janeiro, Santiago) (Simon et al., 2002). This confirmed earlier reports, such as Weissman et al.'s study (1996) that the prevalence of depression varies substantially across cultures.

Depression exists in many forms, and has been recognized for many centuries (Gilbert, 1992). The World Health Organization (2002) predicted that in the year 2020 depression will be, worldwide, the second most important cause of disability after ischaemic heart disease. According to the World Development Report 1993 (World Bank, 1993), mental health problems account for 8% of all lost years of quality life. For adults aged 15–44 years living in demographically developing economies, depression ranks fifth among women and seventh among men as a cause of morbidity (World Bank, 1993).

To compare rates of depression across different countries is not straightforward and requires an understanding of different cultures and the meanings and causes surrounding depression in those cultures. According to Schieffelin (1985) to understand the speech of any person, we should first know the language and the society he/she came from, and further to understand her/his feelings and why they feel in certain way, we must turn to the cultural system in where their feeling is situated. For instance, depression tends to be viewed as primarily a set of physical problems in some cultures because the psychological or psychiatric depression representations are socially illegitimate (Schieffelin, 1985). Good and Kleinman (1985) believe that cultural considerations should be taken into account in the psychiatric diagnostic process, and that the social response to depression may mediate cultural explanations and interpretations (Good & Kleinman, 1985).

Both cultural and genetic information, in interaction with each other influence the course of psychological development. Kleinman and Good (1985) believe that biological factors in depression cannot be ignored, but these authors also believe that biological studies separate from ethnographic research do not have much to add to our understanding of culture and mental health. The 1960s was perhaps the most dynamic period in the history of psychobiological research on depression, including the discovery of antidepressant medication. In order to undertake such research, investigators needed to compare individuals for whom a drug is effective with control groups who do not receive the medication. Discovering the effectiveness of drugs depends not only upon measuring physiological changes, but also on reliable diagnosis of depression and means of distinguishing depression from other mental disorders. It could be said that until the mid-1960 the diagnosis of mental illness was unreliable (Kleinman & Good, 1985) and that medical and psychological conceptions of depression began to crystallise in this period. What has emerged since is that for accurate diagnosis a psychiatrist, psychologist or counsellor needs to learn many factors about the patient's social and psychological development, and this requires an understanding of the patient's culture (Guindon & Sobhany, 2001). Studying depression in relation to a wide range of local contexts may advance our knowledge of the social contributions to the causes and treatment of depression (Good & Kleinman, 1985).

It is increasingly recognised also that the cultural context should be taken into account to better understand the symptoms of depression. Compared with DSM-III, DSM-IV highlighted the fact that people around the world might report different symptoms of depression (DSM-IV, 1994). The more recent studies of mental disorders are concerned with linking them to the sociocultural environment. Cultural differences affect what are identified as significant symptoms of distress; different societies have their own unique ways of expressing emotional distress, and human brain plasticity allows for these various expressions (Castillo, 1997). Stressful life events give rise to distress, which is an emotional and psychosomatic response to stressful stimuli, and that depression is an adaptive reaction to intense or prolonged distress

The progression observable in successive editions of The *Diagnostic and Statistical Manual of Mental Disorders*, by American Psychiatric Association (DSM-IV, 1994) represents a growing attention to ethnic and cultural considerations for various diagnostic categories. DSM-IV recognises that this classification will be used in internationally diverse populations, and attempts to describe mental disorders, as individuals throughout the world experience them. In addition, DSM-IV highlights the idea that the symptoms and course of disorders are influenced by cultural and ethnic factors. DSM-IV proposes that clinicians, who are unfamiliar with the individual's cultural environment, may misdiagnose normal behaviour as abnormal. The diagnosis can be changed; if clinicians take into account the context, and wide cultural variation that can occur, to evaluate individuals. Specifically, major depressive episodes present in some cultures in terms of somatic complaints, rather than psychological complaints (DSM-IV, 1994, p. 324).

In terms of symptoms of depression, different societies express themselves in different ways. Firstly, evidence provided by anthropological studies, indicates that different cultures differ widely in the extent to which they employ psychological concepts and explanations. For example, Kleinman (1985) suggests that Chinese tend to present somatic complaints such as complain of their hearts being squeezed and weighed down; whereas in a few societies depression is associated with guilt. For Native

Americans, hearing a dead relative's voices is considered regular and normal, for another culture that may be a sign of someone from spirit world who tries to find a victim and thus a cause of fear (Kleinman, 1985). Certainly, one of the most commonly observed significant findings regarding culture and depression is the difference between psychological and somatic symptoms of depression, (Thakker, Ward, & Strongman, 1999). Very few researchers however use multiple assessment modalities despite their potential influence on the presentation of depression. Nevertheless, some core features such as loss of interest in pleasure have been identified as universal features of depression (Thakker et al., 1999; Ulusahin, Basoglu, & Paykel, 1994).

Thakker and Ward (1998) have pointed out that, although the DSM-IV gave consideration to cultural diversity, and is the most appropriate system for categorizing mental disorders yet, it has limited cross cultural applicability. The criteria for major depression especially, have emerged as biased towards Western presentations of depression. Although high rates of somatization have been reported in non-Western countries (Ulusahin et al., 1994) the criteria of DSM-IV did not reflect these findings, and gave more weight to psychological symptoms. Thakker et al. (1999) argue that even though DSM-IV acknowledges the influence of culture in its definition of mental disorder, the definition of mental disorders as provided by DSM-IV is that it is caused by mental dysfunction, which means a particular disease model. From a strictly biomedical view, it should be the case that mental disorders present in the same way in diverse cultures. However this view cannot explain the findings of cross cultural research and the evidence of cross cultural variation. Fabrega (1996) argues that Western European systems of psychiatric knowledge to date including (DSM-IV) have only reflected Western culture.

As Littelwood (1992) mentioned, concern has been expressed about the continued use of the DSM-IV especially when diagnosis would be made for a person from a different culture from the clinician's own. Littlewood pointed out that the old idea of culture-bound syndromes, which included somatic symptoms connected with depression in some cultural groups, may be problematic for the use

of classification. Where a form of psychopathology is seen as unique to a particular culture, this conclusion may be premature because of the lack of research into the way in which psychopathology in general manifests with non-Western populations. This might also compromise the validity of the categories in DSM-IV and its revised edition DSM-IV-T-R as they were not based on extensive research (Littelwood, 1992). Diagnosing a major depressive episode in non-Western cultures can be very problematic (Castillo, 1997). For example, a study of the Bedouin-Arabs of the Negev (Al-Krenawi, 1999) identified cases of miscommunication and inappropriate treatment because of culture and language differences between patients and psychiatrists.

The above argument raises important questions about the practical value of the classification of DSM-IV and DSM-IV-TR for non-Western cultural groups. In addition, it indicates that the criterion for a major depressive episode, including the DSM-IV, which is available in Arabic language and widely adopted in Arabic institutions, is derived from Western medicine. As argued above, each culture has its unique modulation of depression, and the concept, symptoms, causes, cure, and treatment, and this might be different for Western and non-Western groups. Misdiagnosed and inappropriate treatment can only be avoided if the diversity of cultures is taken into account. This has important implications for major surveys that should equally represent research from non-Western cultures. In addition, a greater use of qualitative studies across cultures might be applicable for understanding other different features of depression. The current study will contribute to this aim by examining depression: its level, causes, and symptoms, in non-clinical and clinical samples from a non-Western (Libya) cultural group.

Psychiatric illnesses are defined by behavioural symptoms, but these symptoms could vary in the way they are expressed in different cultures, because each society differs in terms of behavioural norms. Societies shape varieties of standards of normality; each society establishes its own distinctive forms of normality with regard to its values, and its own distinctive explanations of abnormality such as mental illness (Faberge, 1996). Culture provides categories for emotional experiences, sources and

symptoms, and influences how people deal with distress, help seeking, and the social response to depression (Kirmayer, 2001). Draguns (1995) moreover maintains that depression is more subject to cultural influences than schizophrenic disorders, but that they are both characterised by a few culturally immutable symptoms. Culture is fundamental to psychology because in different societies, people are likely to go through different experiences and interpret those experiences in relation to different systems of values, so that different cultural perspectives provide new approaches to understanding psychological development (Oyserman & Lee, 2008). Consequently, in order to interpret the way culture works to shape psychological phenomena, we must begin by determining and measuring the main dimensions of cultural values (Triandis, 2004).

Since Hofstede's (1980) book *Culture's Consequence,* an increasing number of studies have been addressed to societies thought to differ in individualism and collectivism as a fundamental dimension of cultural values (Oyserman, Coon, & Kemmelmeier, 2002) and most cultural research has been focused on cultural values. Taras, Steel, and Kirkman (2012) argue that Hofstede's scores no longer represent world culture and raise concerns about 40 years old data (Hofstede's data 1967-1973) and even question whether data from the 1990s are still relevant as cultures may have been changing within recent decades. It may no longer be the case, for example, that the U.S is the most individualistic culture. The findings from Taras et al, (2012) indicated that cultures have changed during recent decades, and countries that were high in individualism now may score lower relative to earlier decades. In the Arabic countries the scores of individualism were gradually decreased, during the 1980s, 1990s, and 2000s; the scores respectively were -0.38, -0.76, and -.94. Over the same period, in the UK, the scores of individualism were gradually decreased, which mean both countries becoming more collectivism (1.00, 0.82, and 0.33) (Taras, et al., 2012).

Researchers have also indicated some of the limitations of individualism / collectivism and developed a critique and alternative measurements; thus Gaines et al. (1997) suggested familism as a distinct cultural value. Moreover, Oyserman et al. (2002) have stated that not all societies were equally represented in the evidence for cross-national differences in terms of individualism and collectivism

(see also Taras et al., 2012). Dell and Diefenbach (2008) argue that current research in health psychology needs to be more engaged with cultural variables than it is currently done. Also as the work of Taras, et al. (2012) shows, cultural values can change over quite short timescales.

According to previous studies, cultural background can influence the level, concepts and symptoms of depression. For instance, Lavender, Khondoker and Jones (2006) conducted an interview study of depression in Yoruba, Bangladeshi and White British people, to increase understanding of diversities and similarities, and concluded that cultural concepts causes and treatments vary between ethnic groups. Abu-Kaf and Priel (2008) demonstrated the moderating roles of culture in depression. Bedouin students were higher in the level of depression than Jewish students. Alansari (2005) stated that there is a need to undertake more studies of the BDI-II with normal populations in Arabic countries. Thus, Non-Western studies may provide better understanding of the phenomena we study, as different nations may be exposed to the great differences in terms of the political, social, and economic context.

Many published studies have supported the conclusion that cultural values, social support, and self-esteem may contribute to the vulnerability to depression. George, Blazer, Hughes, and Fowler (1989) found that the size of social network and subjective social support were significant predictors of depression. Low social support is strongly related to the symptoms of depression (Moore, 1987). Keitner and Miller (1990) found that family relationships play significant roles in the development of major depression. Nasser and Overholser (2005) also carried out a study to identify factors associated with recovery from depression, specifically, support from family, friends, and spiritual beliefs. Nasser and Overholser (2005) found that support was significantly predictors of depression. According to Clark, Beck, and Alford (1999) self-esteem is one such factor that is likely to contribute to the depression. Abe (2004) found that self-esteem was the strongest predictor of emotional distress (depression and anxiety) in Japanese and American students.

The present study examines differences in depression into gender groups, and cultural values, social support, and self-esteem have been considered as independent variables that may have an influence in predicting depression. This study thus seeks quantitative evidence on whether individual measures of collectivism, individualism, familism, social support, and self-esteem are predictors of depression, and also sets out to identify differences between female and male samples in a non-Western country (Libya) in cultural values, social support, and self-esteem. Moreover, the study sets out to identify any gender differences in overall depression scores and symptoms of depression, in a Libyan sample.

Most of the literature of psychology is shaped by Western culture, particularly by Europe and North America (Triandis, 2004) and studies in different nations may shine a spotlight on how psychological phenomena work in non-Western cultures. For example, findings of non-Western studies may be able to demonstrate differences in depression in different cultural groups, in which case it becomes important to know what the cultural values of these groups are, and whether differences between the groups in depression are related to cultural values, and how depression varies with effects of other independent variables. The choice of using Libya may contribute to the field of cultural research in depression, as to date little research on depression has been carried out in Libya. Moreover, to our knowledge no study to date has used a Libyan sample in terms of the specific variables reviewed above. It is important to understand the contributions of culture in depression within different contexts.

I have divided this thesis into six chapters; the first chapter presents the general background. Chapter 2 will deal with depression. Chapter 3 will deal with depression in relation to cultural values, social support and self-esteem. The fourth chapter describes hypotheses, methods, results, and discussion of study 1. The fifth chapter presents study 2. And finally, chapter six will include the overall discussion and conclusions.

Chapter 2

Depression

At the beginning of this chapter I present a definition of depression. Then, I briefly introduce the symptoms of depression and Beck's cognitive theory of depression (Beck, & Alford, 2009), the Beck depression inventory, the prevalence of depression in the U.K, the validation of the Beck inventory in Arabic countries, depression in the context of Arabic and Libyan countries, and depression and its relationship with culture, self-esteem, and social support.

Definition of Depression

Beck and Alford (2009) define depression in terms of the following features:

(1) A specific alteration in mood: sadness, loneliness, apathy. (2) A negative self-concept associated with self-reproaches and self-blame. (3) Regressive and self-punitive wishes: desires to escape, hide, or die. (4) Vegetative changes: anorexia, insomnia, loss of libido. (5) Change in activity level: retardation or agitation. (Beck, & Alford, 2009, p. 8).

The Symptoms of Depression

The syndrome of a major depressive episode as listed in (DSM-IV, 1994, p. 320) contains the following symptoms:

(a) Sadness, or feeling discouraged: some individuals report somatic complaints rather than psychological feelings. (b) Loss of interest or loss of pleasure: some individuals may report a significant decrease from past levels of interest in sex. (c) Change in Appetite, in either direction, eating significantly more or less than usual, and as a result they might present loss or increase of weight. (d) Sleep Disturbance: insomnia is the most common reported symptom from individuals; this might include (middle insomnia; terminal insomnia or initial insomnia). (e) Psychomotor changes: many individuals report agitation, or retardation. Decreased energy is commonly associated with a Major Depressive Episode. Feeling of tiredness or fatigue, without physical cause might have been

reported. (f) Worthlessness or sense of guilt and a negative perception of one's worth, related to slight previous failings at least to some degree, and might be indicator of depression. (g) Reduction of the ability to think, concentrate, or make decisions, is associated with a Major Depressive Episode. (h) Thoughts of death, suicidal ideation, or suicidal attempts. Individuals might think that others will feel relief if they were dead, or at some point, the person might make plans of committing suicide. (DSM-IV, 1994).

According to Beck and Alford (2009) there is substantial agreement in the literature on what are the core symptoms of depression. On the other hand, there has been lack of agreement on many other symptoms. It is generally accepted that the core symptoms of depression include; low mood, pessimism, self-criticism, and retardation. Other symptoms that have been considered as fundamental to the depressive mood include autonomic symptoms, such as constipation, concentration difficulty, slow thinking, and anxiety.

In this study, the symptoms of depression are determined by the Beck depression inventory (BDI-II, 1996) which is the most widely accepted psychometric instrument for measuring depression, and which reflects the diagnostic criteria for major depressive illness outlined in DSM-IV (1994).

Cognitive Theory of Depression (Beck)

Beck and Alford (2009) stated that three psychological processes play a significant role in the pathogenesis of depression. First, a necessary precondition for depression is *the formation of permanent concepts.* People represent their concepts from their experiences early in life, and among these concepts, people's attitudes toward self, environment and future, can be considered in some cases as central in the pathogenesis of depression. People's self-concept is a gathering of attitudes about him/herself, and these attitudes include generalizations they have made on the interactions with the environment. People develop their self-concepts and personalise their understanding of the environment, of others' judgments and of significant others. In environments where a child is treated as inferior, this might consolidate a negative self-concept, and such attitudes can influence subsequent

judgments, and subsequent experiences might be in turn be interpreted according to negative perceptions of the social environment or national environment. This structured concept of self is a cognitive structure. The direction of an individual's self-esteem is determined by attitudes towards self-concept, and negative self-esteem appears with enormous force in depression. The second psychological process that can contribute to the pathogenesis of depression is that of *value judgments and affect.* People make generalizations about themselves; if these generalizations are negative they might extend dislike of a specific trait to rejection of themselves. People's judgments about themselves can become linked to pleasant or unpleasant affect and this depends on the person's concepts. Each time a person makes such negative judgments such as "*I am unworthy*" he / she experiences unpleasant affect such as sadness. Cognitive learning takes place when the relation between a particular concept and the associated affect is established. The third factor in the predisposition to depression is *specific vulnerability* (Beck & Alford, 2009).

The cognitive theory of depression focuses on the *cognitive triad*, which consists of three main cognitive patterns that convince the individual to adopt negative attitudes, about the world, the self, and the future. A depressed person tends to interpret his experiences in the world in a negative way, and misunderstand the interaction with the surrounding environment as one of deprivation. In his/her view, the world is making it difficult for him or her, to reach life's targets. The second component of the cognitive triad is a negative view of self, as unworthy, inadequate, inferior, and deficient. Depressed persons consistently reject themselves, because they view themselves as undesirable. The third component is a negative view of future: the depressed person expects to fail in accomplishing any project in the future, and will continue indefinitely suffering frustration and deprivation (Beck, Rush, Shaw, & Emery, 1987; Clark, Beck, Alford, 1999; Beck & Alford, 2009).

The term *schema* is used for the depressed person's habitual patterns of thought, and this is interpreted as the reason behind maintaining his pain, even though there is objective evidence of positive factors in his life (Beck et al., 1987). Beck and Alford defined schema as follows:

"A schema is a structure for screening, coding, and evaluating the stimuli that impinge on the organism. It is the mode by which the environment is broken down and organized into its many psychologically relevant facets." (Beck, & Alford, 2009, p. 255).

In depression, a complex schema tends to play a very important role, involving a huge number of interrelated ideas, which have a great influence in the way the individual's entire information processing system works (Clark et al., 1999). Individuals selectively concentrate on stimuli that provide content in any situation, and combine these stimuli in a pattern, and an individual tends to respond consistently to similar kind of events. Schema designates a stable cognitive model form, which is the basis for the regularity of understanding of a specific set of conditions. The type of schema used determines how the person structures different experiences. In a specific circumstance, a schema related to this circumstance will activate. Schema is fundamental for representation within cognitions. Individuals categorize their experiences through schemas (Beck et al., 1979). In depression, conceptualisations of particular events are deformed to fit the dysfunctional schemas. The idiosyncratic schemas, which are overly active, disturb the formation of an appropriate schema for a specific stimulus. These idiosyncratic schemas become evoked by less and less logically related and more diverse stimuli. The patient becomes unable to invoke appropriate schemas, and loses the voluntary control over his or her thinking procedure (Beck et al., 1987).

Beck Depression Inventory – Applicability to Sub-clinical Depression

In the current study, depression is defined operationally by the overall score in Beck Depression Inventory (BDI-II, 1996). BDI is the best known, most frequently cited, and most widely accepted instrument for the assessment of depressive symptoms in both clinical, and research settings (Beck et al., 1979; Quilty, Zhang, & Bagby, 2010). It is also useful for detecting and measuring subclinical levels of depression in non-clinical populations (Steer, Beck, & Garrison, 1985; Beck, & Steer, 1993). The BDI has excellent construct validity, and has become the paradigm of other scales for several reasons: the inventor of the scale has made significant contributions to the theory of

depression; this inventory is easy to administer, brief, and broadly accessible in different forms for diverse populations. In the original study, scores of 0-9 are considered as "Minimal"; scores of 10-16 are described as mild depression; scores of 17-29 refer to the moderate range, and scores of 30-63 are considered severe depression (Beck & Steer, 1993). An interview by a clinician is critical for a diagnosis of depression; but BDI total scores greater than 15 in a normal sample may indicate possible clinical depression (Oliver & Simmons, 1984).

Validation of the Beck Inventory in Different Countries and the UK

Many studies across cultures have been undertaken to evaluate the validity of the (BDI) in diagnosis of major depressive disorder and these have generally supported the reliability and validity of the BDI. BDI has been translated into many different language versions (e.g. Jo, Park, Jo, Ryu, & Han, 2007; Arnarson, Lason, Smari and Sigurdsson, 2008; Ghassemzadeh, Mojtabai, Karamghadiri, and Ebrahimkhani, 2005; Sanz, Garcia-Vera, Espinsa, Fortun, and Vazquez, 2005). Relevant studies will now be briefly reviewed in order to establish the reliability and validity of BDI across different languages and populations.

Jo et al. (2007) reviewed the usefulness of the Beck Depression Inventory (BDI) in the Korean elderly population and proposed a cut-off score in order to screen major depressive disorder. This study used the BDI; Mini-International Neuropsychiatric Interview (MINI); geriatric depression scales (GDS) and The Centre for Epidemiologic Studies Depression Scale (CES-D). These tests were administered to a sample of 2729 participants over the age of 60 selected randomly from Ansan City, South Korea, over about 2 years. The study was carried out in two stages, first the survey was carried out over about one year. Second, with the same subjects, the survey was repeated about one year later, by team including clinical psychologists and interviewers. Cronbach's-alpha coefficients and correlations were computed on the first and second BDI scores to assess the internal consistency and reliability. To confirm convergent and construct validity, correlations of the BDI with the GDS and CES-D scores were assessed, also a principal component analysis was carried out on the BDI results.

As a result, the Korean version of the BDI was confirmed as appropriate for screening for depression in elderly Koreans, and established a cut-off score of 16 points. The BDI results showed high internal consistency (0.88), test–retest reliability (0.60, $p<0.001$) and convergent validity (0.59, $p<0.01$) (Jo et al., 2007).

The aim of a study by Arnarson et al. (2008) was to assess an Icelandic version of the BDI-II. The total number of subjects was 1454, of whom 1206 were students (72% female) and 248 were outpatient-clinic patients (82%). The study used BDI-II; The Beck Anxiety Inventory (BAI); the Centre for Epidemiological Studies Depression Scale (CES-D), the Penn State Worry Questionnaire (PSWQ); the Hospital Anxiety and Depression Scale (HADS); and the Mini-International Psychiatric Interview (MINI). Accordingly, the psychometric properties of the Icelandic version of the BDI-II were shown to be very satisfactory, as the internal consistency of the BDI-II for the student sample was 0.91, and for patients was 0.93, and the test retest reliability of the scale for 1-2 weeks was acceptable (0.89). Convergent and divergent validity was supported by strong correlations of the BDI-II with other relevant measures. According to the MINI signal detection analysis; the BDI-II discriminated satisfactorily between patients and non-patients (Arnarson et al., 2008).

Ghassemzadeh et al. (2005) carried out a study to provide a translated version of the BDI-II for use in clinical and general-population in Iran. Ghassemzadeh et al. examined the psychometric properties of the test in 125 Iranian students of whom 50.4% were female. They used the BDI-II-Persian version and a Persian version of the 30-item Automatic Thoughts Questionnaire (ATQ) which measures negative automatic self-statements common in depression. Their study suggested high internal consistency (0.87) and acceptable test-retest reliability for two assessment points 1 to 2 Weeks apart ($r=0.74$). BDI-II correlated strongly with the ATQ. The factor structure of BDI-II-Persian was assessed by comparing the fit of various proposed models for the English version of the test to the BDI-II-Persian data, using the confirmatory factor analysis method. The reliability and validity of the BDI-II- Persian was supported in a nonclinical sample, and they concluded that this instrument can be a used for comparative transcultural studies (Ghassemzadeh et al., 2005).

Sanz et al. (2005) developed a Spanish version of the BDI-II, and tested it on a sample of 305 (74.8% women) aged between 18 and 68 years. They used the BDI-II; Checklist for Depressive Episode (LED); Clinical Multiracial Inventory Millon-II (MCMI-II); and the State-Anxiety Questionnaire Trait (STAI). The internal consistency (alpha) was high (0.89), and the correlations between item scores and the total score of the BDI-II were all statistically significant, and ranged from 0.33 to 0.67. The average inter-item correlation was 0.30 (SD = 0.09), with a minimum of 0.06 and maximum of 0.68. Patients who were diagnosed with major depression scored higher on the BDI-II than the rest of participants, only excepting patients with personality disorder. This study concludes that the Spanish adaptation of the BDI-II is a valid and reliable instrument for measuring depression in psychiatric patients (Sanz et al., 2005).

Many studies have been undertaken to evaluate the validity of the (BDI) in diagnosing major depressive disorders using UK samples (e.g. Hill, Kemp-Wheeler, and Jones, 1986; Veerman, Dowrick, Ayuso-Mateos, Dunn, and Barendregt, 2009; Nuevo et al., 2009). Hill et al. (1986) carried out a study in the U.K. to investigate whether BDI-II is suitable for psychiatrically normal students. The sample consisted of 160 students (86 women, 74 men) aged between 18 and 23, while the sample of patients consisted of 44 women and 21 men. This study used the BDI-II, the Life Events Questionnaire (LEQ), and the Life Experiences Survey (LES). The mean BDI score for students was 6.81 (SD = 5.52) and that for patients was 21.57 (SD = 8.39). Varimax rotated factor analysis of the items of the BDI yielded seven factors for the students' sample, and six factors for psychiatric patients. In both samples a factor clearly emerged that was identified as 'somatic disturbance'. Furthermore, it was suggested that two factors that were interpreted as 'feelings of hopelessness' and 'feelings of unworthiness' in the student sample appeared as 'depressed mood' and 'depressive self-blame' in the patient sample. Four factors correlated significantly with the number of recent negative life events. Thus, this study presented some support for a consistent factor structure, but the authors thought that BDI-II should be used with caution with non-clinical samples (Hill et al., 1986).

Veerman et al. (2009) carried out a study using data from the European Outcome in Depression International Network (ODIN). This multinational study established the relationship between mean BDI scores in the general population and prevalence of clinical depression in populations from Finland, Ireland, Norway, Spain and the UK, both in urban centres (Turku, Dublin, Oslo, Santander and Liverpool) and rural areas (in Finland, Ireland, Norway and Wales) with varied sample size between 200 and 450 per centre. First, the ODIN identified the potential cases of depression in the populations studied by the (BDI-II). Second, people who scored above 12 on the BDI-II and 5% randomly collected from responders were offered to go through a second phase of procedure, applying the Schedule for Clinical Assessment in Neuropsychiatry (SCAN). The mean BDI scores in the index populations ranged between 4.2 in Norway and 10.7 in the UK, while the prevalence of depression ranged between 1.7% in rural Finnish males aged 18–40 and 20.0% among Liverpool females aged 41–65. In the UK the mean BDI scores ranged from 6.0 (Rural males, aged 18–40) to 10.7 (Urban females, aged 41–65). For the rest of the categories the BDI scores were, in decreasing order, Urban males, aged 41–65 (9.7); Urban females, aged 18–40 (9.7); Urban males, aged 18–40 (7.9); Rural females, aged 18–40 (7.2); Rural females, aged 41–65 (7.0), and Rural males, aged 41–65 (6.6). It is noticeable also that both the mean scores and prevalence of depression in the Spanish sample were considerably lower than the other populations. Even after exclusion from the sample of participants with diagnosed depression, the BDI remained positively correlated with the prevalence of depression. This study provides evidence that the number of clinical cases can be predicted by the population distributions of mood.

Using ODIN data, Nuevo et al (2009) investigated the equivalent structure of the BDI and its suitability for valid interpretable comparisons among different cultural groups across five countries (UK, Ireland, Spain, Norway, and Finland) and in urban centers and rural areas of each country. In the first stage, 7934 participants completed the BDI; Item Response Theory (IRT); and Multiple Indicators Multiple Causes (MIMIC). As a result, the mean level of depression was found to be the lowest in Spain 3.1(*SD*= 4.84) and the highest in Ireland 8.51 (*SD*= 9.16), and the UK 8.30. (*SD*= 8.30). For Norway and Finland the means of BDI scores were respectively 5.62, 6.10 (*SD*=6.9; 6.82). Overall

results support the factorial validity of the BDI, with a uni-dimensional structure. Item 19 (weight loss) presented a very small loading on the main factor within the five countries, and it had been suggested that this item might not be related to depression. IRT models, as well as MIMIC models, suggest that complete measurement invariance cannot be assumed across the five countries. The majority of the differences on the different items were obtained from the Spanish sample, thus the BDI might be used with particular caution with Spanish samples.

It will be noted from these studies that factor analysis does not always reveal the same factor structure for the BDI-II. The structures that are most consistently supported by confirmatory factor analysis indicate that there is a general factor representing severity of depression, and two group factors representing cognitive and somatic symptoms (Ward, 2006; Quilty, Bagby and Zhang, 2010).

Validation of the Beck Inventory in Arabic countries

Studies provide strong support for the BDI-II as a reliable and valid measure of depression for Arabic population context, for instance. West (1985) examined the reliability and validation of BDI in a sample of 53 Saudi Arabian psychiatric outpatients, male and female, aged between 15 and 58. The mean score of BDI-II was 25.245 (SD=14.163) Statistical analyses of the internal consistency and stability indicated a high reliability (0.77). This study indicated that the primary symptom of depression, as reported by clinicians was Indecisiveness, with Sadness, and dissatisfaction reported equally as second. This Saudi Arabian version is not necessarily suitable for the other Arabic countries.

Abdel-Kalek (1998) developed an Arabic version consisting of 21 items of BDI and tested it with participant samples in four Arab countries (Egypt, Saudi Arabia, Kuwait, and Lebanon): participant

numbers were 100, 80, 100, and 100 respectively. The use of simple modern standard Arabic was necessary to facilitate understanding for subjects in any given Arab country. Translation and back translation was carried out. The correlation of BDI scores between the Arabic and English forms among bilinguals was .96, which indicated high cross-language equivalence of the two forms of BDI.

Al-Musawi (2001) conducted a cross-cultural study of the BDI–II in Bahrain, and aimed to provide evidence concerning the factor structure validity and reliability of the current scale. With a sample of 200 Bahraini undergraduate students from the University of Bahrain, validity was established using exploratory and confirmatory factor analytic techniques. The alpha reliability of the BDI–II was high (.84), and the self-report measure demonstrated moderate stability over 2-week-long period (r = .75). The overall mean score of the BDI-II was 13.44 (SD= 6.74). The total score on the BDI–II correlated strongly with the overall score on the state-Trait Anxiety Inventory. The item measuring loss of interest in sex did not have strong loadings on any of the extracted factors. The author suggests that Bahraini students are not tending to reveal such sensitive issues as sex, so this finding is matching with the traditions of Arabic culture. Overall, these findings point to the value of BDI–II as a valid measure of depression in normal populations (Al-Musawi, 2001).

Alansari (2005) tested the content validity and internal consistency of an Arabic version of BDI-II items in the context of eighteen Arabic countries, plus an Islamic Pakistan group. A sample of male and female undergraduate students (9,700) from the following 19 Islamic countries was employed (N in brackets): Palestine (600); Lebanon (270); Syria (479); Iraq (841); Jordan (943); Saudi Arabia (780); Kuwait (781); Qatar (356); Bahrain (230); United Arab Emirates (360); Oman (333); Yemen (590); Egypt (735); Sudan (275); Tunisia (291); Libya (298); Algeria (300); Morocco (706); and Pakistan (532). High concurrent validity for the Arabic version of BDI-II used by Alansari (2005) had already been established on an Egyptian sample (463) by Ghareeb (2000) who showed that this version successfully differentiates between normal and abnormal groups, Alpha reliability was 0.83 and t-test-re-test reliability was 0.74. This Arabic version of the BDI-II was administered to the 18 Islamic groups and the English version of the BDI-II (Beck, Steer, & Brown, 1996) was administered to an

additional Pakistani group by Alansari (2005). All the corrected item-total scale correlations were significant beyond the .05 level, using a one-tailed test and the highest item-total scale correlation was .89 (Pessimism). The lowest item-total scale correlation (.21) was for item 16 (Changes in sleeping pattern) and the next lowest was (.27) for item 18 (Changes in appetite), thus, item 16 was found to be relatively unrelated to the symptom cluster of depression, and somewhat less useful in diagnostic specificity. The highest percentages were for the following items: Guilty feelings; Self-criticism; Loss of pleasure; Concentration difficulty; Tiredness; and Sadness, respectively. However, the lowest percentages for the BDI-II items were for Suicidal thoughts; Self-dislike; Worthlessness; Past failure; Loss of interest in sex; and Agitation respectively. This study found that, item 21 Loss of interest in sex had an exceptionally low rate for the normal sample. For the Libyan sample, the overall mean of the BDI-II was 22.72. The highest item means were Self-criticism M= 1.62 (SD= 1.17), crying 1.60 (SD=1.17), tired or fatigue 1.43 (SD=1.14), loss of pleasure 1.36 (SD= 1.07), Agitation 1.21 (SD= 1.16) and concentration difficulty 1.21 (SD= 1.04). The lowest mean items were changes in appetite .84 (SD= 1.04 Suicidal thoughts .70 (SD = 1.04) Self-dislike .70 (SD= .97) Worthlessness .59 (SD= .92). while the rest of mean items ranged from 1.15 to .93 which include Indecisiveness 1.15 (SD= 1.14) General loss of interest 1.10 (SD= 1.12) Sadness 1.10 (SD = .85) Guilty feeling 1.09 (SD= .79) Irritability 1.07 (SD= 1.09) Feeling of being punished 1.05 (SD= .78) pessimism 1.02 (SD= .99) loss of energy 1.00 (SD= 98) loss of interest in sex 1.00 (SD = 1.15) Changes in sleeping pattern .95 (SD= 1.18) Past failure .93 (SD= .97). Based on the normal samples, 17 out of the 21 items reached an item-total scale correlation coefficient above .40, while only two items, as stated above, showed an item-total scale coefficient below .30 (Alansari, 2005).

These studies provide evidence to support the content validity and reliability of the BDI-II as a measure of depression in adults in the Arabic culture. They suggested that the BDI-II seems to be viable in the Arabic context, and its use in cross-cultural studies would be suitable (West, 1985; Abdel-Kalek, 1998; Al-Musawi, 2001; Alansari, 2005). Specifically, the Arabic version of BDI which was developed by Ghareeb (2000) is the most widely studied in Arabic context. Therefore, this is the version that will be used in the present study to measure depression for the Libyan sample.

Depression in the Context of Arabic and Libyan Countries

Few studies are available about depression in Libyan context. Apart from Avasthi, Khan and Elroey's (1991) study, epidemiological data on mental health are not available in Libya (WHO, 2005), and there are no case registers in operation (Avasthi et al., 1991). However, Libya is one of the Arabic countries, and all of the Arabic countries officially speak the same language, are based on Islamic religion, and share the same geographic region, (Collins, 2009). Also, all Arabic countries formed a centralized political entity through long periods of their history; namely the Ommayid and Abbassid Caliphates, and the Ottoman Empire. More recently, they have all been oppressed by the same European imperialism; moreover, "*A hundred million people speak the same language, listen to the same radio programmes, read the same books and see the same films."* (Amin, 1987, p. 10). Also, politically, the United Nations treats these countries as one region. To a considerable extent, this means that Arabic countries are homogeneous entities influenced by Arab-Muslim culture, and I consider Libya to be a good and typical representative of the Arabic countries.

Although Arabic countries are thus described as a homogenous region, mental health related issues show some variations both in services provided and problems encountered, and generally, the quality of the service is not matched to the level of income per capita (Okasha, 2003; Al-Krenawi, 2005). Reviewing reports and observations on the mental health services in Arabic and Libyan context, they reflect a need for qualifications and appropriate training and require some consideration about which facilities are most needed by the patients (Okasha, 2003). Overall, there is a lack of provision regarding mental health services and professionals, legislation and policy, professional training, and the ratio of psychiatric beds to the total population (Al-Krenawi, 2005; Okasha, Karam, and Okasha, 2012).

Hostels, rehabilitation services, and health visitors are only available in big cities. In Jordan psychiatric beds are available only in general hospitals and military hospitals, in Palestine the rate is

0.04 beds per 1000 population (Okasha, 2003). In Libya there are only two hospitals serving the entire country (Avasthi, Khan & Elroey, 1991). According to El-Badri (1995) the first hospital for mental disorders in eastern Libya was established in 1950 at Al-Marj Al Kadim. In 1963 this town was destroyed by earthquake, and the patients were transferred to Tripoli Psychiatric Hospital and the Central Hospital in Benghazi which ran with limited facilities over 11 years. In 1974, the first psychiatric hospital was built in Gwarsha village with 200 beds, and named 'Dar Al-Shafa'. In 1982 modern facilities were provided for mentally ill patients with an additional 200 beds in Hawari, nearby other hospitals. This hospital includes departments of Clinical Psychology, Neurophysiology, Psychiatric Social Services, X-ray, ECG and basic laboratory facilities. The hospital provides services for the whole of eastern Libya, and treatment includes various neuroleptics, anti-depressants and electroconvulsive therapy (ECT) (El-Badri, 1995; Avasthi, Khan& Elroey, 1991). In provision of psychotherapy, behavioural therapy is very under-used due to a shortage of specialized staff (El-Badri, 1995). The Benghazi Psychiatric Hospital is associated to Al-Arab Medical University. In Tripoli, the Gergarish Mental Hospital is a hospital with a capacity of 1200 beds. It accepts patients from all over the country (WHO, 2001). No details about non-government organizations and mental health reporting systems are available (WHO, 2001).

The number of professionals working in mental health services in Arabic countries is far below the demand and most social workers have only minimal training (Al-Krenawi, 2005; Okasha et al., 2012). In Libya, the number of psychiatric beds in mental hospitals per 10,000 populations is 1. The number of social workers per 10,000 populations is 1.5 (WHO, 2005). Libya has less than 0.5 psychiatrists for 100,000 populations, and this number has decreased with respect to the 1998 survey in Libya (Okasha et al., 2012). According to Al-Issa (1990) the first manual for North African Practitioners was established in 1986, by three Arabic psychiatrists from Algeria, Morocco and Tunisia, and this manual replicated the French psychiatric diagnostic system. In Libya, there are as yet no manuals for doctors or social workers (WHO, 2005).

In Libya, the national committee raises awareness of the need for mental health legislation, but the latest one was endorsed in 1975. And regarding policy in the practice of the mental health professions, there is still no regulation, and mental health policy is a part of general health policy, (Okasha, 2003; Al-Krenawi, 2005; WHO, 2005). There is no substance abuse policy in Libya (WHO, 2005).

Follow-up care services in Egypt are still limited because of poor knowledge that most patients need a follow-up after initial improvement (Okasha, 2003). El-Islam (2008) mentioned that family members act as social workers, helping patients to pay the expenses of clinic, to recover physically and mentally, and to cope socially after the incidence. In mental health diagnoses, information from a first-degree patient's relative is an essential assessment for the therapist to make before consultation, with sensitive consideration for the patient's rights of confidentiality. Also, this cooperation with the relative may secure subsequent care and rehabilitation for the patient's recovery (El-Islam, 2008). In Libya, patients are usually discharged to his/her next of kin, and if his/her family refused to accept the patient after several requests, the patient may be taken to a residential hospital. Usually acute wards were locked in the hospital (El-Badri, 1995).

In the Arabic context, cultural beliefs in the impact of sorcery or the evil eye and other superstitions are still powerful cognitive constructions that can affect the presentation of mental symptoms. Traditional healers are the first source of help for the family of mental patients, as those people, from patients' perspective, are properly equipped to deal with superstitious issues (Okasha, 2003; Okasha et al., 2012). El-Badri (1995) mentioned that traditional healers perhaps still play an important role in the treatment of mentally ill people in Libya (El-Badri, 1995)

Belief systems in the Arabic culture are adopted from Islamic and pre-Islamic roots (Okasha, 2003). According to Al-Issa (1990), illustrating the perspective of Algerians towards mental illnesses, they describe such mental disorder as the person being affected and dominated by an external mystical force described in Arabic as *Jinn*, and that is why mental illness has been referred to in their terms as

Jinoon that is, relating to that magical external power possessing the patient's thinking and desires. Thus, often people in such environment refer to a sorceress as the major cause of these unusual states of illness. By which case they mean that they would be paid by a woman to get a husband or by a mother to get her son back at the expense of being separated from his wife (Al-Issa, 1990). In fact this is not the case only in Algeria or only in the Arab countries, but it is rather the case in most Muslim countries.

Again, some mental disorders might be considered to be instigated by the concept of evil eye, which is usually a consequence of envy and or jealous feelings projected towards an individual who is seen as superior to others in society in some way. Some people believe that the symptoms of depression are caused by the evil eye. According to Sayed (2003), *El-Sheikh* or the healer who is supposed to drive the evil eye away, is a religious man who wears special clothes, and repeatedly says specific words, based on Islamic religion. Traditionally *El-Sheikh* plays an important role as someone who can help depressed people, so the patient can get relief from the symptoms of depression (Okasha et al., 2012).

Thus, to deal with such matters, people tend to seek help through religious practice by *El-Sheikh* who may recite some phrases from the Koran or make a charm for the patient to carry, or write some religious words so that the patient can put it in water and drink it (Al-Issa, 1990). Or sometimes even, patients end up being beaten with a stick by their traditional therapists in order to get devil spirits out of them (Al-Issa, 1990; El-Islam, 2008).

Very often this scenario is the case in most Arab countries including Libya, when it comes to dealing with mental illnesses, and especially in the rural areas, where people are distanced from seeking professional assistance, and more connected to their traditional principles and beliefs. However Al-Issa (1990) mentioned that the practice of traditional therapy is illegal in many Arab countries such as Iraq, Kuwait and Tunisia; Al-Issa also suggested that the use of traditional therapy in Algeria may be due to the lack of availability of psychiatric services (Al-Issa, 1990).

Traditional healers are an unofficial component of the health care provision, and present a specific kind of intervention to manage the case of the patient and their families. In most Arabic countries there is no interaction between traditional healers and professions and where it does happen, it remains unofficial and unorganized (Okasha, 2003). El-Islam (2008) mentioned that the relationship between professionals and healers varies within different countries, from no legitimate work for traditional healers, to a mediating role for traditional healers (El-Islam, 2008).

Patients in the Arabic countries tend to express their depressed symptoms in somatised way (Okasha, 2003; Al-Krenawi, 2005). This may protect them from stigma and allow them to seek help from a traditional healer (Okasha, 2003; Al-Krenawi, 2005). In Arabic culture, women in particular characterise depressive symptoms in terms of physical symptoms, especially those women who are in an inferior position (Douki, Ben Zineb, Nacef, & Halbreich**,** 2007). Physical symptoms are more socially acceptable than emotional symptoms, because somatic symptoms are commonly considered as serious and requiring a physicians' aid, while emotional ones are considered as indicative of weakness and low faith, and require religious help (El-Islam, 2008). Stigma makes patients and families less likely to release various facts of family and patients life to the therapist, particularly information about abuse, sexual activities, mental disability, and family income (El-Islam, 2008). Thus people may hide these kinds of mental trial as much as they can, behind somatic illness. Some people travel to get treatment for mental illness from outside of Libya, most likely from Egypt or Tunisia, as people consider that it is shameful for the patient and his family to be mentally ill. And getting treatment from the psychiatric hospital considered a social disgrace (El-Badri, 1995). For women, having depression may reduce the likelihood of getting married for women and getting divorced for married women (WHO, 2000; Al-Krenawi, 2000). Libyan culture tends to have negative attitudes toward formal psychological services, also, and there is a widespread lack of knowledge about the mental health services which are provided from within the country (Al-Krenawi, 2005).

The recent war in Libya has put additional strains on mental health services. According to a report from the International Medical Corps (2011), as many as 20% of people in conflict zones may be suffering from post-traumatic stress disorder (PTSD). Tripoli psychiatric hospital is the only one in the west of the country serving about four million people, with very limited staff, space, and supplies (International Medical Corps, 2011).

Somatic and Psychological Symptoms in Relation to Depression

Authors with the etic view consider that depression is a universal phenomenon while those with the emic view consider that depression may be universal but there is cultural variability in individuals' expression, also that cultural roles may determine what is normal, that some symptoms may vary with culture, and that there are cultural variations in treatment (Kalibatseva, & Leong (2011). According to Kleinman & Good (1985) and Jadhav (1996) it can be assumed that diagnosis of depression is culturally valid for Western countries in which it is a disease defined in terms of subjective states, but the debate is whether it is represented the same way in non-Western countries. Jadhav (1996) argued that terms such as guilt, fatigue, and depression have a unique meaning within White British and other Western European cultures. On the other hand, Marsella (1980) argues that if depression, as defined in Western countries is not well represented in non-Western countries, that does not mean it is absent in non-Western cultures, rather it is conceptualized and experienced differently. Authors have also mentioned that the separation between the mind and the body is implicit in Western psychiatric classificatory systems, but is not culturally universal (Jadhav, 1996). In Arabic culture, however, this distinction also exists because emotional complaints are regarded as shameful whereas physical difficulties are not (Okasha, 2003; Al-Krenawi, 2005).

Lu, Bond, Friedman, and Chan (2010) argued that individuals experience depressive moods arise not just as a result of biological factors, but also because cultural factors can contribute, in that depression may reflect the difficulty of interrelations and interactions in the social context (Lu et al.,

2010). Kalibatseva and Leong (2011) studied the manifestations of depression among Asian Americans in order to improve the mental health services for this population. The authors argued that Asian Americans receive a limited service and poor quality treatment because the heterogeneity of ethnic Asian American groups presents a challenge for the researchers to find representative samples. This methodological problem limits the generality of the studies' findings, and as a result, clinicians tend to fall back on inherent cultural biases when diagnosing depression, particularly when diagnosing depression is based on the DSM-IV. According to Kalibatseva and Leong (2011) some of the symptoms of depression in DSM-IV are related to the Christian religion and may be not apply to the Asian culture.

There is thus growing evidence supporting the position that culture has an influence on how individuals express depressive feelings (Kleinman, & Good, 1985; Jadhav, 1996; Kalibatseva, & Leong, 2011). The expectation that Non-Western people present depression somatically is also a central theme of national studies (Kleinman, 1977). For example, Leff (1973) conducted a study in regard to the difference in somatic and psychological complaints in England and Africa. Leff suggested that developed countries show a greater differentiation between bodily and psychological experiences than developing countries, and that Chinese and African languages have not developed distinctions between bodily and psychological experiences. He supported these findings using data from the international pilot study of schizophrenia from five developed and four developing countries, respectively; Denmark, England, Moscow, Prague, Washington, India, Colombia, Nigeria, and China. It is commonly held that some cultures express depression somatically which can lead to misdiagnosis as Western studies focus more on cognitive aspects (Parker, Cheah & Roy, 2001). Parker et al., found that Malaysian Chinese were more likely to complain of somatic symptoms (60%) on self-report than Euro-Australian sample (13%) when engaging the health care services (Parker et al., 2001).

Although several early studies reported the tendency to somatization in specific non-western cultures, a comprehensive study by Simon, Vonkorff, Piccinelli, Fullerton, and Ormel (1999) reported that somatization in depression was a universal feature. These authors also argued that somatic

symptoms of depression may reflect the characteristics of health care systems as well, that is, that there are variations in the kinds of symptom reports that gain access to medical services; also that the variations of presenting somatic symptoms may depend on how somatization is defined.

Simon et al. (1999) identified three different kinds of depressed patients with somatic symptoms, first, patients who present somatic symptoms and have psychiatric disorders; second, patients who present unexplained somatic symptoms and have psychological disorders and third, patients who deny psychological distress and use the substitute of somatic symptoms (Simon et al., 1999). Simon et al., investigated the common psychological disorders among patients visiting primary care clinics (1991, 1992) using data from WHO in 14 countries: Turkey; Greece; India; Germany; the Netherlands; Nigeria; Germany; United Kingdom; Japan; France; Brazil; Chile; China; and Italy. The centres were grouped into two categories: type A which were characterized by patients-physician relationships, scheduling of appointments, recoded medical state, and attention to privacy. Type B were characterised according to patients-physician relationships, but unscheduled appointments. Also, the centres were grouped according to geographic region (Western Europe and North America vs. Africa, Asia, and South America. The first stage of the study included 25,916 patients who were seeking help from primary care centre facilities, aged between 18 and 64 years. These participants completed the 12-item General Health Questionnaire, and a self-report measure of general psychological distress, before visiting the physician. Based on the score thresholds, 5447 patients were selected for the second stage, and these participants completed a primary care version of the Composite International Diagnostic Interview, a fully structured diagnostic interview. Depression and somatization were assessed in this study according to DSM-IV

The interviewer asked the patients whether they ever complained about each symptom, and whether these symptoms were clinically important, and about the reasons for seeking help. Additionally, physicians categorized each symptom as medically explained or unexplained. This study found that 10.1 percent met the criteria for major depression, and the reporting of somatic symptoms by depressed patients was common across the centres. According to the first definition of somatization

(the reporting of only somatic symptoms) a somatic presentation was more common in type B centres than in type A centres. According to the second definition (the reporting of medically unexplained somatic symptoms) across the all centres there was a strong relation between depression and unexplained somatic symptoms ($P<0.001$ at all centres). According to the third definition of somatization (the denial of psychological Symptoms) the result showed no significant variation of the tendency to admit or deny psychological symptoms of depression. To examine the agreement among the all definitions, 4 percent met the character of all the definitions and 85 percent met at least one definition, 60 percent of the patients presented somatic symptoms but admitted psychological symptoms when they were asked directly about them. Based on this study, somatizations are a core component of the depressive disorder cross all centres, and attention should be paid to both psychological and somatic symptoms in diagnosing depression across cultures (Simon, et al. 1999).

Despite the impact of Simon et al's (1999) study, and the large national data sets used, the study gave rise to a considerable amount of comment and critical discussion as well as continuing research into the somatisation issue. First, Green, Betancourt and Carillo (2000) commented that the Simon et al. (1999) data implied that the practice of treating certain behaviours as culturally typical should be adopted cautiously as it may lead to over generalisation, bias, or false knowledge, such as treating all non-Western cultures as liable to somatization in relation to depression (Green, Betancourt, & Carrillo, 2000). Secondly, Pornoppodol (2000) argued that the data of Simon et al. (1999) included some sampling biases. Each study took place in the largest city in the country, which means that these cities are more likely to Westernized than others, this may limit the generality of the results to people in urban areas only; also, the data was not collected through community based surveys but only through clinics. Furthermore, patients with somatisation disorder were specifically excluded (Pornnoppdol, 2000). Simon and VonKorff (2000) responded to these points by agreeing that cultural stereotypes can bias clinical judgments, and that "somatic and psychological distresses are almost invariably intertwined". Furthermore they accepted that their results may not be applicable to patients from rural areas, or who do not visit primary care clinics.

In support of the findings of Simon, et al. (1999); who found that the circumstances in which symptoms are elicited, such as the characteristics of health care systems, can influence the degree of somatisation; it is interesting to find that cultural differences in somatic symptoms of depression seemed to be greatest when the patient was asked questions by unfamiliar clinicians (Ryder et al., 2008). Moreover, these differences were smaller when the patient was asked to play a role in shaping their symptoms, and disappeared when they replied secretly to a questionnaire (Ryder et al., 2008). According to Ryder et al., 2008 assessment modalities seem to play a role in eliciting different symptoms from the patients, therefore multiple assessments should be used in cross-cultural studies.

Following on from the work of Simon et al. (1999), other researchers have continued to extend and test the findings on somatization in depression in a variety of further cultural contexts. Okulate, Olayinka and Jones (2004) examined the symptoms of depression in a Nigerian heterogeneous sample of 829 males in the army, using self-report and classical DSM-IV criteria. This study found that somatic symptoms were grouped separately from the core depressive symptoms, and that these symptoms were not as good predictors of depression as core depressive symptoms (Okulate et al., 2004).

Studies have also indicated that one reason why depression is under-diagnosed in the UK is because of cultural diversity (Kessler, Lloyd, Lewis and Gray, 1999; Tylee and Gandhi, 2005). Kessler et al. (1999) tested the recognition of depressed cases in Bristol within one general practice of 8 doctors; the subjects were 305 general practice attenders. People who complained of somatic and psychological symptoms sought help from their general practitioner; however, patients with psychologising attributions were more likely to get a psychological diagnosis. General practitioners detected depression in only eight out of 54 patients who were diagnosed as being depressed or anxious, while 46 of 101 were undetected cases. Tylee and Gandhi (2005) mentioned that somatic symptoms are perhaps more frequently reported in culturally diverse populations, and that stigma is mainly responsible for the under-diagnosis of depression. There is thus some evidence of mis-recognized depression, and as a result, untreated patients, in the U.K. This occurs particularly at the initial clinic visit, and within the primary care health system, which is negatively affected by the

burden of treating these patients leading to excessive demands on the primary care system (Tylee, & Gandhi, 2005).

Parker, Cheah and Roy (2001) studied two cultural groups of depressed patients, Chinese and the Australian Caucasians, considering differences according to age and sex. They obtained by rank the prime symptoms after the first assistance, and an inventory of both somatic and cognitive symptoms. Western self-report depression inventories assessed items such as 'depressed mood', 'feeling helpless and hopeless', and 'guilt'. A second questionnaire was designed to assess a number of items that were not necessarily 'cognitive': these items were commonly nominated by depressed Chinese patients, and were selected from a number of Singapore psychiatrists. The result showed that Malaysian Chinese were more likely to report somatic symptoms (hypersomnia, chest pain, inability to breathe and loss of weight) as well as suicidal thoughts, than Australian patients (60% vs 13%). Malaysian Chinese were less likely to refer to helplessness and hopelessness, depressed mood, poor concentration, loss of interest, loss of appetite, self-critical, irritability, sadness, guilt, feeling bad about themselves and thoughts of death, while the Australian patients were more likely to report depressed mood, and cognitive items.

Arnault, Sakamoto, and Moriwaki (2006) investigated somatic symptoms and depression in 50 Japanese and 44 American female students using BDI and the Pennebaker Inventory of Limbic Languidness (PILL). The findings showed that female Japanese sample reported higher BDI scores (M = 12.66; SD = 7.05), while the mean of overall BDI for American was (M = 8.48, SD = 6.55). To determine the amount of variance in the BDI scores that can be explained by the somatic distress, regression analysis showed that in Japanese sample 31% of the symptoms were explained by somatic distress scores, but in contrast only 1% of the symptoms were explained by those scores in American sample (Arnault et al., 2006).

Rong et al. (2009) aimed to compare awareness of depression within two cultural groups, Chinese (N= 220) and Australian (N= 177). The participants were medical students and had been in

formal mental health/ psychiatry training. The international depression literacy survey (IDLS) was employed to examine mental health issues, and to explore personal experience. The findings showed that Chinese students were significantly less likely to consider depression as one of the major health problems for the general public: only a quarter of the Chinese group listed ‘‘brain, behavioural and mental health disorders’’ as a major health problem compared with two thirds of Australian group. In regard to knowledge of the clinical features of depression Chinese students were significantly less likely to consider physiological or somatic aspects such as sleep disturbance and feeling tired, when they were asked to nominate typical symptoms for a depressed person – in apparent contradiction to the view that somatic representations of depression are more common in non-Western societies. Also, features such as ‘‘Being unhappy or depressed’’ ‘‘thinking I’m worthless” were also more often nominated by Australian students compared with Chinese students. Both groups nominated poor concentration and interpersonal difficulties, and Chinese reported ‘‘hav(ing) suicidal thoughts or behaviour’’ more frequently than Australian students. In regard to help-seeking behaviour for severe depression, Chinese students were significantly more likely to seek help from various mental health professionals than Australian students. Additionally, ‘‘not seeking (any) help’’ for depression was common among both cultural groups (Rong et al., 2009).

Lu, Bond, Friedman, & Chan (2010) argued that cultural differences can be understood by analysing measures of its constituent symptoms. Lu et al., examined the relation between physical and psychological symptoms in Chinese and Americans, using confirmatory factor analysis, multidimensional scaling, and hierarchical cluster analysis of the symptom measure. The concept of depression is understood as a medical diagnosis but is not used widely in Chinese daily life, and people with depression are considered as abnormal, while Americans consider depression as a more neutral disorder, and some believe that people can recover one day: both cultures considered affective/interpersonal relationships as an important reference point for depression. Irritable mood, decreased interest or pleasure in daily life, and failure to thrive were reported as earlier response symptoms that participants complain of. The somatic symptoms are referred to as an extension of these psychological feelings. Both cultures tend equally to describe their depression in terms of an

overall construct of depression, and while Chinese individuals tend to respond more to their somatic feelings thereby they are also aware of their psychological problem, Chinese distinguish physical symptoms from psychological symptoms and consider that psychological ones are more serious. Thus the conceptual organization of depression is culture-related, and culturally appropriate modifications in clinical practice should have been done. This study concludes that misdiagnoses of Chinese people by American diagnosticians may be made as Chinese patients tend to express somatic symptoms such as boredom, discomfort and dizziness rather than the psychological symptoms of depression (Lu et al., 2010).

Canel-Çınarbas, Ying and Lauridsen (2011) tested the BDI-II on nonclinical populations of US (487) and Turkish (340) students. They reported that for the U.S. sample, the mean score on the BDI-II was 10.1 (*SD*=7.7), and for the Turkish sample, the mean score on the BDI-II was 14.9 (*SD*= □9.2). The study suggested a two-factor model consisting of Cognitive–Affective and Somatic factors has an adequate fit both for the U.S. and Turkish samples separately which means that there is a high level of consistency for the items across both cultural groups (Canel-Çınarbas et al., 2011).

The goal of the present study is to provide an assessment of the manifestations of depression among Libyans, and therefore both self-report and semi-structured interviews are to be used in the present study, in clinical and non-clinical Libyan samples.

Cross national studies of understanding of depression, its causes and treatment.

Cross national studies addressing depression have assessed the association between depression and personal, cultural beliefs across an extensive range of contexts and settings (Furnham & Malik, 1994; Lai & Surood, 2008; Lavender, Khondoke & Jones, 2006; Selim, 2010). Furnham and Malik (1994) compared beliefs about the causes and cures of depression of female native Britons (primarily from Christian background) and Asian origin Britons (from India, Pakistan or Bangladesh and primarily from Muslim background). The total sample included 152 females who were divided into two groups of middle-aged women (native British and British Asians) aged between 35 and 62, and two, younger

groups aged between 17 and 28 of native British and second generation Asians. The findings suggested that cultural beliefs affect the subject's tendency to recognise, report, and seek help for depression. Middle-aged Asian group were significantly different in their beliefs about depression and depressive symptoms from the middle-aged British and young Asian samples. Also they demonstrated a smaller degree of consensus of views than the other three samples, and reported a significantly greater tendency towards psychiatric morbidity than middle-aged British sample Middle-aged Asians reported less frequently than the other groups that they were depressed or knew someone who was depressed. The young British and young Asian samples tended to have similar perceptions of depression, and both reported a significantly greater tendency towards psychiatric morbidity than middle-aged women (native British and British Asians (Furnham & Malik, 1994).

Lai and Surood (2008) examined factors contributing to depression in older individuals in a sample of South Asian Canadians, comprising 210 participants who were not born in Canada, and whose mean age was 65.8 years. The findings showed that more than one in five individuals reported having depression, also that females reported more depression than males. Physical health conditions and cultural values were the most effective factors that contributed to reported depression; the strongest factor identified in this study was the level of agreement with South Asian culture as measured by a Cultural agreement scale, as established by the investigators regarding adherence to the beliefs and values of South Asian community (Lai, & Surood, 2008).

Lavender et al. (2006) examined the understanding of depression in Yoruba, Sylheti, and white British participants in the U.K. Lavender et al. (2006) found that beliefs about causes and treatment differ among those cultural groups, White British accorded more emphases to psychological causes, while Bangladeshis gave more attention to family factors. Black magic and evil spirits were attended to more frequently amongst the Yoruba.

Using a qualitative method Selim (2010) investigated the dimensions of depression in Bangladesh in two villages of Matlab. The participants included people without a history of

depression, out-patients, healthcare providers, caregivers, and village doctors. The analysis of data revealed that nobody recognizes the word depression, and instead, people described depression using many local terms. Participants talked about the effect of depression on work and family life, and most of them mentioned the association between depression and poverty, lack of education, health problems, and family issues, furthermore, all the participants mentioned socioeconomic circumstances as a major causal factor. Opinions differed between men and women concerning the prevalence of depression, in that men reported that there was more depression in men, while females reported that females are more affected by depression. Men talked extensively about sadness and their great burden, referring to their roles in terms of the main source of support to their family. Somatic symptoms such as aches and pains, sleeplessness, weakness were reported by most participants. A Traditional Healer was rarely the preferred choice for treatment, and patients talked about their dissatisfaction with treatment; they wanted medicine that would cure all the symptoms (Selim, 2010).

National comparative studies have been conducted to assess the level of depression (Weissman et al., 1996; Steptoe, Tsuda, Tanaka, & Wardle (2007). Weissman et al. (1996) concluded from a meta-analysis of the observed differences in the level of depression across nations that cultural differences play a significant role in vulnerability to depression. Weissman, et al. (1996) combined data from large epidemiologic surveys in 10 countries: the United States, Canada, Puerto Rico, France, West Germany, Italy, Lebanon, Taiwan, Korea, and New Zealand, with about 38000 participants in total. This study indicated that the lifetime rate for depression was the lowest in Taiwan (1.5) and the highest in Beirut (19.0). The lowest annual rate was in Taiwan with 0.8 cases per 100 and the highest annual rate was in New Zealand with 5.8 cases per 100 (Weissman et al., 1996).

Steptoe et al. (2007) measured depressive symptoms using the 13-item Beck Depression Inventory (BDI) (Beck & Beck, 1972) in 17,348 university students aged 17-30 (7509 men and 9839 women), from 23 countries including England (Table 1, 2). To explore factors that contribute to depression, this study assessed two variables: low socio-economic status (SES) and perceived lack of control.

Also, they tested whether sense of control mediated SES effects. Significant differences in the range of depressive symptoms between countries and sex were reported, and countries could be divided into three levels: the lowest level of depression was reported in Western and Southern Europe and South and North America; the intermediate level was found in Central and Eastern Europe and the higher levels were found in Pacific-Asian countries. The study identified national and individual predictors of depression, thus depression was associated with younger age, being female, and with poorer socio-economic background. Also, low sense of control was strongly associated with depression and was also associated with less individualistic countries and greater income inequality (Steptoe et al., 2007).

Table 1 modified from Steptoe et al., (2007) to show the ranking of BDI scores across nations

Table 1

Mean Depression Ratings (BDI-II) within 23 countries for women

Women			
	Mean		**%BDI ≥ 8**
Country	**(95% CI)**	**N**	**(95% CI)**
Venezuela	3.1 (2.6 to 3.6)	644	11 (7 to 15)
Belgium	3.2 (2.6 to 3.8)	515	11 (7 to 16)
Portugal	3.3 (2.8 to 3.7)	883	12 (8 to 16)
Netherlands	3.5 (3.0 to 3.9)	687	13 (9 to 17)
Germany	3.9 (3.5 to 4.4)	690	15 (11 to 19)
Bulgaria	4.3 (3.8 to 4.8)	730	18 (14 to 22)
Colombia	4.0 (3.5 to 4.5)	732	17 (13 to 22)
USA	4.1 (3.8 to 4.4)	1599	18 (15 to 20)
Italy	4.1 (3.8 to 4.4)	1767	18 (15 to 20)
England	4.3 (3.7 to 4.8)	704	14 (10 to 19)
France	4.3 (3.8 to 4.8)	669	17 (13 to 21)
Greece	4.3 (3.9 to 4.8)	755	21 (17 to 25)
Spain	4.8 (4.2 to 5.3)	483	23 (19 to 28)
Hungary	5.0 (4.5 to 5.5)	554	25 (21 to 29)
Poland	5.2 (4.7 to 5.7)	707	25 (21 to 29)
Thailand	5.3 (4.9 to 5.7)	843	29 (26 to 32)
Slovakia	5.7 (5.4 to 6.1)	1193	31 (28 to 34)
Romania	6.1 (5.6 to 6.6)	719	33 (29 to 37)
Ireland	6.1 (5.6 to 6.7)	415	29 (25 to 34)
South Africa	6.4 (5.9 to 7.0)	573	31 (27 to 36)
Japan	7.3 (6.7 to 7.9)	427	41 (35 to 46)
Korea	7.5 (7.1 to 7.9)	708	45 (41 to 49)
Taiwan	7.6 (6.9 to 8.3)	351	42 (36 to 47)

Table 2

Mean Depression Ratings (BDI-II) within 23 countries for men

Men			
	Mean		**%BDI ≥ 8**
Country	**(95% CI)**	**N**	**(95% CI)**
Netherlands	2.7 (2.1 to 3.3)	687	7 (3 to 12)
Belgium	2.8 (2.2 to 3.4)	515	8 (3 to 13)
Venezuela	3.0 (2.5 to 3.5)	644	9 (5 to 13)
Germany	3.2 (2.7 to 3.7)	690	11 (6 to 15)
USA	3.4 (3.0 to 3.8)	1599	14 (11 to 18)
Hungary	3.5 (2.9 to 4.2)	554	14 (8 to 19)
Portugal	3.6 (3.1 to 4.0)	883	16 (13 to 20)
Poland	3.8 (3.3 to 4.4)	707	14 (10 to 19)
Italy	3.8 (3.4 to 4.1)	1767	16 (13 to 19)
Bulgaria	3.9 (3.4 to 4.4)	730	17 (13 to 21)
Colombia	3.9 (3.4 to 4.5)	732	14 (10 to 18)
Spain	4.3 (3.6 to 4.9)	483	19 (14 to 24)
Greece	4.4 (3.9 to 4.9)	755	17 (13 to 21)
England	4.5 (4.0 to 4.9)	704	18 (14 to 22)
Romania	4.5 (4.0 to 5.0)	719	18 (14 to 22)
France	4.8 (4.3 to 5.3)	669	18 (14 to 22)
Slovakia	5.3 (4.9 to 5.7)	1193	24 (21 to 28)
Ireland	5.7 (4.7 to 6.6)	415	32 (24 to 40)
Thailand	6.0 (5.5 to 6.5)	843	34 (30 to 38)
Japan	7.3 (6.6 to 7.9)	427	36 (31 to 42)
Korea	7.4 (6.8 to 8.1)	708	43 (38 to 48)
South Africa	7.4 (6.8 to 7.9)	573	36 (31 to 41)
Taiwan	7.9 (7.1 to 8.6)	351	45 (39 to 51)

Stressful Life Events

Stressful life event may contribute directly to depression. Studies have examined the interaction between the exposure to a variety of levels of life events and previous depressive episodes and whether these factors lead to prediction of the onset of major depression (Brown & Harris, 1978; Kendler, Thornton & Gardner, 2000; Horesh, Klomek, & Apter, 2008; You & Conner, 2009; Allam, 2011). Kendler et al. (2000) interviewed a sample of female twin pairs drawn from a population of 2,395 of females over a 9 year period of time. The findings suggested that the number of previous depressive episodes strongly affects the relationship between stressful life events and depressive onsets. However, additional episodes –more than 10- do not influence the association between stressful life events and major depression. Apparently, the association declines with the increasing number of episodes (Kendler et al., 2000). Horesh et al. (2008) indicated that stressful life events such as loss, separation, and other uncontrolled events, play an important role in being depressed, thus the proportion of stressful life events were significantly higher in the depressed group, particularly in the year preceding the first episode (Horesh et al., 2008). Allam, (2011) investigated how stressful life events such as social, political and economic changes, change of residence, financial problems, and housing problems contribute to depression. The overall scores of depression of males and females in their student sample were significantly different. The BDI-IV mean scores for males and females were 18.67 and 25.08 with SD 8.01 and 9.23 respectively. Stressful life events that may be associated with a stressor are culturally constructed, particularly the individual's evaluation of whether specific factors are threatening or not. The individual's own definition of factors that contribute to depression can be problematic (Horesh et al., 2008). I believe that a better evaluation of stressful events is to be found in the social context in which that event occurs. Qualitative inductive study may thus specify exactly what kind of events contribute to depression if sensitively interpreted with knowledge of the social context.

Self-esteem and Depression

A person who has high self-esteem, has self-respect, and considers himself or herself as a person of worth, appreciating his or her own merits while recognizing his or her faults. On the other hand, a person with low self-esteem is an individual who lacks respect for him or herself and considers himself or herself unworthy, inadequate, or otherwise seriously deficient as a person (Rosenberg, 1979, p. 54). Self-esteem may be assessed by a number of scales, including the Rosenberg self-esteem scale (RSE, Rosenberg, 1979), which shows strong validity and reliability as a measure of global self-esteem, and is used widely in cross cultural studies for different ethnic groups.

Cognitive theory (Beck & Alford, 2009) proposes that the activated internal structures most relevant to the depressive experience refer exclusively to the concept of self. The depressive person is consistently viewing themselves in terms of deficiency, trying to fit their negative ideas about the self to negative conclusions that they made, and automatically making inappropriate interpretation of situations. Patients dislike themselves because of self-rejection (Beck & Alford, 2009). A depressed individual may be able to generate reasonable information, if it is related to others, but he or she is not able to process information in a positive way if that related to him or herself, because of the negative self-referent schemas. A depressed person may be expected to have tightly negative self-referent beliefs (Clark et al., 1999). According to the cognitive theory of depression (Beck), individuals who score low on self-esteem are considered to be vulnerable to depression. Scott (2006) examined the role of automatic self-evaluation, and negative self-schemata in depression. Positive automatic self-evaluation was weaker in depressed individuals than non-depressed individuals; this result gives support to the view that negative self-esteem may be implicated in vulnerability to depression. Therefore, having negative self-esteem has an important influence on exposure to depression.

Based on cognitive theory, many studies have addressed the effect of self-esteem on vulnerability to depression (Brown, Andrews, Harris, Adler, & Bridge, 1986; Hayes, Harris, & Carver, 2004; Luxton, & Wenzlaff, 2005). Brown, Andrews, Harris, Adler, & Bridge (1986) examined the prediction of depression from social support and self-esteem in the UK, with a total number of 400 women, in the following year after being exposed to a stressor, Low self-esteem was associated with a

greatly increased risk of depression once a stressor occurred (Brown et., 1986). Hayes et al. (2004) examined why variability in the relationship of self-esteem to depression occurs**.** Their findings suggest that possible therapeutic progress can be made and depressive symptoms may be reduced by identifying the specific contributing factors to low self-esteem that might occur and helping depressed patients to understand the interpersonal bases of their self-esteem and to help them to minimize negative generalization. Luxton and Wenzlaff (2005) examined the uncertainty surrounding the causal role of self-esteem in vulnerability to depression. Luxton and Wenzlaff argue that it is unclear whether negative self-esteem contributes to depression or whether negative self-esteem is simply a result of depression, as most previous studies assessed self-esteem during the depressed state. They used BDI to assess depression and the Rosenberg scale was used to asses self-esteem. With 228 total participants the results indicated that there were no significant differences in the self-esteem level between the at-risk group and the never depressed group, however, the at-risk group were more uncertain about their responses, took longer to respond, and were liable to change their answers. This uncertainty in thinking about the self was accompanied by increased seeking for reassurance and thought suppression (Luxton & Wenzlaff, 2005).

Cultural Studies in Self-esteem

Markus and Kitayama (1991) suggested that people view themselves as separate or connected in regard to others, and that different cultures might hold different shared assumptions about the separation or connectedness between the self and others. The concept of self as independent is based on a Western view which might be not universally valid. Markus and Kitayama characterised these construals of the self, others, and relationship with others, as an *independent* view of the self and an *interdependent* view, and proposed that these different views of self can influence cognition, emotion, and motivation (Markus, & Kitayama, 1991). Accordingly, culture might influence the content and structure of the inner self. In an interdependent view, in comparison to an independent view, others are critically important, and influence one's behavior, and a person may have the same knowledge about some others as they have about themselves. Those interdependent selves are more motivated by the

expectations of others, rather than their personal wishes, to maintain a harmonious social interaction. The interdependent view requires awareness of other's needs, sharing of other's feelings, the ability to think what others think, be sensitive to what others want, and help them to reach their goals (Markus & Kitayama,1991).

Beck and Alford (2009) mentioned that a necessary precondition for depression is *the formation of permanent concepts.* Cognitive learning takes place early in life; people develop their concepts including their values through the interactions with the surrounding environment. The structured concept of self as an *independent* view or an *interdependent* view becomes a cognitive structure based on different experiences, and the view of the self might be considered as central in the pathogenesis of depression (Beck & Alford (2009). In nations where a child has learned to include others even when they think of themselves, this might constitute more pressure, and these values of *interdependent* view of self can influence subsequent judgments, and subsequent experiences might be interpreted according to the negative or positive perceptions of the family group or nation, not according to the perceptions of the independent self.

Cultural values thus might play a significant role in the evolution of the self (Lehman, Chiu, & Schaller, 2004). Three studies by Hetts, Sakuma, and Pelham (1999) examined the implicit and explicit self-evaluations of recent Asian immigrants, Asian Americans, and European Americans in the USA as they were variably exposed to individualistic cultures. The first two studies found clear differences in the self-concepts between the three groups in implicit measures, but the implicit self-evaluations became increasingly individualistic over time whereas explicit measures showed a positive self-concept, within the three groups.

Some studies have addressed the effect of self-esteem on mood in different national groups. For instance, Abe (2004) examined the importance of self-esteem, family cohesion, and support from friends in predicting depressed mood in Japanese and American students, and they indicated that self-esteem was the strongest predictor of emotional distress in both groups. Furthermore, they found that

self-esteem mediated the relation between support from friends and emotional distress across cultures (Abe, 2004).

Libya as a collectivistic country may be expected to represent an interdependent view of self. Collectivists define the self through the groups a person belongs to, such as the position within the family. We might therefore expect that in a Libyan context, it is a person's relationship with family and that defines their level of self-esteem and therefore their vulnerability to depression. Conversely, individualists define themselves as independent of specific collectives, and this can emphasize high self-esteem, which might lead to narcissism (Triandis, 1995). The concept of self as independent might be not a valid view for Libyan nationals.

Social Support and Depression

I shall first consider two definitions of social support. There is considerable agreement about its essential characteristics

"*an exchange of resources between at least two individuals perceived by the provider or recipient to be intended to enhanced the well being of recipient"* (as cited in Shumaker & Brownell 1984; Morrissey & Callaghan, 1993).

"*Social support is defined as the existence or availability of people on whom we can rely, people who let us know that they care about, value and love us"* (Sarason, Sarason & Lindner, 1983, p.128)

The existence of people who provide unconditional emotional support and assistance, in both desirable and undesirable situations, can significantly reduce stress, give us the assistance that we need in order to cope with the situation, assure us that they are there for help, and make us feel comfortable and relaxed. Perceived social support is more relevant to theoretical explanations of depression than

received social support. According to cognitive theories such as Beck's, because of cognitive biases, people tend to interpret other people's behaviour in an inappropriate way. Depressed patients show negative long and short-term expectations that play a significant role in perception of social activities and social support. I am primarily interested in informal social support attempts by: family, friends, and special persons. A widely used and reliable scale for measuring perceptions of social support is The Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988), and this has been chosen for the present study because it measures informal social support.

Beck, Rush, Shaw, and Emery (1987) and Clark et al. (1999) highlighted the important role played by: cognitive biases; negative self-esteem; negative view about the world; negative expectations, and negative effect. All of these factors basically, play as indirect factors to affect the perception of the social environment, in order to maintain major depression. If a depressed patient devalues him/her self, and does not do as expected, they might feel socially undesirable, and that everybody hates him/her. He/she interprets their experiences with others in a detracting way, and might regard others' behaviour as a rejection. Because of cognitive biases he/she tends to interpret other people's behaviour in an inappropriate way. Schemas involved in misinterpreting these stimuli are activated, and condense the stimuli into cognitions. Cognitions refer to any verbal and mental activity including self-instruction and self-criticism. In such a case, the schema provides the conceptual framework to this particular external stimulus (Beck, & Alford, 2009).

A patient's reaction towards others would be affected by his negative impressions, and surrounding people's response in turn, would be a response to his/her reaction. Such cases would eventually lead to the formation of an endless scenario of recycling of dramatic events. Just the unconditional offer of support, from significant others can stop this cycle, and make him/her think again about his conceptual framework.

According to Beck and Alford (2009), depressed patients show negative long and short-term expectations that play a significant role in perception of social activities and preserved support. These

expectations include, engaging in any social movement, and making relationships with others. Depressed patients anticipate that every experience or relationship will face difficulty, and automatically assume they will not enjoy their time, also that any relationship will end in failure. Beck & Alford (2009) propose that the way patients structure their experience determines the way they feel, a patient who thought he/she was rejected, would experience consistently negative affect. He/she is less able to accept the fact that his pessimistic judgments which are driven by such idiosyncratic schemas are mistaken. In such cases, patients imprison themselves inside their constantly inattentive negative thoughts, in such a way that they cannot engage mentally in any external activities (Beck et al., 1987).

Another way to think about the role of social support in depression is that social environment could play a role in either generating depression, or act as protection for the individual from depression (Beck et al., 1987). Avoidance of people surrounding a person might result in him developing clinical depression, ultimately pushing the patient into further isolation. This performance could go on to such an extent that the patient would resist any form of external help or sympathetic support by family, friends, or relatives (Beck et al., 1987). It is also possible that a positive interpersonal approach, and support provided from others surrounding, could prevent the development of a deep depression. The case would be similar when a person receives powerful support from his close society, which increases his self –esteem, value, and respect, and keeps him away from self-underestimation. Consequently, in some cases a close social supporter can be used to cure someone from depression via providing a positive assessment and counteracting one's self-criticism. There are various forms of powerful social links that can be applied which are known to be beneficial to treat depression, for instance; those developed in couples therapy, marriage counselling, or family therapy (Beck et al., 1987).

Studies have found that low levels of social support are associated with greater depression. Brown, Andrews, Harris, Adler, and Bridge (1986) showed that in the follow-up period, social support from husband, lover, or a very close contact is essential to make mobilization, and lack of support was highly associated with depressive symptoms (Brown et al.1986). According to Moore (1987) little

attention has been paid to the psychological processes by which support is derived from environmental events. Moore (1987) examined the importance of social support in the aetiology of depression, and the nature of depressive insufficiency in perceived support. Strong relationships between support and symptoms of depression were found, in cross-sectional analyses, but evidence from longitudinal analyses was unclear. Depression was consistently associated with a discrepancy between needed support and the support thought to be provided. Schematic memory processes found to play roles in social judgements of support (Moore, 1987). The influence of social support on the outcome of major depression was investigated by George, Blazer, Hughes, and Fowler (1989) 150 in-patients were diagnosed with major depression; they were interviewed, and re-interviewed 6-32 months later. It was found that both the size of social network and subjective social support were significantly predictors of depression (George et al., 1989).

Studies have addressed the function of family and its relation to major depression. Miller and Keitner (1990) gave evidence that family plays significant roles in the development of major depression, and the course of depressive episodes is affected by family functioning. The investigators examined changes in family functioning over a 1-year course of major depression. Assessments of family function were collected, initially and 6-12 months after discharge. 45 in-patients were examined by subjective and objective perspectives. Miller and Keitner found that family functioning was associated significantly with recovery from major depression. Nasser and Overholser (2005) also carried out a study to identify factors associated with recovery from depression, specifically, support from family, friends, and spiritual beliefs. 62 in-patients diagnosed with major depression were interviewed and re-interviewed three months later. Analyses tested the relationship between support factors and depression. Support from family and a composite measure of emotional support were both significantly predictors of depression (Nasser, & Overholser, 2005). These results indicate that low social support, may be associated with vulnerability to depression. Therefore, having low social support from family, friends, and significant others, may have an important influence on exposure to depression.

Triandis (1989) suggested that the size of in-groups in complex societies tends to be bigger, as everyone who meets the characteristics of "I" would be an in-group member. In individualist cultures, people can have large social networks, as for example people who agree with me on attitudes can be in my in-group. Also in individualist societies people are more independent, so that if the in-group makes excessive demands, the individual can leave it. In contrast, in collectivist societies people prioritize smaller social networks, such as family (Triandis, 1989).

Wang (2004) investigated the relationships between familial and psycho-social variables and depressive symptoms in Taiwan and Northern Ireland. Wang found that the Taiwanese sample was higher in depression than the Irish sample. The two samples were significantly different in the perception of social support. In the Taiwanese sample, family functioning, and problem-focused coping had a stronger impact in depression, while, in the Irish sample, parental care and emotion focused coping had a higher impact on depression.

Contrary to the idea that collectivist societies provide a strong social support, it is often found that people in individualistic societies, have a wider social support network, and are less exposed to depression.

Chapter 3

Depression In Relation To Cultural Values and Gender Differences

The contents of this chapter are as follows: (a) definition of culture. (b) A review of depression in relation to cultural values. (c) Gender differences in prevalence of depression and the related theories. (d) Gender differences in depression in Arabic countries. Cultural factors risk of depression and Libyan and British samples.

Definitions of Culture

Kashima (2000) defined culture as "a property of humans that transmits information symbolically between and within generations, and provides material and symbolic tools of the people in their social environment, with which they construct and build their own images of their world and themselves" (pp. 19, 20). More specifically, Kleinman provides a short definition of culture as consisting of shared value orientations, including beliefs about the body, the self, illness, and treatment (Kleinman, 1996, p .16). Hofstede (2001) sees culture as a "system of communally shared values collective programming of the human mind that distinguishes the members of one group or category of people from another "(Hofstede, 2001, p. 9). In this study I primarily refer to culture according to Hofstede's definition (2001). Another term that has been identified in this study is nationality, which is defined by Smith, Bond, and Kağıtçıbaşı, (2006) as a social system: "It is evident that nations are social systems because they comprise extensive interconnected networks of people. Social systems define the patterns of behaviour whose meaning is provided by their cultural context." (Smith, Bond, & Kağıtçıbaşı, 2006. P. 32). Hofstede (1997) on the other hand, mentioned that in cross-cultural research, nationality (that is, the passport they hold) is used very often for classification. He defines nations as "political units into which the entire world is divided, and to one of which every human being is supposed to belong" (Hofstede, 1997, p. 11). The Libyan nation is very homogenous in the ethnicity of their population.

Cultural Values in Relation to Depression

Many psychological phenomena are thought to be universal, however the way people express themselves appears to be cultural specific (Triandis, 2004). One benefit from cultural studies is possibility to differentiate between the universal and the culture-specific aspects of the psychological phenomenon in question. In other words, the goal is to identify what is universal and what is due to cultural influences, also showing how various dimensions of culture influence psychological phenomena (Triandis, 2004). Culture matters because in different societies, people are likely to go through different experiences, so different cultural perspectives also provide new approaches to psychological development (Oyserman & Lee, 2008). Apparently, in order to interpret the way culture works to shape psychological phenomena, we must begin by determining and measuring the main dimensions of cultural values (Triandis, 2004).

Many different kind of comparisons between different types of society have been carried out, and in many of these comparisons the observed differences correspond to the constructs of individualism and collectivism (Gaines et al., 1997; Hofstede, 2001; Oyserman, Coon, & Kemmelmeier, 2002; Fiske, 2002, Taras, Steel, & Kirkman, 2012). Hofstede (2001) demonstrated over a long period of time that there are national cultural patterns that reflect the values system of the population. He gathered extensive data of 50 countries and three regions with different questions about IBM employee values. According to correlation and factor analyses based on matched employee samples across countries, Hofstede identified five independent cultural dimensions, power distance, uncertainty avoidance, individualism, masculinity, and long-term orientations. The most important dimension that emerged is individualism / collectivism (Triandis, 2004). Individualism may be considered as the opposite of collectivism, and the IBM database offered the computation for each country and regions of an Individualism Index, which however did not allow distinctions according to occupations, gender, age, and other individual characteristics. Hofstede's (2001) study showed that

Individualism correlated negatively with power Distance, and in European countries, individualism was negatively correlated with uncertainty avoidance.

According to Hofstede (2001) these cultural dimensions have many implications. Cultural dimensions affect people's mental programming, and the structure of many institutions of the societies. For example, in education and politics the concept of collectivism is explained as putting the interest of the group goal above the interest of the individual. In most collectivist societies, children grow up in an extended family learn to think of themselves as a "we" or "in-group" distinct from others of a "they" group, the in-group people in these societies are a source of security and identity, therefore they feel loyalty towards the in-group, whereas, for individualistic societies, people consider the interest of the individual above the interest of the group. In these societies, children grow up in a nuclear family, and they learn to think of_themselves as "I". This I represents a personal identity, distinct from others "I"s, whom they may classify according to individual characteristics (Hofstede, 1997).

"Individualism pertains to societies in which the ties between individuals are loose: everyone is expected to look after himself or herself and his or her immediate family. Collectivism as its opposite pertains to societies in which people from birth onwards are integrated into strong, cohesive in-groups, which throughout people's lifetime continue to protect them in exchange for unquestioning loyalty" (Hofstede, 2001, p. 225)

Individualism characterizes those who see themselves as having a relatively separate identity, whereas, collectivism characterizes those whose identity is more strongly defined by long-lasting group memberships (Smith, Bond, & Kagitcibasi, 2006). Triandis (1989) suggested that people in individualist cultures, tend to sample with elements of the personal self (e.g., "I am busy, I am kind"). People from collectivist cultures, tend to sample elements of the collective self (e.g., "my family thinks I am too busy, my co-workers think I am kind").

Despite the impact of Hofstede's study, and the large national studies using Hofstede's approach, many researchers have indicated its limitations and provided a critique.

First, Hofstede (1980) measured only individualism-collectivism as a single dimension, and indicated that individualism is opposed to collectivism. Indeed we find some people who score high on collectivism in individualistic societies, also some people might score high on both or low on both dimensions, and perhaps only a minority of people who are clearly individualistic or collectivistic (Gaines et al., 1997; Triandis, 2004). This assumption may reflect the bias in the United States to regard individualism / collectivism as a psychological construct (Gaines et al., 1997). Hofstede however mentioned that, these dimensions are anthropological not psychological concepts, they refer to societies, and should not have been measured on the individual level and then interpreted in terms of societies, nor should the country level of analysis be expected to explain individual behaviour.

Second, Individualism, as Hofstede explained, is seen as blessing in some cultures and collectivism as not a good thing. Even though he considered the country level of individualism not as a stable but as a dynamic procedure of cultural development (Hofstede, 2001), each dimension or stage has its own advantages and disadvantages.

Third, using different languages can be problematic; the same word can have different meaning in different countries. Hofstede used questions to get to the findings; also response choice has its limitation when it is used across cultures. The meaning of the scale response must be the same across countries, but choices such as "very much agree" can have different meanings (Oyserman et al., 2002).

Forth, Kitayama (2002) argued that measurements of cultural values using attitudinal surveys can be problematic. These measurements face validity problems, as they are dealing with culture in different contexts.

Familism

The relationship of familism to individualism and collectivism is not straightforward.

Hofstede (1991) argued that familism is a fundamental aspect of individualist societies, whereas Triandis (2004) claimed that familism values are stronger in collectivist societies. Complex cultures are more related to nuclear families, and it has also become common in North America that many families consist of only one parent and children. These kinds of structured nuclear families are said to encourage exploration and creativity, while in extended families we find more obedience and more organized rules (Triandis, 2004). Oyserman et al. (2002) however came up with the result that family orientation did not appear to be closely linked to collectivism. Americans, as representing highly individualistic values, are close to their family; however they are not obligated to them. On the other hand Gaines et al. (1997) argue against the idea of relating familism to collectivism, by stating that individualism and collectivism do not exhaust the possibilities regarding culture value orientations, and that an individual's orientations toward family and community are qualitatively different.

Gaines et al. (1997) examined the internal validity and internal consistency of the separate individualism, collectivism, and familism scales developed by Gaines et al. (1997), and tested whether the scales represent distinct cultural values predicted by race / ethnicity. Gaines et al. define individualism as "orientation toward one's own welfare", collectivism "orientation toward the welfare of one's larger community", and familism as "orientation toward the welfare of one's immediate and extended family". Using the above definitions, and removing forced-choice from the scale, individuals can score high or low in either dimension.

Gaines et al. (1997) examined the three cultural values among Anglos, African Americans, Latinas / Latinos, and Asian Americans. It was proved that the three culture value orientations (Individualism, Collectivism and Familism) were empirically and conceptually distinct. However, Collectivism and familism were positively correlated (Gaines et al., 1997, p. 1461). On all three cultural value orientations, individuals' racial/ethnic identity mediated the impact of race/ethnicity, and racial/ethnic identity was positively related to individualism, collectivism, and familism. Persons of color were found to be higher on collectivism and familism than Anglos. The reliability coefficient

across the four groups studied (Anglos, African Americans, Latinas/Latinos, and Asian Americans) for individualism, collectivism, and familism, were respectively (.57, .76, .88).

Measures of family dimensions might make an important contribution to understanding psychological factors within individuals and cultures. Campos et al. (2008) examined Familism as a function of perceived social support, stress, pregnancy anxiety, and infant birth weight. In total of 31 Foreign-born Latina, 68 U.S.-born Latina, and 166 European American women, Latinas reported significantly higher levels of familism (*M* - 3.25, *SD* -0.46) than European Americans (*M* - 3.20, *SD* - 0.45). Latinas relative to European Americans showed a greater association of familism with social support. Latinas were higher on familism and familism was positively associated with perceived social support, and with less stress. This study indicated that cultural values highlighting positive social relationships may be associated with psychological benefits.

In the current study, Individualism, collectivism, and familism, will be assessed by the scales of Gaines et al. (1997) that represent familism, collectivism, and individualism as distinct scales. I focus on the constructs of individualism, collectivism, and familism because the literature reviewed above about cultural dimension indicates that these three factors make important contributions to psychological processes. The methods I adopt will allow people to score high or low on each scale, considering the evidence that these three cultural values are distinct (Gaines et al., 1997).

Cultural Values and Depression

Although the majority of people live in non-Western cultures, the theories of contemporary psychology are built on data from Western populations which may not be applicable to non-Western cultures, and to make a universal psychology, we need data from the majority of humans. Triandis, (1996) and Kleinman (1977) argue that there are differences in the features of depression across cultures. Psychological theories need to be investigated in non-Western populations to decide whether these theories apply to non-Western populations or need to be modified. Cultural syndromes such as

individualism and collectivism can be used as objective parameters to identify how people from different cultures see the world. Living in the context of individualistic culture which is emphasised in the Western countries, is different from living in the collective culture which is emphasised in non-Western cultures (Triandis, 1996). Oyserman and Lee (2008) argue that cross-national studies are unable to give evidence for a causal process, but literature focused on collectivism/individualism has provided important contributions to psychological processes. But it is not clear whether the effects of the variables are because of the cultural orientations collectivism/individualism, or because of other aspects of those cultures. Using meta-analysis the authors came up with the conclusion that the cross-national studies addressing the effects of individualism and collectivism in psychological phenomena give evidence that these values have psychological consequences for people, and demonstrate differences between different groups (Oyserman and Lee, 2008).

Studies on individualism and collectivism may provide an appropriate exploration of culture and depression, since cultural values of individualism and collectivism are believed to influence the psychological health of people (Caldwell-Harris, & Ayçiçeği, 2006; Scott, Ciarrochi, & Deane, 2004). Caldwell-Harris, & Ayçiçeği, (2006) suggested that idiocentrics (self-centred) (Triandis, Leung, Villareal, & Clack, (1985) had the lowest report of depression, whereas extreme collectivism is the strongest indication of poor mental health. The authors suggested that people who are very independent are less likely to have social anxiety because such individuals care little about the surrounding people. Scott et al. (2004) examined psychological factors in individualism in a sample of 276 Australian university students of whom 222 were female, and 54 were male. Using the BDI-II to assess depression, the findings suggested that higher levels of individualism in an individualistic country were associated with psychological disadvantages including hopelessness and suicidal ideation, but not with depression (Scott et al., 2004).

Researchers have speculated that the match between personality and the values of the society is an important factor for psychological adjustment, particularly in the case of Allocentrics who are more sensitive to social rejection (Triandis, Leung, Villareal, Clack, & Leung, 1985, Caldwell-Harris, &

Ayçiçeği, 2006). Caldwell-Harris and Ayçiçeği (2006) have discussed cultural influences on depression and investigated the effects of personality–culture clash on psychological distress using many scales including individualism–collectivism, personality scales and BDI. With an American sample of Boston University students (n=131) and a Turkish sample of Istanbul University students (96), findings suggested a significant negative correlation between individualism and depression *(*–.28**), and a significant positive correlation between collectivism and depression (.27**) for the American sample. Individuals who were high in Idiocentrism in an allocentric society gave rise to the highest number of significant correlations with clinical scales in the Turkish sample. And allocentrism in an idiocentric society gave rise to the highest number of significant correlations in the American sample, which supports the conclusion that personality cultural clash is a risk factor of depression (Caldwell-Harris & Ayçiçeği, 2006). Countercultural individuals usually feel they are subjugated by their society and they may leave their own countries to find another that may match the individual's values (Triandis, 1996).

In assessing individualism/collectivism, Hofstede (2001) treated Arabic-speaking countries, including Libya, Egypt, Lebanon, Kuwait, Iraq, Saudi Arabia, and United Arab Republic as one region, in which the total number of respondents was 141. Hofstede admitted that the group was less homogeneous than it should be (Hofstede, 2001). The Arabic world emerged in this study as one composed of collectivist societies. In Hofstede's (2001) ranking of individualism across cultures, the Arabic world was ranked 26th out of the 53 countries and regions assessed, with score of 38.

Gender differences in prevalence of depression

Established literature suggests that women are at significantly greater risk than men of depression, with greater differences in prevalence in depression found in women in studies in the United States and Europe (DSM.IV.TR, 2000; WHO, 2001). Also, epidemiological studies in Arabic countries have consistently shown the greater risk of depression for women than men (Daradkeh, Ghubash, & Abou-Saleh, 2002; Alansari, 2006; Hamdan, 2009). The higher depression rates in

women first appear in adolescence and may begin with puberty (DSM.IV.TR, 2000). While gender differences in biological factors may be important, most of the gender difference in prevalence of depression may originate from culturally constructed differences in the roles and experiences of women and men (Bussey, & Bandura, 1999).

Research studies have consistently indicated that women show higher rates of lifetime depression than men (Weissman et al., 1996; Angst et al., 2002; Moskvina et al., 2008; Moskvina et al, 2008; Velde, Bracke, Levecque, and Meuleman, 2010; Winkler et al; 2004). Weissman et al.'s review reported a significant gender effect in all 10 countries that were studied, and the rates of major depression were always higher for women than men (Weissman et al., 1996). A comprehensive study carried out by Angst et al. (2002) investigated gender differences in the symptoms, causes, help-seeking, and coping strategy in depression in representative population samples selected from six European countries: Belgium; France; Germany; the Netherlands; Spain; and the United Kingdom (see U.K. Department of Health, 2000). In the original study carried out in 1995, the total sample was 38,434 men and 40,024 women who were analyzed for gender differences in depression. The second wave was conducted 6-12 months later, including specifically those treated for depression (N=1884). The participants were interviewed in their households, using a specially designed depression questionnaire. Findings from wave I found that depressive symptoms among females were higher (22.4%) than males (13.9) and females also reported twice as often feeling sad, depressed, down, and loss of interest/joy (15.8 %) for females and (8.7 %) for males. A total of 5,343 males (6.4 %) and 8,966 females (12.9 %) of wave I sought help and treatment. The gender differences for major depression were consistent across all age groups. In wave II of the study (563 males and 1,321 females) men reported fewer symptoms than women (Angst et al., 2002).

Moskvina et al. (2008) studied a total of 878 individuals, 270 men and 608 women, including 475 sibling pairs. Findings suggested that there were some sex differences in frequency and severity of depressed mood, thus women showed significant earlier onset of depression, greater frequency of several features of depression, and longer duration of episodes. In sib-pair data there was a

significantly greater frequency of fatigability, appetite gain, weight gain, and hypersomnia. In siblings data five symptoms accounted for the sex differences including: phobia, hypersomnia, appetite loss and appetite gain though women reported more weight gain. Also women were higher than men in tearfulness, loss of self-esteem, pathological guilt, morning depression, and loss of reactivity (Moskvina et al., 2008).

A study by Velde et al. (2010) covered 25 European countries (2006-2007) with participants aged 15 and over, and the greatest gender differences were found in Southern European countries and the former Soviet countries. Across nearly all countries females reported significantly higher level of depression than males, but this was not the case for Ireland and Finland. The highest levels of depression were reported in Ukrainian females and Hungarian males, whereas the lowest depression levels were reported in Norwegian females and Norwegian males (Velde et al., 2010).

Winkler et al. (2004) examined gender differences in the psychopathology of depressed inpatients, comprising 104 female and 113 male depressed patients in Vienna, but no gender differences were reported regarding the severity of depression. On admission into the hospital, women showed more affective lability than men, while males were higher in affective rigidity, also, men were significantly higher in decreased libido, hypochondriasis and hypochondriac delusions, on discharge from the hospital, and women were significantly higher in dysphoria while men were higher in compulsive impulses. The findings suggested differences in the core symptoms of depression whereas the severity of illness was equal for both sexes (Winkler et al., 2004).

In order to present a background for the analysis of gender differences in depression, I will introduce major features of some theories of gender typing that have been proposed to explain gender differentiation. These theories influenced the psychological literature: social learning theory, cognitive developmental theory, gender schema theory, and response styles theory.

According to social learning theory (Bandura, 1977) people learn repertoires of behaviour by either direct experience or observation. Actions that people make produce negative and positive effects, and people learn from the results of those effects: they select successful responses of behaviour and discard ineffectual once (Bandura, 1977). People learn also through modelling by observing others, thus modelling gives an example of how the learned behaviours are performed, a guide for performing any behaviour, and errors that might be made (Bandura, 1977). Social learning theory is based on forms of learning such as respondent conditioning, operant conditioning, and rule-Governed Behaviour (Thyer, & Myers 2006). Observational learning is stressed to account for gender-typed behaviours that are learned without necessarily engaging in such behaviours: in this way children could absorb the same sex models and integrate rich information about gender roles from those people around them (Bussey & Bandura, 1999; Martin, Ruble, & Szkrybalo, 2002).

The experience of the modelling influences is determined by social context, thus people are more likely to adopt modelled behaviour around them. Social roles are learned, through individuals who have been exposed to the significant people around, and observations of how others behave provide a standard of what is an appropriate or not for being a man or a woman. If the family is oriented to treat each sex unequally, individuals who have grown up in this environment will tend to behave according to this expectation. Since 1999, social learning theory has been changed toward a more cognitive orientation, as reflected in its current title which is social–cognitive theory (Bussey & Bandura, 1999; Martin et al., 2002). Social cognitive theory focuses on the ability of children to symbolize the environment, in order to make it more comprehensible. The advanced ability for modelling influences observational learning and allows those children to expand their skills without having to make direct responses and experience the consequences (Bussey & Bandura, 1999). Self-efficacy beliefs are proposed to play a crucial role in children's development underlying children's gender-typed behaviours (Bussey & Bandura, 1999; Martin et al., 2002)

Cognitive-Developmental Theory

Children achieve gender constancy about themselves from what they are exposed to around them, and this information about their gender identity is essential to guide their behaviour: they value their gender identity, and behave in accordance with that stereotype (Bussey & Bandura, 1999). Individuals go through cognitive processes that maintain consistency about their self-conception because this is rewarded by those around them (Bussey & Bandura, 1999). Cognitive-Drevelopmental theory stresses that gender development includes an active comprehension of the meaning of gender categories initiated by internal factors rather than by external socialization factors (Martin et al., 2002).

Gender Schema Theory

The gender schema is most likely created from interactions between the individuals and their environment, as well as response to situational changes (Bussey & Bandura, 1999). Like cognitive developmental theory children are guided by gender-label matching of stereotypes of their own sex. Gender schema theory would rely more on common knowledge structure about gender-linked preferences than cognitive-developmental theory (Bussey & Bandura, 1999; Martin et al., 2002). Gender-typed behaviours are a production of interaction of environmental events, personal aspects, and behaviour patterns (Martin et al., 2002).

The cognitive perspective of these theories to understand gender typing leads to stress on the importance of the cultural determinants of gender development (Martin et al., 2002). In the above theoretical perspective, the concept of gender and its roles are the result of a broad social network of social operations that influence a person on a daily basis, and gender differences add important influences operating interdependently because many of the roles in males and females tend to be differentially valued (Bussey & Bandura, 1999). People live in different status groups, such as those defined by social context, educational level, and socioeconomic status, so that people of different status are not expected to behave the same way (Bussey & Bandura, 1999). The environmental

background and observational learning conditions may influence the differences between females and males evident in different cultural practices.

Response Styles Theory

Nolen-Hoeksema (1987) proposed this theory to explain females' greater vulnerability to depression than males. Nolen-Hoeksema argued that most people experience depressive symptoms, but the way people respond to or cope with the mild or moderate depressive episode can make the difference between an episode lasting for few days, and a more severe depression persisting to the point where they acknowledge it and seek professional help (Nolen-Hoeksema, 1987). Thus, regardless to the initial causes, people may recover fast by engaging in activities that distract them from depressive mood, or else may tend to ruminate about the symptoms and causes of their depressed feeling (Beck, Rush, Shaw, & Emery, 1979; Nolen-Hoeksema, 1987). Nolen-Hoeksema (2008) argued that a ruminative response for depression may increase depression in several ways. Rumination makes it more likely that people use negative memories to understand their status, makes thinking more pessimistic, and leads to increasing stressful circumstances (Nolen-Hoeksema, 2008, Nolen-Hoeksema, & Larson, 1999).

Particularly, women's responses tend to be more ruminative, they show less distracting responses, and rumination amplifies during depressive episodes, while men's responses tend to be more behavioural and active (Nolen-Hoeksema,1987). Hoeksema, Morrow, and Fredrickson (1993) addressed these questions and found that women were more likely than men to engage in ruminative thinking. Also regardless of gender, people who ruminate more about their depressed moods they are depressed for a longer time (Hoeksema, Morrow, & Fredrickson, 1993). Rumination is defined by Nolen-Hoeksema (2008) as process of thinking rather than by the specific content of thinking. Rumination involves repetitive and passive thinking of the possible causes and symptoms instead of taking action to solve the problems or change circumstances (Nolen-Hoeksema, 2008). Nolen-Hoeksema (2008) linked the content of ruminative thought to the cognitive styles that have been

studied by cognitive theorists (pp. 00) (Beck, 1967, Nolen-Hoeksema, 2008). In contrast to the ruminative response there is the distracting response which has been defined as thoughts or behaviours that may absorb depressed mood and twist it towards a pleasant mood (Nolen-Hoeksema, 2008). Nolen-Hoeksema, and Larson (1999) findings mentioned the effects of chronic strains and burdens that women carry which are a greater load than for men, also women feel lower in status and less appreciated than men. Chronic strain is found to be a contributor to the gender differences in depression, which, it emerges, is mediated through rumination; chronic strain leading to more rumination in women than men, maybe because some women feel that they have little control over their circumstances (Nolen-Hoeksema & Larson, 1999).

Another factor that has been suggested to contribute to the gender differences in depression according to Nolen-Hoeksema (2002) is interpersonal orientation. Women tend to sacrifice their needs greatly to keep positive relationships with others, they show more care and concern about others, and about negative events, and that may lead her to develop depression. Also, women are more inclined than men to enhance negative thinking through rumination when sad or when engaged with problem solving, which makes it even more difficult for her to solve problems that may be related to depression (Nolen-Hoeksema, 2002). People with a ruminative response style repetitively think of the reasons for and symptoms of their depression without taking action to solve the problems that are related to their depression in a positive way, and they think excessively before they decide (Nolen-Hoeksema, 2000).

Based on the response style theory and gender typing theories, men may tend to respond effectively by positively making an action such as avoiding negative incidents or by getting angry, and may function according to the means of an appropriately masculine response in particular social context. According to Addis (2008) the ways that men and women respond is according to culturally approved gender norms, particularly parents' response to emotions associated with decrease or increase over time (Addis, 2008). Addis (2008), Parker and Heather (2010) argue that women are more likely to admit to depression than men, and the true rates of major depression in men may be underestimated as a result of masked depression in men. Thus, the prevalence of depression might be

the same in men and women but social cultural pressures lead men to behave in a gender appropriate schema; men perhaps hide the disorder from others and even from themselves (Addis, 2008; Parker & Heather, 2010). In view of that possibility, Borooah (2009) examined gender differences in the rates of depression in the United States between 2001 and 2003, in terms of exposure and response to depression. Borooah found that the difference was largely explained by differences between men and women in their response to the depression (Borooah, 2009).

Parker and Heather (2010) argued that biological factors lead women from puberty to be at greater risk but these factors are modified by socio-cultural factors. Also, some artefactual factors may be seen contribute to the gender difference, if we accept that women respond differently when asked to fill in depression rating measures, and are more likely to seek help (Parker & Heather, 2010). Women often experience depressions during their periods and some investigators have mentioned that the activation of gonadal hormone systems can contribute to depression. However, women whose depression may be attributed to hormonal changes at puberty, in the premenstrual period, in the postpartum period, or at menopause are a minority: the mass of evidence does not support this view (Nolen-Hoeksema, 2002). Many studies have offered different explanation to gender differences in depression however no one variable can explain these differences individually (Nolen-Hoeksema, 2001). Women are more exposed than men to specific severe stressful events such as sexual, physical, and psychological abuse and these events may make women feeling helpless and more sensitive to stress (Nolen-Hoeksema, 2001). Women continually face constant burdens due to her status relative to men, women are more likely to be sexually under pressure on her job, looking after children, elderly family members and domestic house work, all the general distress of these factors could contribute (Nolen-Hoeksema, 2001).

According to some established literature, studies examining risk factors of depression that might differentially affect females and males indicated that women are more likely to experience chronic negative circumstances such as battering and suicidality (Golding, 1999; Pico-Alfonso et al., 2006). In a Meta-Analysis Golding (1999) addressed the effect of intimate partner violence (IPV) by

men against women in increasing the risk of mental disorders, among women with a history of intimate partner violence, domestic violence, and battering**.** Across 18 studies, the mean prevalence of depression among battered women was 47.6%. Golding also found that among thirteen studies of suicidality the prevalence rates ranged from 4.6% to 77% among battered women with mean of 17.9% (Golding, 1999). In Spain, Pico-Alfonso et al., (2006) used structured interviews with physically/psychologically abused women (75) and psychologically abused women (55), and those women were compared with nonabused women (52). This study indicated that psychological intimate partner violence was an independent and stronger predictor of depression than physical IPV. Sexual, with both physical/psychological and psychological IPV increases the severity of depressive symptoms (Pico-Alfonso et al., 2006).

You and Conner's (2009) study suggests that severe life events were significantly associated with current depression in women however these roles did not apply for women with history of depression. It is noticeable that severe life events in men were associated with depression with no consideration of depression history (You & Conner, 2009). A cross cultural study has been done by Colla, Buka, Harrington and Murphy (2006) among participants from West Africa and North America to examine the hypothesis that depression is higher in modern societies compared with traditional societies. The authors came up with the findings that the prevalence of depression was highest among urban residents in the United States and lowest among rural Nigerians, particularly those under 45 years and who had living children. This study suggested that traditional way of life may protect those women from stresses associated with modern societies (Colla et al., 2006).

Gender Differences in Depression in Arabic Countries (Cultural Practice, and Depression)

According to a study by Daradkeh, Ghubash, and Abou-Saleh (2002), the greatest gender differences in depression in the literature were recorded in Al-Ain in the United Arab Emirates. With total participants N=1394 the lifetime rates in males and females were 2.8 and 10.3%, respectively. It is interesting to find that the prevalence of depression fell after the age of 55. The authors explained that by socio-cultural roles as older people enjoy respectful treatment and receive more financial and

moral support (Daradkeh et al., 2002). Alansari (2006) examined gender differences in depression from 17 Islamic countries namely: Saudi Arabia, Qatar; Syria; Egypt; Algeria; Oman; Iraq; Yemen; Lebanon; Palestine; Kuwait; Morocco; Jordan; Sudan; UAE; Tunisia; Pakistan. Among 8,538 undergraduate students aged between 18 and 25. Alansari found significant gender differences in 9 countries, females tended to report higher level of depression on BDI-II than males. Specifically in: Iraq; Syria; Egypt; Pakistan; Algeria; Oman; Qatar; Morocco; and Kuwait. However, males tended to be higher in depression scores than females in Saudi Arabia, and there were no significant differences in depression in Lebanon, Tunisia, Palestine, U.A. Emirates, Yemen, Jordan, and Sudan (Alansari, 2006).

Future studies may account for the contribution of the relevant cultural differences affecting men and women, as potential risk factors for depression as well (Hamdan, 2009). Based on Arabic and Islamic culture there are many relevant factors that may increase the chance of developing depression in women. Given that particularly in women severe stressful life events are established as significantly associated with depression (You & Conner, 2009), looking closely at the culture may give evidence of what kinds of stressful life events contribute to developing depression in women in this particular culture.

In Libya as in most Islamic countries, religion is seen as a strong cultural feature, and plays a crucial role in determining women's rights. During Jahiliya (the pre-Islamic period) 1400 years ago, women were treated like slaves and could be inherited as goods also; the practice of mistreating female children was uncontrolled; they were even denied the right to live. The birth of a daughter in a family was regarded with shame, fear of economic burdens and the humiliation frequently caused by girls being arrested by a hostile people. Moreover, in times of war, women were treated as part of the prize (Engineer, 1996). The killing of female new born, in the pre Islamic period, was a widespread practice, and the Koran has clearly described those people

"When the news of (the birth of) a female (child) is brought to any of them, his face becomes dark, and he is filled with inward grief! He hides himself from the people because of the evil of that whereof he has been informed. Shall he keep her with dishonor or bury her in the earth; Verily evil is their judgment? (An-Nahl, 16:58-59)

Despite the methodological biases and the limited research in the Arabic countries addressing women's conditions (Douki, Ben Zineb, Nacef, & Ghashem, 2007; Hamdan, 2009) some studies are available suggesting that specific cultural aspects may contribute to the risk to an Arab woman of developing major depressive disorder, regardless of the huge variation between those countries. These aspects may include marriage, family structure, treatment, abuse, and attitudes toward violence.

Cultural Risk Factors of Depression

The major aim for women in the Arabic culture is to get married; parents let their daughters be educated just enough to be good housewives and mothers. Thus, girls may withdraw from schools in very early ages (Douki et al., 2007). An arranged marriage remains common in many Islamic countries, and marriage is considered as a societal affair. In the Arabic world where the taboo of women's sexuality is still controlled (Douki et al, 2007) honour killing is still the only way for some families to clean the family name in front of society (WHO, 2000). And as a result illegitimate pregnancies are significantly associated with several social and psychological problems such as running from home and suicidal behaviour (Douki et al., 2007).

In terms of family structure, Haj-Yahia (2000) mentioned that despite women becoming stronger in terms of work outside the home and being financially more independent, Arabic families are still influenced by the patriarchal power structure that believes in inequality between men and women. The relationships between the sexes thus may reflect general patriarchal power relations (Haj-Yahia 2000), and considerable power is based on the men's position in the family; thus men have

power in relation to their wives, sisters, and daughters. From childhood, boys are expected to dominate and girls are supposed to be weak and passive. It is the commonly accepted role that women are caretakers, who should look after family members, particularly those who suffer from physical or mental illnesses, and women's health is lower in priority compared with the other family members (Douki et al 2007; WHO, 2000).

From birth, women receive an inferior position in Arabic culture and a lower standard of health care than men, because of the favouritism towards male children. This may be due in part to inability of women to transmit the family name (Douki et al., 2007). Women in the Arabic world have less chance of medical treatment and are less likely than men to have access to mental health services, and mentally ill women may not get the same benefits as men (Douki et al., 2007). Many studies have reported delays in care seeking among women, poor compliance and under-representation among psychiatric inpatients. In Libya, the majority of hospital population is male; women represented 38% of the 1009 patients admitted to a psychiatric hospital during a calendar year (Avasthi, Khan, & Elroey, 1991) and were 30% of the total inpatient population at the single psychiatric hospital in Tunisia. The authors suggested that women may be encouraged to seek traditional help (Avasthi et al., 1991). The other reason may be that women are more stigmatized than men, also stigma may damage women's marriage by being more likely to be separated or divorced, or for single women to reduce the likelihood of marriage (Al-Krenawi, 2000).

Beside the cultural aspects discussed above, violence against women is thought to be high but hidden in the Arabic context (Douki et al., 2007). Women are the main victims of domestic abuse, but this is hidden by police; law, and victims themselves, and reports of abuse may be ignored or misinterpreted by professionals (Douki et al., 2007). Furthermore, despite its increasing frequency, domestic abuse is not considered as a major issue. Relative to this, these issues are widely addressed and policies formulated to deal with them in the Western countries (Douki, 2003, Al-Nsour, Khawaja & Al-Kayyali, 2009).

Studies in Arabic countries have consistently highlighted a series of culture-related factors that may contribute to vulnerability to depression in women, and studies of women subjected to domestic violence during their marital life, studies are discussed below. A recent study in Jordan based on 356 participants, (Al-Nsour et al., 2009) found that intimate partner violence was prevalent, indeed 87% of women reported many kinds of abuse during the past year including emotional abuse, wife beating, and neglect. The most prevalent form of abuse was emotional abuse such as shouting insults at 47.5%. The next most prevalent was wife beating at 19.6%, then, neglect which was reported at 12.3%.

In addition, two studies have been conducted in West Bank and the Gaza Strip by Haj-Yahia (1999). In (1999) the first Palestinian National Survey was conducted, with a random sample of 2,410 women, indicating that Palestinian women during the 12 months prior to the study had experienced high levels of: psychological abuse (52% of the women indicated that their husbands had variably abused them); physical violence (23% of the women indicated that their husbands had pushed them, kicked or tried to knock them at least once); sexual abuse (37.6% of the Palestinian women reported that their husbands had sex with them without their consent); and economic abuse (about 45% of the they had been economically abused by their husbands on one or more occasions). The second Palestinian national survey on violence against women (Haj-Yahia, 2000) sampled 1,334 participants and the findings also referred to high levels of abuse by their husbands, at least once during the 12 months preceding the survey. Of these women 87.2% reported that they have been psychologically abused, 54% physically abused, 40% sexually abused, and 44% economically abused.

In view of perceptions and attitudes toward abuse of wives, cultural factors and religion play an important role in determining the rates of violence and attitudes towards its acceptability in the Arabic region (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003). Domestic violence can be interpreted as being influenced both by religion and by patriarchal ideologies. In Islamic countries, religion is used to rationalize this matter, even while women are being denied the rights that were given to them by God from Islamic perspective. It is not Islamic religion's ideology but rather the

misconception of the ideology in Islamic societies that leads to the oppression of women (Douki et al., 2003).

". . . He created mates for you from yourselves that you may find rest, peace of mind in them, and He ordained between you love and mercy. Lo, herein indeed are signs for people who reflect." (Koran 30:21).

According to Douki et al. (2003) in Arab societies, violence against women is considered as a private matter rather than criminal problem (Douki et al., 2003). These considerations make the wife suffer in silence, and keep the problem in secret. The wife may face social exclusion if she takes action to remove the violence and she may disapproved of by her community, because family stability is considered pre-eminent and the family comes first even at the expense of a wife's suffering (Douki et al., 2003; Haj-Yahia, 2000).

According to Haj-Yahia (2000) parents are supposed to maintain the family unit, and mothers especially are expected to ensure her children's stability so that the failure of the marriage is always the female's fault. The blood related family of a battered woman may provide some support but this is limited and for short time and conditional on the woman remaining loyal to her own family, and refraining from tarnishing the family's reputation. These women while receiving some support know they will be pressured to return to the husband, as the unity of the nuclear family is so important. The temporary family's support may reduce husband's violence, but the pressure to go back to her husband may increase the feeling of helplessness, lack of confidence, and weakness (Haj-Yahia, 2000). Furthermore, abused women are likely to lose the conditional support from her family if her husband convinced them that she does not meet the expectations as a wife and mother (Haj-Yahia, 2000). These societies lead individuals to sacrifice personal aspirations for the family welfare, reputation and honour (Haj-Yahia, 2000). And women are supposed to make accommodations in their relationships with men, which reflect excessive self-sacrifice (Haj-Yahia, 2003).

Studies that addressed perceptions and attitudes toward wives abuse include: Haj-Yahia, 2003; Al-Nsour, Khawaja & Al-Kayyali, 2009; Haj-Yahia, 2010**.** In a study by Haj-Yahia (2003), a considerable proportion of the Arab men justified wife beating, and furthermore blamed abused women for being victimized, and reported that the violent husband is not responsible for his behaviour (Haj-Yahia, 2003). In addition, men tend to blame the wife for provoking violence against her, 33% of the Arab men participating agreed that in most cases it is the wife's mistake for being abused, particularly, 43% of participants gave strong support for blaming the wife for being abused if she "treats her husband inappropriately" and 39% if she "takes care of her children inadequately" (Haj-Yahia 2003). Al-Nsour et al. (2009) also indicated that about a third of the women participants accept the use of violence from husbands against themselves, and justified wife beating as a means to discipline or punishment of the women. Among Palestinian physicians Haj-Yahia's study (2010) mentioned that considerable percentages of the Palestinian physicians believed that women are to blame for violence directed against her. Wife abuse could be justified as due to the wife's lack of belief in God, or to the wife's failure to understand her husband's life conditions, or lack of support for her husband. Some Palestinian physicians tend to justify wife abuse, *"because of the abnormal way they treat their husbands,"* These findings were interpreted by the author as reflecting the characterization of women in patriarchal contexts and to the sex role-stereotyped expectations of marriage in particular, where women are understood to be the source of anarchy and dishonesty (Haj-Yahia, 2010).

Studies in the Arabic context indicated that women with experiences of abuse are more likely to have depression than non-abused women (Haj Yahia, 1999; Haj Yahia, 2000). Haj Yahia (1999) examined wife abuse and its psychological consequences (distress, anger, and fear) as revealed by the first Palestinian National Survey on violence against women. The author found that the more Palestinian women experienced physical violence, sexual abuse, psychological abuse and economic abuse by their husbands, the greater their psychological distress. Also, battered women expressed higher level of anger than women who had not been abused by their husbands. In the second study, Haj Yahia (2000) examined the implications of wife abuse on self-esteem, depression, and anxiety as

revealed by the second Palestinian National Survey on violence against women. The result showed that, women's experiences with abuse significantly explained levels of depression, low self-esteem, and anxiety. In comparisons, women who were abused or beaten by their husbands revealed a higher level of depression. Also, regression analysis indicated that, the more women experienced physical violence, psychological abuse, physical violence, sexual abuse, and economic abuse the higher their level of depression (Haj Yahia, 2000).

To sum up, the specific risk factors for higher rates of depression in women than men in both the UK and Libya include hormonal changes; specific severe stressful events; and sensitivity to stress (Nolen-Hoeksema, 2001). Also, Arabic women may be at greater risk of developing depression, and under greater pressure because of many cultural factors (Haj Yahia, 1999; Haj Yahia, 2000; Haj-Yahia, 2003; Douki et al., 2003; Douki et al., 2007; Daradkeh, Ghubash, & Abou-Saleh, 2002). Also, women are more stigmatized than men, and have less chance of treatment (Douki et al., 2007).

Chapter 4

Study 1

The contents of this chapter are as follows: (a) Hypotheses. (b) Participants. (c) Procedure. (d) Measures. (e) Reliability of the scales of both samples. (f) Findings. (g) Discussion.

In this study I introduced the main hypotheses within Libyan sample. The primary objective of this study is to test the prediction that individualism, familism, social support, and self-esteem are significant negative predictors of depression; while collectivism is a significant positive predictor of depression. A further objective is to explore whether female and male groups differ on measures of depression, and whether this difference is because of variation in cultural values; social support; and self-esteem.

Libyan and British Samples

For both samples, I set out to use stratified sampling (in which a population is divided into a number of pre-determined sub-groups on the basis of existing groupings or strata, or according to some pre-determined design characteristic. According to McQueen and Knussen (2006, p. 94) “this is a useful development of simple random sampling in that it ensure that important sub-groups within the population are fairly represented”. The specified subsets were nationality, gender, age, ethnicity and (for the British sample) different religion. The Libyan sample is from a homogenous society not culturally or racially diverse, so I was just asking for Libyan citizens, female, male, aged 18 and over, and from different educational category. But I found difficulty collecting stratified data from a British sample, and as a result I gained small quantity so I actually used a snowball sampling method. For this reason it was not possible to obtain a British sample matched on demographic variables so the main data analysis will be applied to the Libyan sample.

ANCOVA Analysis

According to Howitt and Cramer (2008) analysis of covariance (ANCOVA) allows researchers to control for the effect of the covariates, so the remaining variation cannot be because of the covariates. One of the data conditions for ANCOVA is that these covariates should be correlated with dependent variables, and poorly correlated with each other. ANCOVA is an alternate form of ANOVA (Howitt & Cramer, 2008, p. 204-205). ANCOVA is suitable both for measuring to what extent the covariates can predict depression in each gender, and to what extent, that the level of depression is different for Libyan males and females after controlling of covariates. Regression can then be used to show the prediction of depression from the IVs for Libyan males and females separately. In the current study, some of IVs are continuous such as individualism; collectivism; familism; social support; and self-esteem, and one is categorical that is, gender. In ANCOVA I can achieve the aim of study and preserve data, with no need to force gender to be continuous (regression) or the other IVs to be categorical (ANOVA). Thus there is no need to reduce data and I can look at wide range of scores and separately to each category (Huitema, 1980).

Hypotheses

Psychological and somatic Differences in the Symptoms of Depression

Many authors have argued that psychological definitions and theories of depression including (DSM-IV) have only reflected Western culture (Good, & Kleinman, 1985; Fabrega, 1996; Triandis, 1996; Kleinman, 1977; Thakker, Ward, & Strongman, 1999; Dell & Diefenbach, 2008). Others maintain that major depressive disorder presents in some cultures in terms of somatic complaints, rather than psychological complaints, For instance, Chinese were more likely to report somatic symptom (Ryder et al., 2008; Parker, Cheah & Roy, 2001; Lu, Bond, Friedman, & Chan, 2010). 31% of the symptoms were explained by somatic distress scores in a Japanese sample, but in contrast, only 1% of the symptoms were explained by those scores in American sample (Arnault, Sakamoto & Moriwaki,

2006). The DSM-IV mentioned that Mediterranean cultures give emphases to somatic complaints rather than psychological complaints (DSM-IV, p. 324). Contrary to all the above demonstrations, Simon et al., (1999) concluded that the reporting of somatic symptoms of depression may reflect the characteristics of health care systems (pp. 39) and the study found that somatizations were a core component of depressive disorder found in all 14 of the (Western and non-Western) countries they studied. Also, Ryder et al., (2008) demonstrated that somatizations on depression disappeared when the sample used self-report scale. Due to the interest of the topic and the ongoing debates in the literature, it is proposed to assess the levels of reporting of somatic and psychological symptoms in a Libyan sample, and compare these with published data in other national groups using similar methods.

(H1) there is a significant difference between somatic and psychological symptoms in Libyan sample.

Cultural Values as Predictors of Depression

There is to date no full account of how cultural differences might give rise to differences in national rates of depression. One possible variable that has not previously been considered in this context is familism and no study has been found that examines familism as a cultural value and its relationship with depression. In many of the studies cited in the previous chapter, collectivism was more associated with depression than individualism. Therefore, I would expect cultural values such as familism and individualism / collectivism to play a significant role in determining vulnerability to depression. I predicted that

(H2) Individualism is a significant negative predictor of depression.

(H3) Collectivism is a significant positive predictor of depression.

(H4) Familism is a negative predictor of depression.

Social Support as Predictor of Depression

According to the Beck theory of depression (Beck & Alford, 2009; Beck et al, 1987) social support is an important factor in depression (pp. 52, 54). Negative expectations may play a significant

role in perception of social activities and preserved support and depressed people may automatically assume they will not enjoy their time with others, also that any relationship they make will end in failure (Beck & Alford, 2009). Studies have found that low levels of social support are associated with greater depression. Keitner and Miller (1990) found that supportive family functioning was associated significantly with recovery from major depression (pp.54). Nasser and Overholser (2005) found that support from family was significantly predictive of depression (Nasser & Overholser, 2005) As reviewed in the previous chapter, studies have found that low levels of social support are associated with greater depression. I hypothesise that (H5) Social support is a negative predictor of depression.

Self-esteem as Predictor of Depression

Low self-esteem is one of the components of Beck's cognitive triad, and consists of a negative view of self as unworthy (Beck & Alford, 2009, pp. 48) Individuals who score low on self-esteem are considered to be more vulnerable to depression, and because the activated internal structures that are relevant to depression refer exclusively to the concept of self (pp.48) the depressed person has tightly negative self-referent beliefs (Clark, et al., 1999, Beck, et al, 1987; Clark, et al., 1999; Beck & Alford, 2009). Studies give support to the view that negative self-esteem is implicated in vulnerability to depression. Thus, positive automatic self-evaluation was weaker in depressed individuals than non-depressed individuals in Scott (2006). Low self-esteem was associated with a greatly increased level of depression (Brown, Andrews, Harris, Adler, & Bridge, 1986). However, Luxton and Wenzlaff (2005) argued that it is not clear whether negative self-esteem is a cause or an effect of depression, these authors suggested that significant lower self-esteem is only found in dysphoric group. Findings from other studies showed positive automatic self-evaluation was weaker in depressed individuals than non-depressed individuals Scott (2006) pp. 00. Also, Orth, Robins, Trzesniewski, Maes, and Schmitt (2009) suggested that self-esteem is a risk factor for depression. Also, in Abe's (2004) study, self-esteem was the strongest predictor of distress in Japanese and American groups. Studies reviewed in

the previous chapter give support to the view that negative self-esteem may be implicated in vulnerability to depression:

(H6) Self-esteem is a negative predictor of depression.

Gender Differences in Depression

Many studies have recorded that females have higher rates of depression than males (Weissman et al., 1996; Angst et al., 2002; Winkler et al; 2004; Moskvina et al., 2008; Velde, Bracke, Levecque, & Meuleman, 2010). Reviews of the literature show some progress in understanding gender differences in terms of different risk factors that lead to depressive symptoms in males and females, and differences in symptoms, treatment, and help seeking.

Theories of gender typing have been used to explain social risk factors of depression in females (Bandura, 1977; Thyer, & Myers, 2006; Bussey & Bandura, 1999; Martin, Ruble, & Szkrybalo, 2002). Different cultural roles of women and men may explain gender differences in depression in each culture and gender differences across cultures. Also, ruminative coping styles may be responsible for the rising rate of depression in women Nolen-Hoeksema (1987). Gender differences can be explained also by such factors that put women in specific conditions such as more frequent stressful life events, sexual, physical, and psychological abuse, greater burdens, and negative circumstances (Golding, 1999; Haj-Yahia, 1999; Nolen-Hoeksema, 2001; Haj-Yahia, 2000; Douki, 2003; Haj-Yahia, 2003; Pico-Alfonso et al., 2006; Al-Nsour, Khawaja & Al-Kayyali, 2009; Al-Nsour, Khawaja & Al-Kayyali, 2009; Haj-Yahia, 2010).

Some risk factors perhaps are greater in the Arabic women, such as withdrawing girls from schools at very early ages, honour-related problems such as honour killing or violence, and suicidal behaviour (Douki et al., 2007). The influence of the patriarchal power structure (Haj-Yahia 2000) means that women have less chance of medical treatment, and are more stigmatized than men (Avasthi et al.,

1991; Al-Krenawi, 2000). Women lack job opportunities, and lack the freedom to express their feelings (Alansari, 2006). There is widespread hidden violence against women but this is not considered as a major issue (Douki et al., 2007; Douki et al., 2003). Therefore, from the literature reviewed earlier in this chapter, it could be argued that gender roles play an important role in contributing to depression, and women in Libya are expected to be higher in overall BDI-II score than men. I hypothesized that females would show higher overall depression scores than men.

(H7) females are significantly higher in depression than males in Libyan sample.

Gender Differences in the Symptoms of Depression

Another question is whether there are gender differences in the symptoms of depression. There are many studies regarding differences between males and females in the rates of major depressive disorder, though there is less data in regard to the differences in symptoms of depression in terms of gender**.** Differences have been found in fatigability, appetite gain, hypersomnia, phobia, hypersomnia, appetite loss, tearfulness, and loss of self-esteem, pathological guilt, morning depression, and loss of reactivity (Moskvina et al., 2008). Females also reported as twice as in feeling sad, depressed, down, and loss of interest/joy (Angst et al., 2002). Women were more liable to dysphoria, whereas men showed more affective rigidity, decreased libido, hypochondriasis, hypochondriac delusions, and compulsive impulses (Winkler et al., 2004).

On the basis of the evidence reviewed above and in the previous chapter, I predict there are differences in the symptoms of depression between men and women in both samples.

(H8) There are significant differences between women and men in the symptoms of depression in the Libyan sample

Methods

Participants

Participants were recruited by different methods in Libya and Britain. Because of structural differences in the Libyan and UK populations, matched samples would not be representative, and representative samples would not be matched. Because of the diverse and non-representative nature of the British sample which is not comparable with the more uniform Libyan sample they will not be used as a control sample for the Libyan data. However, to confirm the validity and reliability of the questionnaire scales, alpha reliability and construct validity data from the two samples will be presented.

British sample

The sample consisted of 83 participants all of whom identified themselves as British, and had been living in the UK for at least 5 years. They were all from London, and 57 (68.7%), were born in the UK, followed by 19 (22.9%) were living in the UK more than 10 years and 7 (8.4%) for 5 to 10 years; 41 (49.4%) were males, and 42 (50.6%) were females. Of these 83 participants, 49 (59.0%) were aged between 18 and 30; 22 (26.5%) were between 31 and 40; 7 (8.4%) were between 41 and 50; 4 (4.8%) were between 51 to 60; and 1 (1.2%) was over 60**.** Of the total British sample, 46.8% had acquired a high educational level, whereas 53.2% of them had a middle educational level; 11.4 % of the participants had a high socioeconomic level, 82.3% were in the middle level, and 6.3% were in the lower socioeconomic level. The majority of respondents were Muslim (46), 13 were Christian, and there was minor representation from other groups; 6 Hindu, 2 Buddhist, 12 Non-Believers, and 2 Unknown. Ethnic backgrounds were 43% Arabic, 33.7% White British, 14.5% Asian, 3.6% Black African and 1.2% Bosnian.

Table 3

British Sample

Residence	UK born: 57 (68%), Resident >10 years: 19 (22.9%), Resident 5-10 years: 7 (8.4%)
Gender	Males: 41(49.4%), Females: 42(50.6%)
Age	18-30: 49 (59.0%), 31-40: 22 (26.5%), 41-50: 7(8.4%), 51-60: 1(1.2%)
Education	High level: 46.8%, medium level: 53.2%,
Socioeconomic	High level: 11.4%, medium level: 82.3%, low level: 6.3%
Religion	Muslim: 46, Christian: 13, Hindu: 6, Buddhist: 2, Non-believer: 12; Unknown: 2
Ethnic background	Arabic: 43%, White British: 33.7%, Asian: 14.5%, African: 3.6%, Bosnian: 1.2%

Libyan Sample

In a sample of 169 participants, 77 (45.6%) were male and 92 (54.4%) were female. The majority, 109 (64.5%); of the Libyan sample were aged between 18 and 30: 44 (26%) were between 31and 40**:** 11 (6.5%) between 41 and 50; 1 (.6%) was between 51 and 60; and 1 (.6%) over 60: 2 ages were missing 1.2%**.** The majority of the total Libyan sample (62.7%) had acquired a high educational level, 31.4% of them had a middle educational level and 5.9% had a low educational level. 6.1% of the participants had a high socioeconomic level, 92.1% were in the middle level, and 1.8% were in the lower socioeconomic level**.** The entire Libyan sample is Muslim, born in Libya and had been living in Libya all their life, the whole sample was recruited from Tripoli, this is thus an urban population but is otherwise representative of the country as a whole because Libyan society is not culturally diverse.

Table 4

Libyan Sample

Residence	Libyan born (100%)
Gender	Males: 77 (45.6%), Females: 92 (54.4%)
Age	18-30: 109 (64.5%), 31-40: 44 (26.0%), 41-50: 11(6.5%), 51-60: 1(0.6%), >60: 1 (0.6%).
Education	High level: 62.7%, medium level: 31.4%, low level: 5.9%
Socioeconomic	High level: 6.1%, medium level: 92.1%, low level: 1.8%
Religion	Muslim: 100%
Ethnic background	Arabic: 100%,

Procedure

Ethical approval was obtained before starting collecting data (Appendix 1, pp. 209-218) English language instructions and materials were used for the British sample, and the Libyan sample responded to Arabic version of the questionnaires. For the Libyan sample, Arabic language instructions and materials were used. The question items, (English and Arabic versions) are shown in Appendix 2-11 (pp. 213 -227). All questionnaires used were self-administered, paper-and-pencil-type questionnaires. Each participant had to read and sign an informed consent form as shown in Appendix 12-13 (pp.228-231) before answering the questions. Clear instructions were written at the beginning of each questionnaire, giving some information about the current research. Oral explanations about the right to leave the study at any time, were given as well, and all participation was voluntary. For the British sample, participants who preferred to delay their response, were given a self-addressed stamped envelope, to post back the questionnaires to be collected by the investigator.

Libyan sample materials

Arabic versions of the scales were used to measure the variables of interest in the Libyan sample. For the Beck Depression Inventory (BDI-II) the Arabic version of Ghareeb (2000) was adopted to measure depression in the Libyan sample. For the rest of the scales, the first task was to translate these questionnaires from English to Arabic language. Translation and back translation was conducted in order to confirm accuracy and appropriateness of wording**,** the Individualism (IND), Collectivism (COL), and Familism (FAM) scales; the Multidimensional Scale of Perceived Social Support (MSPSS); and the Rosenberg Self-Esteem (RSE) scale questionnaires were translated by a bilingual doctoral student of English Literature. These questionnaires were then back translated into English by a bilingual proof reader in psychology. The back translation was conducted with no prior exposure to the English-language version of the questionnaires. Then, the questionnaires were modified based on the discussions among the principal investigator and translators. To avoid any limitation of the applicability of these versions of the scales, the final translations were in classic

Arabic, which can be used in other Arab countries with different dialects. The Arabic versions of the questionnaires are shown in Appendix 7-11 (pp. 221-225).

Validity and reliability of Measures used

Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996) was administered to assess depression; the 21-item BDI-II assesses aspects of depression that have occurred in the past 2 weeks. The BDI-II items assess the following symptoms: Sadness; Pessimism; Past failure; Loss of pleasure; Guilty feeling; Punishment feeling; Self-dislike; Self criticalness; Suicidal wishes; Crying; Agitation; Loss of interest; Indecisiveness; Worthless; Loss of energy; Change in sleeping pattern; Irritability; Changes in appetite; Concentration difficulty; Tiredness; and Loss of interest in sex. Each category is rated with four possible responses ranging from 0 normal to 3 severe and the total score can range between 0 and 63, higher scores being representative of more severe depression. Respondents are asked to indicate which statements best characterize the way they have been feeling during the past two weeks. The cut-off scores for the BDI suggested in the 1993 version are as follows: Scores of 0-9 are considered as "Minimal"; scores of 10-16 are described as mild depression; scores of 17-29 are referred to the moderate range, and scores of 30-63 indicate severe depression (Beck & Steer, 1993). The validity of BDI-II has been supported in Arabic samples (West, 1985; Abdel-Kalek, 1998; Al-Musawi, 2001; Alansari, 2005). The Arabic version of the BDI-II, developed by Ghareeb (2000) was therefore adopted for the Libyan sample. In the current study, the internal reliability of the scale was satisfactory, for both British and Libyan samples: Cronbach's alpha was .81 and .91 respectively. Following a principal axis factoring, inspection of the unrotated factor matrix shown in Table 5 and examination of the scree plot shown in Appendix 14-15 (pp. 218, 232) indicated that all of the items loaded positively and achieved loadings greater than .30 for British and .24 for Libyan samples. Therefore, the depression scale was shown to be valid both for British and Libyan samples.

Table 5

Factor Matrix of Depression Items for British and Libyan Samples

Item	Factor Loading For British Sample	Factor Loading For Libyan Sample
Sadness	**.75**	**.46**
Pessimism	**.72**	**.43**
Past Failure	**.61**	**.45**
Loss of Pleasure	**.57**	**.52**
Guilty Feeling	**.51**	**.42**
Punishment Feeling	**.54**	**.34**
Self-dislike	**.62**	.25
Self-Criticalness	**.45**	**.39**
Suicidal Wishes	**.31**	**.38**
Crying	**.52**	**.47**
Agitation	**.66**	**.36**
Loss of Interest	**.58**	**.29**
Indecisiveness	**.37**	**.48**
Worthless	**.37**	**.46**
Loss of energy	**.65**	**.51**
Change in sleeping pattern	**.68**	**.48**
Irritability	**.65**	**.34**
Changes in appetite	**.52**	**.42**
Concentration difficulty	**.66**	**.52**
Tiredness	**.69**	**.53**
Loss of interest in sex	**.58**	**.34**

The Individualism, Collectivism, and Familism Scales (Gaines et al., 1997) were used to obtain subjective reports of IND, COL and FAM. These scales consist of 10 items for each subscale. Each item is rated using a scale from 1 (strongly disagree) to 5 (strongly agree). Sample items for Individualism; collectivism; and familism are, respectively, "*I am the master of my own fate* "; "*I don't feel that I am a success unless I've helped other succeed as well* "; and "*When it comes to social responsibility, blood really is thicker than water*". Higher scores are representative of greater adherence to the relevant values. In the present study, Cronbach's alpha for the Individualism, Collectivism, and Familism Scale, for the British sample, was found to be .75; .75; .88 respectively. And for Libyan sample, alpha was found to be .57; .75; .86 respectively. The highest alphas were found for familism for both British and Libyan samples .88; and .86 respectively. Following principal axis factoring, inspection of the unrotated factor Matrix shown in Table 6 and examination of the scree plot shown in Appendix 16, 17(pp. 234 , 235) indicates that all of the items loaded positively and achieved loadings greater than .16 for the British and .14 for the Libyan sample. Therefore, the individualism scale was shown to be valid for the British and the Libyan sample.

Table 6

Factor Matrix of Individualism Items for British and Libyan Sample

Item	Factor Loading for British sample	Factor Loading for Libyan sample
I am not to blame for other's misfortunes.	**.**16	.15
I feel that I am the master of my own fate.	**.55**	**.25**
I really feel that " pull-yourself-up-by-bootstraps" philosophy makes a lot of sense	**.70**	**.33**
These days, the only person you can depend upon is yourself.	**.48**	**.36**
I take great pride in accomplishing what no one else can accomplish.	**.69**	**.53**
I actively resist other people's efforts to mould me.	**.41**	**.39**
Before I can feel comfortable with anyone else, I must feel comfortable with myself.	**.56**	**.31**
I place personal freedom above all other values.	**.44**	**.37**
I know myself better than anyone else possibly could know me.	.21	**.35**
I see nothing wrong with self-promotion.	**.67**	**.53**

Note. Loadings greater than or equal to .30 are shown in boldface

Collectivism

Following principal axis factoring, inspection of the unrotated factor matrix shown in Table 7 and examination of the scree plot shown in Appendix 18-19 (pp. 236, 237) indicates that all of the items loaded positively and achieved loadings greater than .21 for the British sample and .29 for the Libyan sample. Therefore, the collectivism scale was shown to be valid for the British and the Libyan sample.

Table 7

Factor Matrix of collectivism items for British and Libyan Samples

Item	Loading For British Sample	Loading For Libyan Sample
I don't feel that I am a success unless I've helped other succeed as well.	.21	**.37**
I want the opportunity to give back to my community.	**.59**	**.43**
I'm the type of person who lends a helping hand whenever possible.	**.60**	**.71**
I consider myself a team player.	**.37**	**.59**
My major mission in life is striving for social justice for all.	**.51**	**.56**
My heart reaches out to those who are less fortunate than myself.	**.65**	**.52**
If another person can learn from my mistakes, I'm willing to share my ups and downs with that person so that he or she can do better.	**.59**	**.66**
It feels great to know that others can count on me.	**.61**	.29
I have an important role to play in bringing together the people of the world.	**.36**	**.41**
I believe in the motto, "united We Stand, Divided We Fall."	**.46**	**.41**

Note. Loadings greater than or equal to .30 are shown in boldface

Familism

Following principal axis factoring, the unrotated factor Matrix shown in Table 8 and examination of the scree plot shown in Appendix 20, 21 (pp. 238 , 239) indicates that all of the items loaded positively and achieved loadings greater than .43 for the British, and .35 for the Libyan sample. Therefore, the familism scale was shown to be valid for British and Libyan sample.

Table 8

Factor Matrix of Familism Items for British and Libyan Samples

Item	Loading for British Sample	Loading for Libyan Sample
When it comes to social responsibility, blood really is thicker than water.	**.43**	**.36**
My family always is there for me in times of need.	**.72**	**.59**
I owe it to my parents to do well in life.	**.68**	**.69**
I know that my family has my best interests in mind.	**.68**	**.77**
I cherish the time that I spend with relatives.	**.65**	**.55**
I will do all that I can to keep alive the traditions passed on to me by my parents and grandparents.	**.58**	**.43**
Even when I'm far away from home, my family ties keep me feeling safe and secure.	**.73**	**.72**
To this day, my parents' teachings serve as my best guide to behaviour.	**.74**	**.74**
In my opinion, the family is the most important social institution of all.	**.72**	**.67**
I cannot imagine what I would do without my family.	**.66**	**.69**

Note. Loadings greater than or equal to .30 are shown in boldface

The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988) is a brief measure that was used to obtain subjective reports of social support. 12 items were selected to reflect support from family, friends, and significant others. A typical item is "There is a special person who is around when I am in need". Each item is rated using a scale from 1 (strongly disagree) to 5 (strongly agree). In current study this scale has shown good reliability, and Cronbach's alpha of the total scale in British and Libyan sample was .93; and .69 respectively. Inspection of the unrotated factor matrix shown in Table 9 and examination of the scree plot shown in Appendix 22, 23 (pp. 240, 241) indicates that all of the items loaded positively and achieved loadings greater than .56 for the British and .17 for the Libyan sample. Therefore, the social support scale was shown to be valid for British and Libyan sample.

Table 9

Factor Matrix of Social Support Items for British and Libyan Samples

Item	Loading for British sample	Loading for Libyan sample
There is a special person who is around when I am in need.	**.77**	**.58**
There is a special person with whom I can share my joys and sorrows.	**.85**	**.**17
My family really tries to help me.	**.72**	**.47**
I get the emotional help and support I need from my family.	**.76**	**.50**
I have a special person who is real source of comfort to me.	**.81**	**.68**
My friends really try to help me.	**.71**	**.76**
I can count on my friends when things go wrong.	**.73**	**.73**
I can talk about my problems with my family.	**.63**	**.48**
I have friends with whom I can share my joys and sorrows.	**.79**	**.74**
There is a special person in my life who cares about my feelings.	**.78**	**.56**
My family is willing to help me make decisions.	**.56**	**.60**
I can talk about my problems with my friends.	**.76**	**.59**

The Rosenberg Self-Esteem scale (RSE, Rosenberg, 1965). This scale consists of 10 items; some of these items assess positive self-esteem: “On the whole I am satisfied with myself”, “I feel that I have a number of good qualities”, “I am able to do things as well as most other people”, “I feel that I’m a person of worth at least on an equal plane with others”, “I take a positive attitude toward myself”, and others assess negative self-esteem: “At times I think I am no good at all”, “I feel I do not have much to be proud of”, “I certainly feel useless at times”, “I wish I could have more respect for myself”, “All in all I am inclined to feel that I am a failure”. Each item is typically administered using a Likert-type response format, from 1 (strongly disagree) to 4 (strongly agree) and it can be administered in a few minutes (Rosenberg, 1965). In the current study, Items are scored from 4 to 1 for items assessing positive self-esteem, and from 1 to 4 for items assessing negative self-esteem. High scores thus indicate high self-esteem. In the present study, Cronbach’s alphas for the self-esteem scale for British and Libyan samples were.84; and .47 respectively, which is not adequate for the Libyan sample.

Inspection of the unrotated factor Matrix shown in table v-ii and examination of the scree plot shown in Appendix 24, 25 (pp. 242, 243) indicates that all of the items loaded positively and achieved loadings greater than .50 for the British and .22 for the Libyan sample, except item 3 which has an exceptionally low loading (-.068): *I feel that I have a number of good qualities*. After excluding item 3 from both samples, Cronbach α for British and Libyan samples was respectively .77 and .73. Therefore, this item has to be excluded from both samples.

Table 10

Factor Matrix of Self-esteem Items for British and Libyan Samples

Item	Loading for British sample	Loading for Libyan sample
On the whole, I am satisfied with myself.	**.67**	**.49**
At times, I think I am no good at all.	**.55**	**.59**
I feel that I have a number of good qualities.	**.62**	-.07
I am able to do things as well as most other people.	**.53**	**.49**
I feel I do not have much to be proud of.	**.50**	**.45**
I certainly feel useless at times.	**.59**	**.68**
I feel that I'm a person of worth, at least on an equal plane with others.	**.55**	**.40**
I wish I could have more respect for myself.	**.62**	.23
All in all, I am inclined to feel that I am a failure.	**.59**	**.63**
I take a positive attitude toward myself.	**.69**	**.51**

Note. Loadings greater than or equal to .30 are shown in boldface

Although self-esteem was shown to be sufficiently reliable for the British sample, item 3 was excluded for both samples as its alpha reliability was not sufficient for the Libyan sample. Inspection of the unrotated factor Matrix shown in table 11 and examination of the scree plot shown in Appendix 26, 27 (pp. 244, 245) indicates that all of the items loaded positively and achieved loadings greater than .51 for the British sample and .22 for the Libyan sample. Therefore, the revised self-esteem scale was shown to be valid for British and Libyan sample.

Table 11

Factor Matrix of Self-esteem Items for British and Libyan Samples after Excluding Item 3

Item	Loading For British Sample	Loading For Libyan Sample
On the whole, I am satisfied with myself.	**.69**	**.49**
At times, I think I am no good at all.	**.62**	**.59**
I am able to do things as well as most other people.	**.44**	**.49**
I feel I do not have much to be proud of.	**.51**	**.44**
I certainly feel useless at times.	**.65**	**.67**
I feel that I'm a person of worth, at least on an equal plane with others.	**.47**	**.40**
I wish I could have more respect for myself.	**.62**	.22
All in all, I am inclined to feel that I am a failure.	**.61**	**.63**
I take a positive attitude toward myself.	**.67**	**.51**

Note. Loadings greater than or equal to .30 are shown in boldface

Exploratory Factor Analysis

To assess construct validity, principal axis factor analysis using the unrotated factor matrix method was used on all items of each scale used in this study, Examination of the scree plot of eigenvalues revealed in each scale that the curve levelled off after one factor, so that one factor was sufficient to account for substantial variance across both cultures, and that correlations of factor 1 with scale items were substantial and positive, confirming validity of all scales for both samples (see Table 12) . The only exception was for item 3 in the self-esteem scale which was excluded from both samples because it was not correlated positively with Factor 1 for the Libyan sample.

Table 12

Factor Analysis for Substantial Variances Across Libyan and British Samples

	British sample		Libyan sample	
Scale	Eigenvalue Factor 1.	% Variance Explained	Eigenvalue Factor 1.	% Variance Explained
Depression	7.766	36.979	4.639	22.091
Individualism	3.344	33.439	2.209	22.086
Collectivism	3.319	33.186	3.291	32.909
Familism	4.948	49.484	4.571	45.712
Social Support	7.082	59.019	4.783	39.856
Self esteem	4.168	41.68%	3.070	33.76

Results

The main purpose of this chapter is to examine and report the tests of the hypotheses. First, differences were tested between Libyan males and females on all scales, that is, depression; individualism; collectivism; familism; social support and self-esteem. Second, correlational analyses are reported for the Libyan sample. Third, the prediction of depression scores from gender, individualism; collectivism; familism; social support; and self-esteem were examined in an ANCOVA model (H2, H3, H4, H5, and H6). And finally, the differences in the symptoms of depression in regard to gender were tested in the Libyan sample (H8).

Tests of differences between males and females in the Libyan sample

Depression

The following analysis tests hypotheses concerning the influence of gender on Libyan sample on depression. First, for the depression variable, the BDI-II score was examined using univariate analysis of variance (ANOVA) with Libyan males and females. The independent variable was gender and the dependent variable was the overall score of the BDI-II scale. Descriptive statistics including mean and standard deviations of the BDI-II are shown in Table 13. There was a significant effect of gender on depression, $F(1, 203) = 12.4$, $p<0.001$. Libyan females reported much more depression than Libyan males. According to BDI norms, of the females, 12 (16%) had scores indicating minimal depression, 30 (40%) mild depression, 30 (40%) were moderately depressed, and 3 (4%) of this non-clinical sample were classified as severely depressed. Of the males, the BDI scores of 20 (33.9%) indicated minimal depression, 27 (45.8%) were mildly depressed, 10 (16.9%) were moderately depressed, and 2 (3%) scored in the severely depressed range. This supports hypothesis [7], that Libyan females have significantly higher depression scores than Libyan males.

Table 13

Depression by Gender in Libyan Sample

Sex	Mean	Std. Deviation	N
Male	11.53	7.83	59
Female	16.04	7.33	75
Total	14.05	7.86	134

Individualism

To examine the differences between Libyan males and females on overall scores in individualism, ANOVA is carried out, with individualism as dependent variable and gender as independent variable. The descriptive statistics are summarized in Table 15, no significant difference was found between males and females, $F(1, 223) = .001$; $p = .978$.

Table 14

Individualism by Gender in Libyan Sample

Sex	Mean	Std. Deviation	N
Male	39.07	4.15	70
Female	37.57	4.99	84
Total	38.25	4.68	154

Collectivism

Collectivism scores were compared between Libyan males and females. Gender emerged with a significant effect $F(1,228) = 4.694$, $p < .05$, females scored higher than males. The descriptive statistics are shown in Table 15.

Table 15

Collectivism Scores by Gender in the Libyan Sample

Sex	Mean	Std. Deviation	N
Male	38.44	5.13	71
Female	39.54	4.39	83
Total	39.03	4.76	154

Familism

In ANOVA there was a significant effect of gender on familism, $F(1,227) = 15.348$. $p < .0001$. Libyan females reported more familism than Libyan males. The descriptive statistics are shown in Table 16.

Table 16

Familism Scores by Gender in the Libyan Sample

Sex	Mean	Std. Deviation	N
Male	40.94	6.16	67
Female	43.01	4.99	83
Total	42.09	5.62	150

Social Support

Social support scores were compared between Libyan males and females. The differences were not significant. The descriptive statistics are summarized in Table 17.

Table 17

Social Support Scores by Gender among Libyan Sample

Sex	Mean	Std. Deviation	N
Male	65.76	14.39	71
Female	66.29	10.68	81
Total	66.05	12.51	152

Self-esteem

Descriptive statistics including mean and standard deviations of the self-esteem measure are shown in Tables 18. ANOVA showed there were no significant differences in self-esteem between Libyan males and females, $F(1,222) = .683$, $p = .409$.

Table 18

Self-esteem by Gender in the Libyan Sample

Sex	Mean	Std. Deviation	N
Male	27.53	3.55	68
Female	28.57	3.98	84
Total	28.11	3.82	152

Correlational analysis

In order to investigate hypothesis 1, bivariate correlations between all pairs of variables were considered (Pearson *r*). The correlations for the Libyan sample are presented in Table, 19. Correlational analysis for the Libyan sample shows that individualism, ($p< .05$) social support ($p< .05$) and self-esteem ($p< .01$) were each significantly negatively correlated with depression. This indicates support for hypothesis [2]; individualism is a negative predictor of depression, hypothesis [5]: social support is a negative predictor of depression, and hypothesis [6]; self-esteem is a negative predictor of depression. Additionally, Individualism was significantly correlated with collectivism, $p< .05$; and self-esteem, $p< .05$. Collectivism was significantly correlated with individualism and social support at $p< .05$; and familism and self-esteem $p< .01$. Familism was significantly positively correlated with collectivism, social support, and self-esteem, all at $p< .01$. Social support was significantly negatively correlated with depression $p< .05$, and significantly positively correlated with collectivism familism and social support all at $p< .01$. Self-esteem is negatively correlated with depression $p< .01$; and positively correlated with individualism and familism, at $p< .05$, and collectivism, and social support all at $p< .01$.

Table 19

Bivariate Pearson Correlations amongst Variables Studied for the Libyan Sample

** p<0.05 ** p<0.01*

	Depression	Individualism	Collectivism	Familism	Social support	Self-esteem
Depression	1	-.202*	-.023	.091	-.213*	-.291**
Individualism	-.202*	1	.234*	.128	.121	.242*
Collectivism	-.023	.234*	1	.362**	.342**	.303**
Familism	.091	.128	.362**	1	.402**	.194*
Social support	-.213*	.121	.342**	.402**	1	.272**
Self-esteem	-.291**	.242*	.303**	.194*	.272**	1

ANCOVA Analysis

In this step, I tested to what extent, that the level of depression is different for male and females in the Libyan sample after controlling of covariates. One way ANCOVA analysis was carried out with depression as the dependent variable, sex as a fixed factor, and individualism, collectivism, familism, social support and self-esteem as covariates. The ANCOVA allows us to test a model into which all the predictors are entered simultaneously. Sex continued to have an effect on depression after controlling for all covariates, $F(1,96) = 10.243$, $p<0.005$. Of the covariates, the only one having a significant effect on the dependent variable in the ANCOVA model was self-esteem, $F\ (1, 96) =8.279$, $p<0.005$.

It was expected that self-esteem would be a significant negative predictor of depression (hypothesis [6]), and this was confirmed. It was expected that collectivism would be a positive predictor of depression, but, neither individualism nor collectivism emerged as a significant predictor for depression. Also, social support did not emerge to be a predictor of depression in the ANCOVA model. Table 21 shows the ANCOVA analysis for predicting depression in Libyan sample.

Table 20

The Means of Depression for Libyan Samples

sex	Mean	Std. Deviation
Male	10.41	8.13
Female	16.02	7.73
Total	13.51	8.36

Table 21

ANCOVA Analysis for Predicting DV from IVs, With Gender as Fixed Factor in Libya

Dependent Variable: Depression

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	1699.009[a]	6	283.168	5.01	.000
Intercept	638.047	1	638.047	11.29	.001
Selfest2	467.680	1	467.680	8.27	.005
Individualism	105.417	1	105.417	1.86	.175
Collectivism	17.105	1	17.105	.30	.583
Familism	72.516	1	72.516	1.28	.260
Social support	135.580	1	135.580	2.40	.125
Sex	578.611	1	578.611	10.24	.002
Error	5422.719	96	56.487		
Total	25934.000	103			
Corrected Total	7121.728	102			

Self-esteem and sex emerged as significant factors in depression. The ANCOVA shows the same mean score for depression in Libyan sample even after all the measured scales are partialled out. Even after controlling IVs the adjusted mean value of depression scale is substantially unchanged from the unadjusted value. The unadjusted and adjusted means on depression in Libyan sample reported in Table 22.

Table 22

The Unadjusted Means and Adjusted Means of Depression for Libyan Samples

Mean	Std. Deviation	N	
13.676	8.413	105	
Mean	Std. Error	95% Confidence Interval	
		Lower Bound	Upper Bound
13.545	.697	12.169	14.921

Emerging from the ANCOVA model, we have one demographic predictor of depression (gender) and one personality score predictor of depression (self-esteem). The demographic and personality score predictors are independent, as shown by ANCOVA.

MANOVA Analysis of BDI-II items and subscales

The next data analysis assessed the differences in the scores for different symptoms of depression in the Libyan sample and investigated whether gender differences influence the experience and expression of depression in terms of symptoms, and furthermore whether Libyan sample report more somatic symptoms than psychological symptoms, also, whether the females in the Libyan sample emphasized more somatic symptoms than the males. The BDI-II was analysed at item level using multivariate analysis of variance (MANOVA). The independent variable was gender, and the dependent variables were items of the BDI-II scale. Self-esteem was entered as a covariate. In regard to the psychological symptoms, the mean score ranged from self-criticalness (M=1.13) to suicide wishes (M=0.07), while somatic symptoms ranged from changing in sleeping pattern (M= 0.81) to agitation (M= 0.47).The female sample reported higher scores across all of the symptoms of depression. Descriptive statistics including mean and standard deviations of the BDI-II item scores are shown in Table 24. It can be seen that female scores were higher than male scores on every item. Multivariate tests (Pillai's trace) confirmed that the effects of sex, $F(21, 166) = 1.819$, $p<.05$; and self-esteem, $F(21,166) = 3.144$, $p<.0005$ were significant in the overall model. Significant differences were found between males and females for: sadness; guilty feeling; crying; indecisiveness; worthless; suicide wishes; concentration difficulty; and loss of interest in sex at $p< .01$.and for: Past failure; self-critical; and tiredness at $p< .05$. In general, the study found that the females reported both more psychological and more somatic symptoms on the BDI-II questionnaire as compared with the male sample. Thus hypothesis [8] was confirmed in that significant gender difference arose on specific items, but no gender difference in somatization was found. Note also, that self-esteem accounts for significant differences on many BDI-II items, but that there were no significant gender differences in self-esteem.

Table 23

MANOVA Analysis of BDI-II Items and Subscales of Libyan Male and Female Samples

	Sex	Mean	Std. Deviation
Sadness	Male	.34	.60
	Female	.59	.51
	Total	.48	.57
Pessimism	Male	.34	.69
	Female	.51	.78
	Total	.43	.75
Past failure	Male	.17	.46
	Female	.33	.65
	Total	.25	.57
Loss of pleasure	Male	.61	.72
	Female	.73	.85
	Total	.68	.79
Guilty feeling	Male	.66	.71
	Female	.93	.62
	Total	.80	.67
Punishment feeling	Male	.55	.71
	Female	.85	.97
	Total	.71	.87
Self-dislike	Male	.15	.52
	Female	.22	.48
	Total	.18	.49

Self-criticalness	Male	.92	1.16
	Female	1.32	1.09
	Total	1.13	1.14
Suicide wishes	Male	.02	.15
	Female	.12	.33
	Total	.07	.26
Crying	Male	.62	1.18
	Female	1.18	1.28
	Total	.92	1.26
Agitation	Male	.41	.78
	Female	.52	.84
	Total	.47	.82
Loss of interest	Male	.51	.82
	Female	.62	.89
	Total	.57	.86
Indecisiveness	Male	.49	.77
	Female	.84	.94
	Total	.68	.88
Worthless	Male	.17	.43
	Female	.33	.63
	Total	.25	.55
Psychological	Male	.39	
	Female	.65	
Loss of energy	Male	.58	.62
	Female	.68	.76
	Total	.63	.69

Sleeping pattern	Male	.74	.84
	Female	.88	.82
	Total	.81	.83
Irritability	Male	.39	.65
	Female	.59	.76
	Total	.49	.72
Changes in appetite	Male	.68	.81
	Female	.89	.93
	Total	.79	.88
Concentration difficulty	Male	.48	.71
	Female	.77	.77
	Total	.63	.76
Tiredness	Male	.63	.76
	Female	.87	.97
	Total	.76	.88
Loss of interest in sex	Male	.15	.54
	Female	.41	.79
	Total	.29	.69
Somatic	Male	.50	
	Female	.72	

Table 24

Tests of Between-Subjects Effects

$p_{crit} = 0.05/22 = 0.00227$. * Significant at $p < .05$, Bonferroni-corrected.

Source	Dependent Variable	Type III Sum of Squares	Mean Square	F	Sig.
Corrected Model	Sadness	3.53	1.76	5.70	0.004
	Pessimism	4.82	2.41	4.50	0.012
	Past failure	3.59	1.79	5.74	0.004
	Loss of pleasure	2.42	1.21	1.96	0.144
	Guilty feeling	3.81	1.90	4.33	0.014
	Punishment feeling	10.42	5.21	7.31*	0.001
	Self-dislike	4.16	2.08	9.14*	0.000
	Self criticalness	8.02	4.01	3.16	0.044
	Suicide wishes	1.35	.67	10.84*	0.000
	Crying	19.44	9.72	6.49*	0.002
	agitation	1.78	.89	1.34	0.263
	Loss of interest	6.07	3.03	4.27	0.015
	Indecisiveness	14.81	7.40	10.55*	0.000
	Worthless	7.72	3.86	14.34*	0.000
	Loss of energy	3.26	1.63	3.42	0.035
	Sleeping pattern	6.60	3.30	5.03	0.007
	Irritability	4.53	2.26	4.54	0.012
	Changes in appetite	2.79	1.39	1.82	0.164
	Concentration difficulty	10.27	5.14	9.80*	0.000
	Tiredness	7.05	3.52	4.69	0.010
	Loss of interest in sex	5.22	2.61	5.66	0.004
Intercept	Sadness	3.59	3.59	11.61	0.001
	Pessimism	8.41	8.41	15.70	0.000
	Past failure	4.70	4.70	15.02	0.000
	Loss of pleasure	9.08	9.08	14.70	0.000
	Guilty feeling	6.77	6.76	15.36	0.000
	Punishment feeling	17.53	17.52	24.59	0.000
	Self-dislike	5.83	5.82	25.58	0.000
	Self-critical	13.15	13.14	10.37	0.002
	Suicide wishes	1.26	1.26	20.18	0.000

	Crying	20.26	20.25	13.53	0.000
	Agitation	5.03	5.03	7.58	0.006
	Loss interest	14.007	14.00	19.70	0.000
	Indecisiveness	21.46	21.45	30.58	0.000
	Worthless	9.94	9.93	36.90	0.000
	Loss of energy	10.46	10.47	22.00	0.000
	Sleeping pattern	19.31	19.31	29.46	0.000
	Irritability	7.85	7.84	15.74	0.000
	Changes in appetite	8.07	8.07	10.55	0.001
	Concentration-Difficulty	16.26	16.26	31.01	0.000
	Tiredness	15.34	15.34	20.41	0.000
	Loss of interest in sex	4.20	4.20	9.11	0.003
Selfest	Sadness	0.52	0.52	1.67	0.197
	Pessimism	3.40	3.40	6.35	0.013
	Past failure	2.44	2.44	7.81	0.006
	Loss of pleasure	1.75	1.75	2.84	0.094
	Guilty feeling	0.34	0.34	0.79	0.375
	Punishment feeling	6.01	6.01	8.44	0.004
	Self-dislike	3.93	3.93	17.27*	0.000
	Self-critical	0.63	0.63	0.49	0.481
	Suicide wishes	0.92	0.92	14.74*	0.000
	Crying	5.04	5.04	3.37	0.068
	Agitation	1.15	1.15	1.74	0.189
	Loss interest	5.48	5.47	7.70	0.006
	Indecisiveness	8.96	8.95	12.76*	0.000
	Worthless	6.58	6.57	24.43*	0.000
	Loss of energy	2.76	2.75	5.79	0.017
	Sleeping pattern	5.65	5.64	8.61	0.004
	Irritability	2.50	2.50	5.02	0.026
	Changes in appetite	0.73	0.73	0.95	0.329
	Concentration-Difficulty	6.19	6.18	11.79*	0.001
	Tiredness	4.20	4.20	5.59	0.019
	Loss of interest in sex	1.84	1.84	3.99	0.047
Sex	Sadness	3.23	3.22	10.41*	0.001
	Pessimism	1.85	1.85	3.45	0.065
	Past failure	1.47	1.47	4.70	0.031
	Loss of pleasure	0.88	0.87	1.42	0.235
	Guilty feeling	3.65	3.64	8.27	0.004
	Punishment feeling	5.38	5.37	7.54	0.007

	Self dislike	0.44	0.44	1.93	0.166
	Self-critical	7.73	7.73	6.10	0.014
	Suicide wishes	0.56	0.55	8.91	0.003
	Crying	15.89	15.89	10.62*	0.001
	Agitation	0.79	0.79	1.19	0.276
	Loss interest	0.97	0.97	1.36	0.244
	Indecisiveness	7.23	7.23	10.31*	0.002
	Worthless	1.71	1.70	6.34	0.013
	Loss of energy	0.74	0.74	1.56	0.213
	Sleeping pattern	1.43	1.42	2.18	0.141
	Irritability	2.45	2.45	4.92	0.028
	Changes in appetite	2.28	2.27	2.97	0.086
	Concentration-difficulty	5.05	5.04	9.62*	0.002
	Tiredness	3.51	3.50	4.67	0.032
	Loss of interest in sex	3.83	3.83	8.30	0.004

The items that were significantly accounted for by both sex and self-esteem (separately) were indecisiveness and concentration difficulties. The items that were significantly accounted for by sex alone were sadness and crying. For these items females scored higher than males. The items that were significantly accounted for by self-esteem alone were suicide wishes and worthlessness.

In the original BDI, items 1-14 are counted as psychological, and items 15-21 as somatic (Thombs, et al., 2010). However, this does not necessarily apply for BDI-II. To assess whether, in a Libyan sample, there was a greater tendency to self-report somatic as compared with cognitive symptoms, items within the BDI-II were assigned to cognitive and somatic subscales. BDI-II items were therefore classified according to a recommendation by Vanheule, Desmet, Groenvynck, Rosseel, & Fontaine (2006). This was based on confirmatory factor analysis in which Venheule, et al. compared 10 alternative factor models for BDI-II on a sample of 404 clinical and 695 nonclinical Dutch adults. The best-fitting model, that of Buckley, Parker and Heggie (2001), had unidimensional subscales which assess a somatic, an affective, and a cognitive dimension. The six items in their study which loaded on the cognitive factor were Item 2: pessimism; Item 3: past failure; Item 6: punishment feelings; Item 8: self-criticalness; Item 9: suicidal thoughts; and Item 14: worthlessness. The six items loading on the somatic factor were: Item 16: changes in sleeping pattern, Item 17: irritability; Item 18: changes in appetite; Item 19: concentration difficulty; Item 20: tiredness or fatigue; and item 21: loss of interest in sex.

Mean scores were therefore calculated for these two sets of six items for the Libyan sample, and entered as a within-participant factor, subscale (cognitive, somatic), into a 2 x 2 mixed ANOVA, with gender (male, female) as the between participant variable.

Results confirmed a significant main effect of gender, as was found with the overall BDI-II score, $F(1,167) = 15.51$, $p < .0005$, with females scoring higher than males (males $M = .483$, females $M = .753$). Also, there was a significant main effect of subscale, $F(1,167) = 10.5$, $p < .005$, with scores on

the somatic items higher than scores on the cognitive items (somatic M = .698, cognitive M = .577). The Subscale x Gender interaction was non-significant, $F(1,167) = 1.3$, *n.s.*

These results give support to hypothesis [1] that somatic symptoms are more pronounced than cognitive symptoms in a nonclinical Libyan sample, and suggest a way in which BDI-II can be used to assess somatization. There was no significant subscale x gender interaction, therefore no significant difference in the tendency of males and females to somatise.

Discussion

Summary and discussion of the study

The present study examined a number of psychological and demographic predictors thought likely to contribute to depression among a Libyan non-clinical sample. The covariates tested were personal and demographic: individualism; collectivism; familism; social support, self-esteem, and gender. These covariates have been statistically taken into account in ANCOVA analysis, which has shown that the differences between the depression scores of males and females in the Libyan sample are independent of the covariates. The single covariate that was a significant predictor of depression was self-esteem.

Comparisons have been made to determine whether the current result of the overall mean of the BDI-II scale for the Libyan sample is statistically different from the mean data that has been published for a wide range of other countries. In the present study, the Libyan sample showed similar scores to a Turkish sample on the BDI-II (Canel-Çınarbas et al., 2011) and obtained a mean score of the BDI-II higher than the scores obtained on American samples by Beck et al. (1996); and in the UK by Hill et al (1986), Nuevo et al (2009), and Veerman et al., (2009). Current findings also contradict the claim of Colla, Buka, Harrington and Murphy (2006) that depression is higher in modern societies than traditional societies.

Considering the scores on the BDI-II in Arabic studies, findings in the present study were within the range reported by Al-Musawi (2001), and Alansari (2004) in non-clinical samples. However, the present Libyan sample scored lower than the score reported by West (1985) in a Saudi Arabian clinical sample (see table 25).

Gender differences in the overall BDI and the item-level symptoms of depression were investigated in the current study. As expected gender was found to be a predictor of depression in the current study, being female was a predictor of depression. This finding has been reported in many countries (Weissman et al., 1996; DSM.IV.TR, 2000; WHO, 2001; Daradkeh, et al, 2002; Angst et al, 2002; Winkler et al; 2004; Alansari, 2006; Stepoe et al, 2007; Hamdan, 2009; Moskvina et al., 2008; Velde, et al, 2010) and the current study extends this conclusion to Libyan females.

The present findings also suggest that Libyan females report higher levels of depression compared with American and Japanese female samples (Arnault, Sakamoto, & Moriwaki, 2006). The difference between Libyan and American females is substantial: Libyan females' scores were double those from a study of American females (Arnault et al., 2006). Also, Libyan males and females reported more depression than British males and females in Veerman, Dowrick, Ayuso-Mateos, Dunn, & Barendregt (2009). However, Libyan females and males reported lower BDI score than Pakistani sample (Alansari, 2006).

Table 25 compares the present study with the Arabic samples of (Alansari, 2006). In regard to both the national and gender differences. Libyan females reported lower BDI score than all females from the Arabic countries, but higher than all the Arabic males. The BDI score was similar for Libyan males, Moroccan, and Yemeni males. Libyan males reported slightly higher scores than males from Kuwait; Saudi Arabia; Qatar; Lebanon; and Sudan, and slightly lower BDI scores than males from Algeria, Oman, and Jordan. But the males from Iraq, Syria, Egypt, and Tunisia were much more depressed than Libyan males (see table 25). Note that the present study had a broader sample in demographic terms than the student samples of Alansari (2006).

Table 25

The Mean and Standard Division in Libyan, Arabic, and UK Samples

Study	Country	Sample	BDI score males (mean, SD)	BDI score females (mean, SD)	BDI score (mean, SD)
Hill, Kemp-Wheeler, and Jones. 2006	UK	Students			M=6.81 (SD, 5.52)
		Patients			M=21.57 (SD= 8.39)
Veerman et al. 2009	UK				M=10.7
Nuevo et al. 2009	UK				M=8.30 (*SD*= 8.30)
West, 1985	Saudi Arabia	Out-patients			M=25.24 (SD=14.163)
Ghareeb (2000)	Egypt	Students	M=20.2 SD=8.56	M=18.79 SD=7.84	
Ghareeb (2000)	Egypt	Patients	M=22.58 SD=13.04	M=25.13 SD=46.27	
Al-Musawi (2001)	Bahrain	Students			M= 13.44 SD= 6.74
Alansari.2006	Kuwait	Students Smokers-non-smokers			Smokers M=15.85 SD=11.75

				Non-smokers M=14.70 SD=11.95
Alansari.2004	Kuwait	Students	M=14.44 SD=10.45	M=15.12 SD=9.42
Alansari, 2006	Iraq	students	M=15.4 *SD*= 9.37	M=20.2 *SD*= 10.68
	Syria	Students	M=21.6 *SD*= 10.3	M=27.4 *SD*= 8.43
	Saudi Arabia	Students	M=18.1 *SD*= 11.4	M=14.2 *SD*= 10.1
	Egypt	Students	M=16.8 *SD*= 9.09	M=19.7 *SD*= 9.12
	Algeria	Students	M=14.2 *SD*= 8.20	M=17.5 *SD*= 8.76
	Oman	Students	M=14.3 *SD*= 14.3	M=18.3 *SD*=.963
	Morocco	Students	M=14.0 *SD*= 9.17	M=16.0 *SD*= 10.1
	Kuwait	Students	M=13.0 *SD*= 9.73	M=15.0 *SD*= 9.17
	Qatar	Students	M=12.3 *SD*= 8.24	M=15.1 *SD*= 9.05
	Pakistan	Students	M=21.1 *SD*= 13.3	M=23.8 *SD*= 14.0
	Lebanon	Students	M=14.1 *SD*= 8.32	M=15.8 *SD*= 7.87
	Tunisia	Students	M=17.8 *SD*= 9.65	M=19.9 *SD*= 8.81
	Palestine	Students	M=17.7 *SD*=	M=18.6 *SD*= 9.51

		10.0		
	U.A. Emirates	Students	M=19.3 *SD*= 13.0	M=17.8 *SD*= 11.2
	Yemen	Students	M=15.8 *SD*= 9.20	M=16.3 *SD*= 10.5
	Jordan	Students	M=17.3 *SD*= 10.5	M=17.7 *SD*= 9.91
	Sudan	Students	M=14.6 *SD*= 9.62	M=15.2 *SD*= 10.2
Abuhajar, 2013	Libya	Non-clinical	M=11.53 *SD*=7.83	M=16.0 *SD*=7.33	M=14.05 SD=7.86

Many factors may contribute to depression for women; however no single individual factor may explain the reason behind the consistent difference observed between males and females (Nolen-Hoeksema, 2001). The response style theory (Nolen- Hoeksema, 1987) explains it in terms of a general female response bias towards ruminative thinking instead of distracting behaviour (Nolen-Hoeksema, 1987) but it does not explain why women should ruminate more than men. A further explanation is the great load that women are carrying (Nolen-Hoeksema & Larson, 1999) though adopting an interpersonal orientation, that entails more caring for others, and a tendency to sacrifice their personal needs in order to maintain their relationships with others (Nolen-Hoeksema, 2002), and this places the explanation firmly in the sociocultural context. Biological factors are also significant according to Parker and Heather (2010). In addition, there is evidence that women are more exposed to specific severe stressful events (Nolen-Hoeksema, 2001; Golding, 1999; Pico-Alfonso et al., 2006). Severe life events were significantly associated with depression particularly in women (You & Conners, 2009). The prevalence of depression in men may however be underestimated because of a greater tendency for hiding depression in men (Addis, 2008; Parker & Heather, 2010).

The Libyan females reported higher overall depression than the Libyan males. The different social networks and cultural practices may have an effect on gender roles according to the culture where the individual is living (Bussey, & Bandura, 1999). Arabic culture may cause women to be at greater risk than men in the same culture, (1999 Haj-Yahia, 2000; Haj-Yahia, 2003; Douki et al., 2003; Douki et al., 2007; Daradkeh et al., 2002). Women are expected to look after all the family members, including children, old family members, and disabled ones, also violence against women is hidden by police, law, family members, victims themselves, and even professionals, and most of these factors may be interpreted as resulting from patriarchal ideologies (Douki, 2003, Al-Nsour, Khawaja & Al-Kayyali, 2009; Douki et al, 2007; WHO, 2000; Haj-Yahia, 2000). Psychological, physical, and sexual abuse also may be found in the sample (Haj-Yahia, 1999; 2000; 2003; 2010). Cultural practices may include also attitudes that justify wife abuse, even blaming women for being beaten, and considering that violence against women is a private matter in the family rather than criminal issue (Haj-Yahia, 2003; Al-Nsour, et al., 2009; Haj-Yahia, 2010; Douki, 2003). These cultural orientations

may lead women to keep silence, as a wife is expected to maintain the family unit rather than it being the responsibility of men, and divorced women are always the ones to blame from the people around (Douki et al., 2003; Haj-Yahia, 2000).

In regard to the differences between reporting psychological symptoms and somatic symptoms, the results broadly confirmed Simon et al., 1999, in that both psychological and somatic symptoms were reported. However, in support of the somatization hypothesis (Hypothesis 1), a significantly higher score was found on key somatic items in comparison with cognitive items, as defined by Buckley et al. (2001) and Vanheule, et al. (2006).

The results of the current study also highlight the importance of self-esteem as negative predictors of depression. Concerning Beck's theory, support is found for the hypothesis presented that is predictor of depression. These findings are consistent with previous studies that have examined each of these variables in different contexts (pp. 49) but little previous information is available for the Libyan sample, as the current study is the first to examine these particular variables in a Libyan context.

All of the items of the questionnaires that have been used in the present study have the same meaning in the Libyan and the British sample. The failure of item 3 "I feel that I have a number of good qualities" which was deleted from the list, to load on factor of Rosenberg scale for the Libyan sample might have been due to cultural differences in the meaning of good qualities. Given that individuals who score low on self-esteem may be at risk of depression (Beck & Alford, 2009), there must be other factors involved since the effect of gender are independent from the influence of self-esteem. The self-esteem finding is supported by Scott, (2006); Brown et al., (1986); Hayes, Harris, and Carver, (2004); and Luxton, and Wenzlaff, (2005). The fact that self-esteem and gender emerged as predictors of depression in Libyan is a matter of substantial theoretical interest.

Strengths and limitations of the present study

The main limitation for the research was the small size, relative to the diverse nature of the British sample. Unfortunately, the disproportionately small numbers for certain cultural subgroups in the British sample means that it does not detect real differences in depression in different sectors of the population and for that reason comparison between Libyan sample and British sample cannot be made, this study could be improved by using representative data from British sample, also, by using exactly the same method of collecting data from both samples. To my knowledge, this study is the first to address cultural value orientations in Libyan society, and the first to study relationships between these variables and depression. It is important to understand depression in different societies. The present study does not specify what exactly in gender is responsible for the difference in level of depression as the covariates did not account for differences in depression between males and females. Another limitation of the study is that it is based on self-report questionnaires administered to a non-clinical sample and may not give a clear indication of the causes of depression in Libya.

The finding of gender differences of depression scores therefore raises further questions about the role of social structure in the Libyan context. Inductive qualitative study in the Libyan context may discover answers to the following question: What is the unique experience of depression in individuals who have been diagnosed as clinically depressed, and is there anything in that experience that can be identified as related to risk of depression, particularly in women? Additional factors that have been identified in previous research as depression risk factors can be looked for in the accounts of clinically depressed patients, such as the impact of stressful life events. Also, such accounts may reveal the influence of specific cultural practices that may act as risk factors of depression, and give an indication of the levels of received (as well as perceived) social support. Because the first study did not lead directly to further hypotheses about the causes of the gender differences in depression scores I decided that a qualitative study of depressed Libyan females was required, in order to understand their experiences and attributions.

Chapter 5

Study 2

Perceptions of depression in a sample of outpatients in Libya

The contents of this chapter are as follows: (a) Background of study 2. (b) Previous related qualitative studies. (c) Semi-structured interviews. (d) Assessing reliability and validity in qualitative research. (e) Method. (f) Research participants. (g) Characteristics of the research participants. (h) Interview schedule. (i) Data collection. (j) Transcription, translation and back-translation. (k) Data analysis. (l) Findings. (m) Discussion.

Background

Study 1, a quantitative investigation of research participants in Libya and Britain, yielded for main conclusions. First, the study highlighted the importance of self-esteem as a personal negative predictor of depression and gender as a demographic predictor of depression in a non-clinical Libyan sample. Second, Libyan females tended to record higher scores of depression on the BDI-II scale than Libyan males. In a third regard, females in Libyan sample reported significantly higher scores than males in a number of areas that included sadness; guilty feeling; crying; indecisiveness; worthless; suicide wishes; concentration difficulty; loss of interest in sex; past failure; self-critical; and tiredness. In a fourth respect, the effect of gender on depression remained higher in Libyan sample even after three cultural dimensions (collectivism, individualism, familism) and social support and self-esteem were controlled out. Thus, the indication of high scores among the Libyan sample on the BDI-II scale could not be explained fully by the predictor variables. There was thus a need to engage directly with the lived experience of depression, and to adopt a more flexible and nuanced qualitative approach that might identify less quantifiable cultural perceptions and factors with regard to the experience of depression in Libya. Accordingly, this second study employed qualitative methods of data collection and analysis to address the perceptions and interpretations of a clinical sample of depressed Libyan

informants in three broad respects – their understanding of the symptoms and causes of depression, how they cope with the symptoms, and help-seeking behaviour. But, before turning to these findings I will further contextualise the research with reference to previous apposite research and then describe the qualitative methodology in more detail.

Previous related qualitative studies.

There are relatively few studies that have used qualitative methods of research to investigate depression in an Arabic context. For example Sulaiman, Bhujra, and Silva (2001) conducted a qualitative study in Dubai with the aim of identifying the concept of depression of the native Dubai population. A series of four focus groups were conducted with 53 participants. All individuals had experienced a close relative or friend's depression. Subjects who themselves had experienced a psychiatric disorder were excluded. For various reasons, 13 from the sample were unable to participate, so only 20 females and 20 males contributed to the study. This study identified various symptoms of depression. These included social withdrawal, fear, and irritability, loss of sleep and loss of interest in sex. This provided partial support for an emphasis on somatic symptoms of depression in an Arab culture, but most of the key concepts overlapped with those described in DSM-IV. Causes of depression that were identified included marital problems, relationships, and problems as a result of polygamous marriages and, for females, passing the conventional age of marriage. To cope with depression participants talked about reading the Koran and praying, asking God for help and being open with friends and family. Stigma about depression was also mentioned and people often did not distinguish between serious illness and depression. Indeed, participants sometimes used the term general ill-health to describe depression (Sulaiman et al., 2001).

In another study, semi-structured interviews were conducted with Arabs in Negev, Israel, by Al-Krenawi (1999) in order to investigate the symptoms of mental illness and views on the causes of mental illness. A total of 60 patients, 36 females, and 24 males, were interviewed in a clinic and re-

interviewed two weeks later by the authors. An emic approach (foregrounding the individual's perceptions and his/her perceptions of context) was used to interpret the data collected in the study. Al-Krenawi found that all the participants explained their symptoms as caused by supernatural power such as God's will, evil-spirits, or sorcery (regardless of educational level, social class and diagnosis). Indeed, none of the patients or family members involved in their care referred to orthodox medical explanations. There was however gender differences in the perception of the causes of their symptoms. Nearly 30% of males viewed the causes as God's will or as punishment for some sin that the patient had committed (this group had up to ten years of schooling). Two-thirds of the men in the sample attributed depression to evil-spirits – this group tended to be less educated than the first. But over 97% of the female informants - typically without any formal education - attributed their symptoms to sorcery. But the author also adds that patriarchal Bedouin-Arab culture traditions and rigid gender roles influenced the perceptions and experiences of women with regard to depression. Girls are, typically, closely watched by families, may be violently punished for infractions, and their non-familial relationships are highly prescribed. This, again, speaks to the importance of culture in shaping and mediating perceptions and interpretations related to depression. Indeed, Al-Issa (1990) investigation of depression in Algeria reinforces the importance of cultural context. He notes that although diagnosed mood disorders appear rare this might be due to the fact that patients tend not to verbalise symptoms in a cultural milieu that frowns on the expression of strong feelings.

Cultural-specific perspectives on the causes of depression have been reported in other ethnic groups. In a comparative study, Lavender, Khondoker, and Jones (2006) investigated the perception of depression among distinct ethnic groups in south London between 2002 and 2004 a total of 20 Yoruba (Nigerian), 20 Bangladeshi and 20 white British people who ranged between 18 and 80 years in age (with an equal number of men and women in each group). All the Bangladeshi people were Muslim while most of Yoruba and about half of the white British were Christian. Views on the causes of depression varied substantially across the three ethnic groups. Curses, black magic, evil spirits and the devil were mentioned more frequently by Yoruba informants than Bangladeshis but not at all by the

white British informants. And only Yoruba informants explained mental illness with reference to the misdeeds of their ancestors. Indeed, in terms of whether depressed person can be considered as "ill", two Yoruba argued that in Nigeria he would not be considered ill but that he would be seen as ill in Britain. But the Bangladeshi informants placed more emphasis upon family pressures (particularly financial demands from Bangladesh) than either of the two other groups. Family problems were also among the cited causes of depression among the white British and Yoruba informants but problems with friends and partners were also mentioned as causes of depression. Yoruba and white British informants in particular also noted that some individuals are more vulnerable to depression than others. There was however more variation with regard to stigma, No Bangladeshi informants and only two white British people mentioned feelings of stigma – it was mentioned more frequently by those of Yoruba origin or descent. With reference to support, among all three groups family and friends were perceived to be the main source of support - recourse to a doctor considered as the next choice. And all three groups were unconvinced about the use of antidepressants.

Semi-structured interviews

In light of these qualitative studies, semi-structured interviews appeared to be the most appropriate means of data collection in the second study. Interviews allow researchers to obtain a comprehensive picture about the topic being studied but also provide flexibility for researchers and interviewees. Researchers can follow up interesting conversation topics that emerge in the interview and the interviewees can expound on responses at length (Smith, 1995). Clearly though, the approach to data analysis can be crucial in this respect. As Braun and Clarke (2006) observe, rigorous qualitative analysis can yield rich detail about the phenomena under study. Such analysis can help to make meaningful an individual's experience of observable phenomena - an approach that draws upon the individual's perception of reality and thus allows the researcher to move beyond and beneath empirical description. And, in relation to the research described here, qualitative exploration and analysis is particularly attuned to gauging the manner in which social and cultural contexts shape and mediate subjective interpretations and meanings (Braun & Clarke, 2006). The credibility of such

insights rests, however, on the rigour and transparency employed in the coding of data and in the generation of themes. Such codes and attendant themes can be generated deductively on the basis of insights from previous research, inductively or – as in this research – reflect a mixture of the two approaches (Boyatzis, 1998).

Assessing reliability and validity in qualitative research

Reliability is "consistency of judgment of observation, labelling, or interpretation, among various viewers; and over time, events, and settings" (Boyatzis, 1998, p.144, p.147). Consistency of judgment among multiple viewers seems to be a suitable approach to establishing reliability for this study. With regard to validity, Smith, Flowers and Larkin (2009) observe that qualitative studies can meet the particular criteria described by Yardley (2000), among others. Yardley suggests, first, that a qualitative study should provide sensitivity to context and that can be found by exploring thoroughly, for example, "the socio-cultural milieu in which the study is situated, the existing literature on the topic, and the material obtained from the participants" (Smith et al., 2009, p.180). Yardley also argues that the researcher should be able to demonstrate rigour but also an awareness of the manner in which interaction between the researcher and the researched helps to shape attendant data. Consideration has to be given to ensuring that participants express themselves as freely as possible without being "led" by the researcher. The researcher must also be reflective and self-critical in analysing such data. And, in a related respect, the investigator should adhere to the principle of *transparency and coherence*. These refer to how the researcher writes up the research process. Finally, Yardley refers to the *impact and importance of the study* - the extent to which the research adds something to the reader's understanding, to the academic community, to the people or social groups who are studied or to those who are concerned with their welfare (Smith et al., 2009; Yardley, 2000).

Method

Research participants

Subjects (research participants) were identified from psychiatric clinics and general medical practice (a Tripoli hospital). Initially I sifted the relevant details of all individuals who contacted Tripoli hospital for medical treatment in relation to depression in the period between (19/05/2010; 01/06/2010) and (28/06/2010 -03/08/2010). I visited the hospital on 19/05/2010; I introduced myself to the director of the hospital, and had a meeting with psychiatrists in the hospital, I gave them some information about my study and description of the sample required, and let them know that I am coming back on July for interviews, to give them some time to contact with the out-patients. Although this could be characterised as a pragmatic sample, the fact that participants were drawn from the country's largest population centre and beyond makes it very likely that their experiences and responses with regard to depression might reasonably be applicable to Libyan people more generally. Each eventual research participant received a diagnosis of depression (with no psychotic features) according to the DSM-IV criteria. Symptoms of severe depression, evident for more than two weeks, were evident in all the patients who acted as research participants.

Characteristics of the research participants

The research participants encompassed 22 Libyan out-patients who had been diagnosed by psychiatrists as moderately or severely depressed according to the criteria of DSM-IV: 15 were female and 7 male. The mean age of the female research participants was 34 years (ranging between18 and 55 years). The mean educational level was 11 years (5 patients were between 16 and 14 years of education, 5 patients were between 12 and 11 years, 4 patients were between 8 and 6 years, and only one patient was illiterate). Eight of these participants were single, four were married and three were divorced. Six were housewives, one was unemployed; one worked in a nursery; four were full-time students; one a teacher; one worked in communications and the other was also employed. The mean age of the male participants was 38 years, with a range between 25 and 48 years. The mean educational level was 13 years (4 of the patients were between 17 and 14 years, 3 patients were

between 12 and 9 years). Four patients were single, and three were married. In terms of occupation there was one teacher; two businessmen; a project manager; a full-time student; a mechanic and another salaried employee. Demographic details of the participants are summarized in Appendix 28 (PP. 246).

Interview schedule

I used a semi-structured interview schedule, which was prepared to answer the general question: how does culture affect the experience of depression in the Libyan context? Also the schedule was designed to explore outstanding questions arising from study 1, in which the Libyan female sample reported a higher mean score in BDI-II than the Libyan male sample, and this could not be explained by the various predictor variables that were measured (individualism, collectivism, familism, social support, self-esteem). The schedule guidelines were designed to focus on the phenomenon of depression individually, to gain a comprehensive picture of how the depression experience is described by Libyan people from emic point of view, and in order to explore the factors identified as causes of depression by individuals themselves in a depressive Libyan sample. The schedule guidelines were refined in discussions with a professional psychiatrist doctor to identify the general areas that the interview should cover. The guidelines included: the concept of depression; the symptoms of depression; the causes of depression; Dealing with depression; the Kinds of treatment people seek for help; and evaluation or appraisal of her/his own worth. I also recorded the gender, age, marital status, and social economic level, educational level, and occupation. The framework for the interviews is given in Appendix 29, pp. 247,248.

Data collection

Research ethics approval was obtained before starting the fieldwork (Appendix 30, pp. 249,255). Through a meeting with psychiatrists arranged by the Psychiatrists of Tripoli hospital, I

asked for volunteers to take a part in the study by displaying some information about the study, the aim of study, and the character of participants required, that is, Libyan patients, aged 18 or older, born in Libya and have been living in Libya for all their lives. All the out-patients who met the inclusion criteria were referred to the investigator by the psychiatrist after giving brief information about the study.

I introduced myself to participants as a researcher doing a study on the effects of culture in depression. Each potential participant was invited to read and sign an informed consent form as a pre-requisite for inclusion in the research interview. Some information was given about the current research and it was made clear to the participants that their involvement was voluntary and that they had the right to terminate the interview at any time. As the meetings took place, some of the participants were not interested to continue for any longer so that the meetings were widely varied in length. The duration of some meetings was for about 90 minutes and others showed no interest in continuing after about 15 minutes. All the interviews were conducted by the investigator, in a room specified by the director of the hospital, and all the interviews took place within 2 months. The interviews were conducted in the hospital within normal working hours but at the convenience of the participants. The interviews were tape-recorded accordingly with the participants' permission.

Transcription, translation and back-translation

I personally transcribed the interviews (in Arabic) and then reviewed the transcripts against the recordings for accuracy (Braun & Clarke, 2006). Translation and back translation was then conducted in order to further bolster accuracy and the appropriateness of wording for analysis in the English language medium. I translated the interviews from Arabic to English. These interviews were then back-translated into Arabic by a bilingual proof reader (this back-translation was conducted with no prior exposure to the Arabic language version of the interviews). Any remaining ambiguities were then resolved on the basis of the discussion between the investigator and the back-translator.

Data analysis

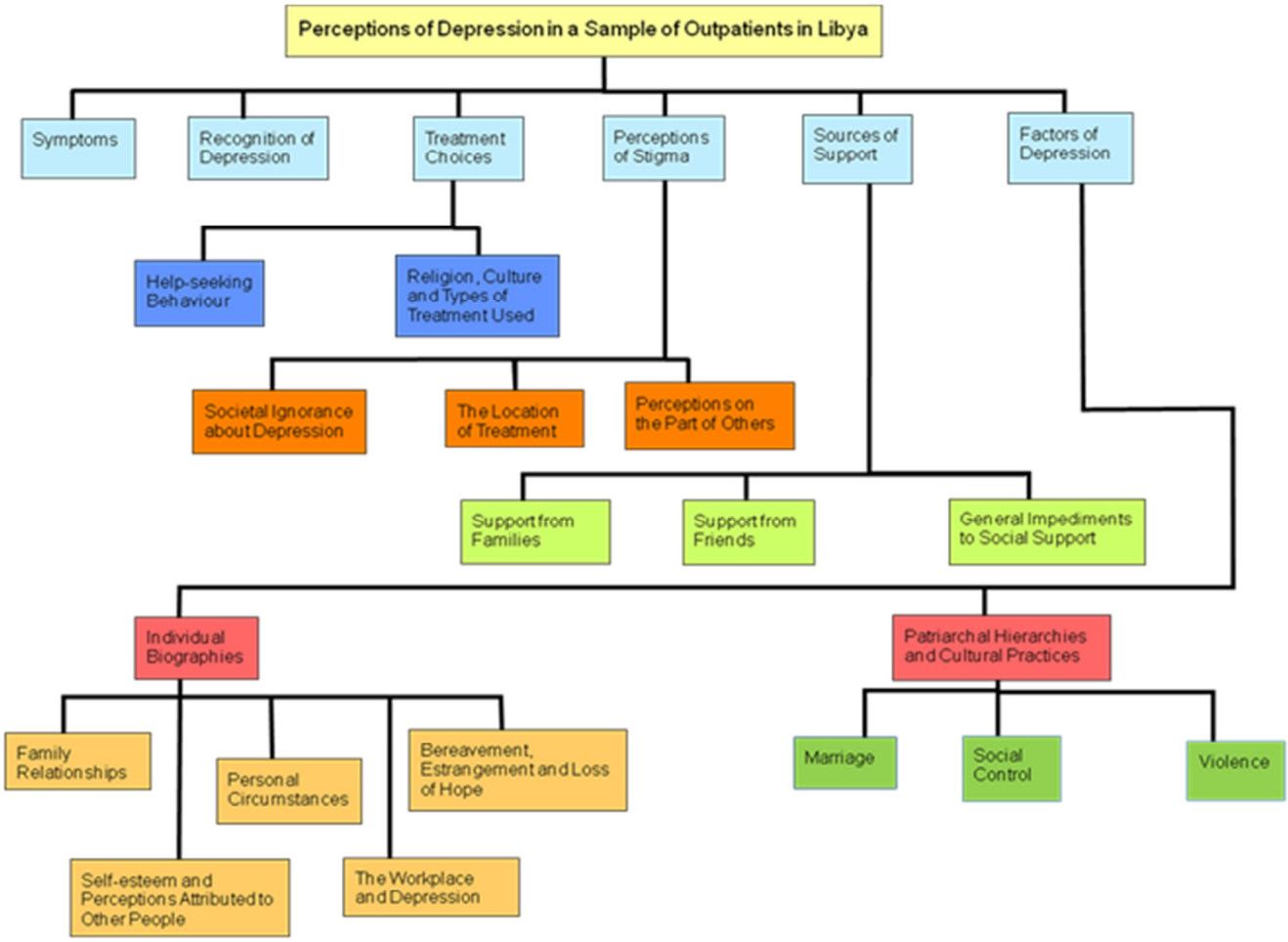
A thematic analysis was used to develop iteratively a coding frame through which to identify appropriate themes within the data (Braun & Clarke, 2006). The themes obviously reflected initial interview prompts in many cases but were also based on the detailed responses from participants (particularly with regard to the effect of culture on depression in the Libyan context). The first step in the analysis was to read each transcript several times and begin to highlight relevant ideas, words, and phrases. These initial codes were refined or changed iteratively in the light of new insights from reading subsequent transcripts. This process resulted in an initial set of codes for the data set. These were then examined for emergent themes and relationships between themes in order to further elaborate the coding frame. As these themes began to solidify they were given mutually exclusive labels (itself an iterative process). Emergent themes were then checked again against the original transcripts and revised, as necessary, to ensure that all themes could be applied to the data without ambiguities. The themes were then organized and grouped together - where applicable - under broader categories so that the relationship between higher order themes and sub-themes could be identified. And, in order to enhance validity, another Doctoral candidate cooperated in the coding process and discussed the iterative development of the themes (Boyatzis, 1998).

Findings

Six major themes emerged from an iterative inductive analysis of the interview data – symptoms that would come to be associated with depression; recognition of depression; treatment choices; perceptions of stigma; views on sources of support and factors seen to lead to depression from the patients' perspective. The interrelationships of these themes, as identified in a sample of out-patients in Libya, are shown in Figure 1.

Figure 1

Perceptions of depression in a sample of outpatients in Libya



1 Symptoms.

The word depression has an equivalent in the Arabic language which is (*Ekteab*) but this word is used mostly in formal Arabic language; the Libyan word *(Katry dayg)* which stands for heart tightness is used very often by the patients. Out-patients identified a myriad of symptoms that included loss of control of feelings, social disengagement, sadness and social withdrawal. One female participant, for example, described how her quality of life, happiness and sense of self were undermined by depression:

> *I think depression is something that takes you out of real life; I wanted to be invisible, feeling deep inside that I wanted to go out of myself, from my home… I didn't think of committing suicide, but when I was walking on the street, sometimes I wished I would be killed by accident, or something very bad would happen to me and I would lose my life…I lost the taste of life, the taste of pleasure. I couldn't feel happy, whatever happened. I found no joy in meeting friends, buying new clothes…A sadness that I couldn't control, feeling I am different from the people around me. Even if I was with others I feel alone and I did not feel that I was attached to anyone…I have been in situations that I couldn't cry, I was very depressed but no crying, that was the worst. I do not feel secure when I am alone…I was suffering from pain in my stomach; maybe because I was barely eating, I lost considerable weight; I was 37kg…I felt as if I was on the battlefield, fighting constant feelings of pessimism. I was afraid about what was going to happen tomorrow, and the end of every day I say to myself, thank God, nothing happened today… sometimes I feel I desperately need a cuddle.* (Female patient 2)

In the same vein, a male patient isolated himself for a year, felt unable to talk to his colleagues and friends, unable to go back to work and lonely:

> *I feel worried and afraid of people even who were in a lesser position than me, and I can't stop in front of them and talk. I am weak, because my self-esteem is becoming lower as I am a*

failure. I feel my friends don't want to work with me. I am a failure because I made the wrong plan. Why didn't I make a good future for my kids without all of this failure? My kids will be affected by all of this failure... I am a failure because my plan was wrong…I know people may complain for physical reasons as well as for psychological reasons, but it is so difficult to get over the whole situation, I tried hard to be as I used to be, but I couldn't... I feel I should give up, and stop trying…Even if I start working, I cannot achieve anything; I already have many projects, but I need money, and if I get my confidence back I will work in private business…I have no motivation to start my day. (Male patient 5)

Typical symptoms were also evinced by a woman who had lost weight, slept excessively and felt perpetually weak:

Sometimes I feel too weak and fell down… I feel I am ill. I cannot do anything in the whole day, even study. I feel miserable. Once I come back from the university, I go to the bed until the next day. I am not sure I am sleeping all the time, I don't do anything I have no energy. I cannot concentrate. I don't eat. I lost about 9 KG…When things get to the worst I totally stopped talking … I prefer not to sit and talk with anyone… I feel that I am so weak, suspicious. Even when I do my exams, I double check whether I wrote the word or not…lose of interest, just sleeping…I have been serious all of the time, either doing something or sleeping. I was helping with the housework, but after becoming ill I have stopped doing that.
(Female patient 8)

And an indication of how depression impedes routine daily activities was described by many of the interviews:

I don't want to select my own clothes as before, and feel exhausted, so that I avoid doing anything, whereas before I was active … I am fighting myself to cope with these daily requirements, and if I could do as I like, I would not even touch the water. I sleep wherever I

find myself, whereas before I was concerned to sleep in my own bed...I have got pins and needles and headache. I don't cook, I don't eat, I eat when I go to my friends, but when I go back to my room, I become ill again…I am crying a lot, sometimes I feel like I want to cry but I cannot, and I wish that I were able to cry to get some relief. Recently I've been continually crying, but after getting medicines I get better... I'm afraid of everything; before I used to sleep in the dark, but recently I've been sleeping in the light, and I've avoided taking a shower or cooking something to eat…I hate my room, I prefer to stay out of it, and just sleep. I used to love my room, but as it is something in it has really made me depressed. You know, I tear the clothes I am wearing, because I think that might give me some relief. I cry till I get to sleep, then wake up crying, then sleep again. I cry loudly, continually, and my life is like a circle. I'm living in hell. (Female patient 10)

Informants also spoke of feelings of guilt and somatic symptoms (including shaking, bad temper, tiredness and loss of weight). Indecision and a lack of concentration were also discussed:

I open my wardrobe to wear something. I look for it for a long time. I don't know what I am going to choose. I don't know what I want. I sit with the computer. I know that I have to work. I just watch it...When my mum asks for something I look at her, but I don't recognize what she is saying… My mind thinks, and doesn't think, I think a lot, but what exactly I want, I don't know. (Female patient 11)

Another common refrain from interviewees was that they were losing what they regarded as their old self and a sense of normal life. One patient, who described himself as well educated and, usually, concerned to improve himself gave an account of this perception:

Now I cannot get started on any project, and I am hesitant about starting any project...Everyone I know can be a witness to the fact that I am a successful man, and that because of that I have been selected to run several companies…I can't make any decision to go

ahead, and for about one year I've isolated myself, in my farmhouse, and I escape even from my kids. (Male patient 5)

A lack of confidence was discussed by several interviewees. In one case, a divorced woman compared herself unfavourably to an animal:

As a result of my circumstances, I feel a cat is more important than me; even animals can be respected, but even when I say 'Hi!' my family doesn't reply. (Female patient10)

Many interviewees also referred repeatedly to feeling unnecessary guilt about past behaviour:

I feel very upset. Before getting depressed, I would respond to anyone who said something bad or criticised me, but lately... yesterday I was with someone and he said something which upset me. I couldn't defend myself, but later, I critiqued myself; why I didn't say this and that, why I remained silent and didn't defend myself. (Male patient 19)

In the face of such symptoms, how did the patients come to recognise themselves as depressed?

2 Recognition of depression

As some of the symptoms discussed above indicate, many patients did not, initially, recognise their condition as depression:

I didn't know that I am depressed; it was the doctor who told me that. In the first place I came for my daughter, since she needs psychological help. I'm neglecting myself, but my condition is dramatically increasing. (Female patient 10)

Indeed, the term "depression" was avoided by most of the interviewees in the course of my discussions with them – frequent reference was instead made to being unwell or ill. A female informant was typical in this respect:

I became ill for two months…I was becoming ill from time to time… …but whenever I do go I become ill…I faced hardship for 10 years before I became ill…I became ill, with a pain in my heart…When I take medicine I am fine, but if I stop I become ill…Before my illness… when I am not well… My illness and the stress that I'm living with, make me more vulnerable to be depressed. (Female patient12)

Three patients did, however, effectively diagnose themselves as depressed. A female patient, for example, knew that she was suffering from a psychological problem, she told her family but felt that no one was listening:

> *I went to a doctor for my stomach and told him I was afraid that the pain was caused by a psychological reason and nothing to do with my stomach, I felt that the illness I was suffering was because of the condition I was living with in my family but he gave me a lot of medicine. I told my family that I need to see a doctor in Gergarsh [hospital], I knew that I was depressed, but they did not believe me. My mum said that I was exaggerating the things I had been through.* (Female patient 2)

This last interview excerpt points to some of the uncertainties and differences evident with regard to the treatments sought and accepted by the patients within the study. These motivations and decisions are discussed below.

3 Treatment choices

The theme of treatment choices adduced from the findings encompassed two broad emphases within the interviews - accounts of help-seeking behaviour and thoughts on how cultural and social context mediated attitudes towards types of treatment.

Help-seeking behaviour

Help-seeking behaviours among the patients fell into three categories - people who did not ask for any help, people who sought only professional help and those who sought both traditional and orthodox medical assistance. Mixed help-seeking behaviour, combining traditional and professional, help was not untypical. Patients sometimes sought a mixture of such help directly but, more usually, they sought one kind of assistance initially and then switched to another:

> *At the beginning I went to a Sheik [traditional healer]. But I didn't feel any better, then I went to a doctor…My sister is studying psychology. She told me about it, and later the doctor diagnosed me as depressed.* (Male patient 19)

> *My family took me to a clinic in Tunisia. All of the clinical investigations came up normal. I spent two nights in the clinic. Later I went to a psychiatrist. He told me that I was depressed and gave me anti-depressant medicine. I took the medicine for two days. Then my family [took me to a Sheikh] who threw all of the anti-depressants away, and gave me traditional medicine. It did not work for me, so I went back to my doctor, and he re-described anti-depressant medicine, which makes me feel much better*. (Female patient 3)

Such references to traditional, folk, sources of help were indicative of the importance many informants placed on religion – an issue that I explore in more detail below.

Religion, culture and types of treatment used

Several patients spoke of recourse to religion when attempting to cope with their depression. It is though important to note that only two interviewees (a female teacher and a housewife) framed their understanding of the *causes* of depression in supernatural terms (and even then, only tentatively):

I think some people did magic. I know who did it. (Female patient 9)

I was becoming ill from time to time, especially when I went to parties. I have been told that was because of the magic, I don't know, it might be. (Female patient 12)

More generally, religion was seen as a source of help in difficult times and the informants tended to be quite positive about the immediate impact of such belief. Practices discussed in positive terms included reading the Koran, *Du'aa* (invocation and supplication to God) and *wudhoo* (ritual cleansing of parts of the body):

After that I tried to treat myself by praying and reading Quran…Sometimes it happens to me, that I see the entire world as a very dark place. But I read the Koran to feel better I feel there is hope, and I feel I am stronger than before. I think mental illnesses are really worse than physical illnesses, because people do not know how to deal with this kind of problems. (Male patient 1)

I woke up in another world, and home is very small for me. I just start praying, making du'aa, and I'm treating myself with medicines and through my religion, feeling fine afterwards and getting relief. (Female patient 12)

My relationship with Allah is very strong, when I feel I am not fine, I make wudhoo, and pray. That makes me feel comfort and security. I went through counseling, I read many books about how to treat yourself, they are really beneficial. (Female patient 2)

The influence of Islamic beliefs and culture also, maybe not surprisingly, influenced attitudes towards alcohol as a coping mechanism in the face of depression among some interviewees. This male patient typified the attitudes of the few informants who spoke about the issue:

> *I smoke to feel better, travel, go to parties, but I haven't drunk alcohol, only the last two times, and I feel I will drink again as I feel better…Lately I have been thinking of drinking alcohol, but I didn't find friends to drink with: I couldn't make new friends, while at the same time I couldn't drink with my existing friends, because of my reputation as a good-mannered person. I used to advise them not to drink, so I can't come along now and drink with them. I cannot - after all, I am afraid that my brothers will find out, so that they will feel upset, and as a result, I destroy everything I've built up.* (Male patient 5)

But did the invocation of such cultural mores and broader religious culture also reflect any particular, perhaps culturally mediated, attitude towards orthodox medical treatment among the Libyan interviewees? There emerged no obvious relationship between attitudes towards conventional treatment and religious beliefs and practices with regard to depression. Several informants did however exhibit scepticism towards biomedical interventions (particularly with regard to the possibility of addiction):

> *I started taking medicine, but I did not take the drugs regularly as the doctor asked. I took the drugs for two weeks, sometimes more, sometimes less, and stopped after that. I do not like taking medicine as it makes me feel sore in my throat. I did not take the medicine as required.* (Male patient1)

> *I am afraid of being addicted to drugs, of taking drugs all of my life, or one day my state becoming worse.* (Female patient 3)

This last observation is indicative of a fourth theme to emerge from the interviews with regard to understanding depression in the context of Libyan society - stigma.

4 Stigma and depression.

The theme of stigma reflected three constitutive emphases within the interview data. These encompassed *(i)* a view that Libyan society as a whole often failed to distinguish between serious mental illness and depression; *(ii)* concerns about the location of treatment for depression; impact on perceptions of where treatment was administered and *(iii)* worries about perceptions on the part of others.

Societal ignorance about depression

There was a feeling among some interviewees that wider society often failed to distinguish between serious mental illnesses and less serious conditions, such as depression. A male interviewee encapsulated this sentiment:

> *Libyan people treat anyone who has a psychological state as crazy, despite the fact that this depressed one could be appearing a normal person.* (Male patient 1)

This concern was reflected in thoughts concerning the location of treatment.

The location of treatment

Patients mentioned the location of treatment as a source of discomfort. The stigma and discrimination surrounding depression could, it was argued, make it difficult for people to seek help through hospitals (at the time of writing there are only two hospitals in Libya that offer free treatment in this regard). Patients indicated that stigma prevents depressed people from accessing medical

services and seeking professional help. This patient, for example, was desperate for treatment but was averse to the reputation of the hospital:

> *I wish if I could find a better place (hospital). People disapprove of this place, wish I could go to another place, I mean this hospital. I wish it was different… I hate coming to this hospital. I came because I feel my mind will explode. I cannot accept being here. I wish there was a free clinic in another place…Some people do not seek help until their state becomes very bad, and they are forced by their relatives to come to the hospital, because of a critical condition they are going through. Some depressed people are committing suicide instead of asking for help.* (Male patient1)

This last comment reflected a more general concern with the potentially negative views of other people.

Perceptions on the part of others

One patient, typically, observed that people do not ask for help from the hospital because the institution's reputation is poor and treatment there might generate negative talk among friends, colleagues and relatives. This patient suggested it was vital to build general hospitals that include mental health services unit in order to mask treatment for depression and other mental health problems:

> *It should be a general hospital, a hospital for different illnesses, not only for mental illnesses; so that people think that you come for different reasons. Gergarish has a bad reputation, and people view it as a place for mad and psychotic patients. People who have depression are afraid to come to seek professional help.* (Male patient 1)

Another patient asked her friend not to tell anyone that she was receiving professional help from a psychiatrist because of the anticipated perceptions of others:

When I went to Gergarsh [hospital] for the first time, I called my friend, and told her that I am getting professional treatment. She talked to me in a strict voice and told me do not tell anyone that you went [to the hospital]. (Female patient 2)

Because of stigma, some patients hid the fact that they were depressed, even from their close relatives.

I cannot tell my family that I am depressed. I feel it is a very big issue. They will think that I have a problem in my mind. I know it should be fine, but from their perspective, they will treat me like a crazy man…No-one knows that I am depressed, even my wife. (Male patient 1)

Worries about the views of others, societal ignorance about depression and concerns about the location of treatment all contributed to negative self-evaluations on the part of some patients. The most extreme consequences of such influences were perhaps best illustrated by the observations of one patient:

Most [depressed people seeking help] go to the Sheik [traditional healer]. Some go to the hospital, and some just commit suicide…In my area, from time to time, we hear that someone has committed suicide. People are wondering why these people are hanging themselves. I know that they did that because they had been depressed. They did not consider their state, and thought that there was no solution for such a problem. They came to such a state that they brought a rope and hung themselves in a tree. People in our area do not know why that happened. I understand why those people did that, because of their conditions. (Male patient 1)

More positively, what types of social support were available to the patients suffering from depression?

5 Social support

The theme of social support reflected three emphases that emerged from analysis of the data. The first encompassed thoughts on support from families and a second centred on help from friends. A third emphasis revolved around more general impediments to social support.

Support from families

A minority of interviewees indicated that they received very useful support from their families:

My family really stood with me. They supported me by taking me to clinics, providing medicines, offering money, hugging me most of the time. My mum, all my brothers and sisters tried to help, and they were there for me. (Female patient 3)

My husband is really supportive. My boys and daughters are always there for me.
(Female patient 21)

Some aspects of such support reflected a cultural specificity. In this case, a woman commended her husband for not taking a second wife in response to her illness:

Anyone in [my husband's] position might get a second marriage, but he was patient with me,
(Female patient 12)

Indeed, there was some evidence of gendered behaviour. All three of married men who were interviewed were more reticent about disclosing the full extent of their medical condition to their wives

I don't talk to [my wife] about problems I am facing in my work. She doesn't even know how much I have in my bank account, she is just a great housewife, and all she has in mind is me,

the kids, and home. She's very kind, clean, and does everything to make me happy. (Male patient 5)

I have got a really good wife. She helps me when things go worst. I wish that she could forgive me… she is a very patient wife…No-one knows that I am depressed, even my wife. She is not well educated. She does not know what it means to be depressed. She thinks that everyone feels sad sometimes, and it is a normal state. (Male patient 1)

More generally, however, patients indicated that – for a variety of reasons - they lacked support from family. One, for example, blamed a lack of family cohesion for the limited degree of support from relatives:

They are helpful if anyone from the family has an obvious problem that others can see, for example financial issues, or health problems. No-one came to me to ask how I am really doing, how I am feeling. I think if I had really strong relationship with my brothers, sisters, and my wife, that might help me to deal with my state. If I received good support from them, I am sure that would make the experience of depression much easier. They see me every day and think that I am 100% well, while I am suffering every single day. No-one asks me how am I. They cannot imagine how hard my life is. (Male patient 1)

In a more extreme case a divorced woman discussed her brother's refusal to let her live in the family home after her divorce:

My brother kicked me out of the home; he said I don't have the right to stay at home with my daughter. (Female patient 10)

Other negative family reactions included a feeling of constant surveillance and a perception of lost respect:

They are watching me all the time. I feel guilty. And they put me under heavy pressures at the same time. I cannot face them because of what I have done. They should help me to be a better person not to pay attention to me all the time, even when I sit in my room my dad says, come and sit with us. (Female patient 11)

They don't understand me. I know they love me and care about me. I knew that I made a huge mistake. They are saying that if I am in another family, they have killed me. Even my sisters don't consider me. My brother doesn't reply when I talk to him. (Female patient 16)

Conversely, another informant consciously chose to maintain a distance from his brothers – a conscious attempt to retain their respect at the expense of foregoing their active support:

They love me, respect me, and see me as a VIP. But there is distance between us. I am the one, who is responsible for them, and so I give them advice, but I cannot talk to them about my problems or they will lose respect for me. (Male patient 5)

The mixed experiences of support from families were paralleled by those in relation to friends.

Support from friends

Many patients were positive about the support received from friends and, in some cases, neighbours. This woman was typical:

I and my daughter have been in very difficult circumstances, but friends, neighbors and people I know give me great support. A friend of mine told me, "You have the right to get support from us, since we all might be in the same situation, and if you want money, we will give you money, and if you want us to buy everything for you, we will bring you everything at home". She provided me with all my furniture, food, water supply, and money, while another friend

offered me a nice flat, and everything I need. But my brother refused, saying, "What are people going to say?" I don't work, but I've never been short of money…People I know are very helpful, they have brought me everything I needed, and my auntie helped me more than my sister. (Female patient 10)

The experiences of a minority of patients were not so positive:

I had [a close friend] before I got married, but he mixed with people I don't accept, so I just let him do what he wanted. His attitudes had changed, he was not the person I had known. (Male patient 5)

Beyond these individual experiences, two other, more general, impediments to support were identified by the interviewees.

General impediments to social support

The first such obstacle was a perceived lack of knowledge about depression on the part of other people. A patient mentioned that her family made the experience of depression more difficult, because, after a physical medical examination indicated no problems, they thought she was pretending to be ill:

What makes things worse is my family, they don't understand what I have gone through, don't understand me and my state. They treat me as if I pretend to be ill, as a doctor told them that I have no health problems, to the point that I left home to my granny's home. (Female patient 8)

However, the same patient believed that her family changed their view of her when they realised her true condition:

When things get to the worst I totally stopped talking. At that time, they believed that I wasn't acting, and they treated me very nicely…And they becoming more supportive… At the present stage, my parents were very supportive. They took me to the doctor, and provided all of my requirements. They were very worried when I was in a very bad condition. But in the beginning, my dad thought that I had problem dealing with boys. He said "you have problems in your college, and you are escaping from something" as if I had done something wrong. That really hurt me. I don't deal with boys. (Female patient 8)

The second broad factor that prevented people from obtaining professional support was ignorance about the services available. Indeed, some patients discovered sources of help almost by chance:

A friend of mine, her husband was depressed and her sister as well, said that she knew this condition from her own experience. She told me that her husband was treated by professionals and he was getting better, so I went to a psychiatrist. (Female patient 2)

These lengthy reflections on support, or its absence, for patients with depression were matched by thoughts on the possible causes of depression.

6 Patient views on the causes of depression

Nine potential causes of depression were identified by the interviewees. These included very specific individual circumstances but also factors such as bereavement and estrangement; the impact of others upon self-esteem; family relationships; problems in the workplace; lack of protection against violence and the limited rights available to women. Further iterative analysis of the data suggested, however, that such factors were enveloped by two core categories - individual biographies (life experiences) and gendered cultural hierarchies practices. Clearly, the two core categories are not mutually exclusive. It became clear, however, that the experiences reported by some individual

women had, for heuristic reasons, to be framed in terms of patriarchal hierarchies and control if they were to be fully understood.

6.1 Individual biographies

Many different life events were reported by patients when explaining their depression.

Personal circumstances

A male patient, for example, recalled his early responsibilities:

I brought up my brothers, was father and mother to them, and I was financially responsible for them till they graduated from universities. I was working for them for years, so I can't just destroy everything in a minute...My father passed away when I was 7 years old, my mother remarried when I was 10 years old. I am the oldest child, and I have taken on family responsibilities since then. I brought up my brothers, got a flat for them when I was 18, and a good salary, and they really appreciate that I was working to offer them a good education. (Male patient 5)

Another interviewee was scarred by a previous relationship that had been curtailed by the family of her prospective family:

I was engaged for a year, and preparing for the wedding, but his family changed his mind, and everything was cancelled. He told me that he is not leaving me, but his purpose was another thing. He wanted to take advantage of me, then go back to his family, and leave me, as I was not suited to them. I am the one who should be blamed. We were together for a year. He stopped loving me and left me scarred. For the time being, I broke with him. I knew that he was playing and using me. Everyone was saying that, my family and friends. My family know

what's happened between me and him. At the beginning my family stood with me, and took me to a doctor. But they don't trust me anymore. (Female patient 16)

Such specific worries were accompanied and paralleled by factors more generally associated with depression - bereavement, estrangement and despair.

Bereavement, estrangement and loss of hope

This female patient, for example, mentioned the death of her father:

I still remember everything about him. I was really attached to him, more than anyone in the family. I was shocked when he passed away. I was asking about him (crying). He was spoiling me, and suddenly he disappeared. (Female patient 7)

Other interviewees also mentioned distancing from friends and family as triggers for depression:

I felt bad when my sister got married and left home. Also dealing with problems, stress because of studying. I don't see my sister very often. (Female patient 18)

My friends started avoiding me…I am always afraid that I will lose people I love. (Male patient 6)

Loss of hope as a cause of depression was related to a number of issues by the research participants. These included factors such as childlessness and the state of marital relationships:

The problem is I got married nine years ago. The doctor told me that there is a quite little hope for me of giving birth. I am always thinking of having children, and I am unable to have them. (Female patient 14)

As time goes on, I am convinced that this is [my husband's] nature, and there's no way to make him change, but year after year, I feel that he is doing things more than I can take. (Female patient 12)

A significant proportion of such biographical accounts also centred on how the patients might be perceived by other people and the consequences for self-esteem.

Self-esteem and perceptions attributed to other people.

One interviewee spoke, for example, of the efforts she made to retain a facade of sociability while another highlighted the stress caused by attempts to conceal aspects of her private life from relatives:

The next day I became ill, with a pain in my heart, and I didn't want to see anyone, because I didn't want people to think of me as though there is something is going on with me. (Female patient 12)

My self-esteem is always very low…I am an unworthy person. I feel guilty because I am dealing with men. I am talking to them, wishing that I can convince someone to marry me. But I have no luck. All the boys I know, they talk with me, take advantage of me, try to get what they want and leave me afterwards. I feel guilty because I do not respect myself. I have no dignity. I want to escape from my family and myself. (Female patient 3)

Beyond this private sphere, reference was also made to employment as a perceived cause or trigger for depression.

The workplace and depression

In one case, an interviewee described how the nature of his work (in close proximity to colleagues in the desert) made it difficult to avoid contacts that upset him:

> *In any other workplaces place, you can just leave everything behind as you change the location, but in the desert I cannot avoid people upsetting me. We are all in the same place. Wherever you go you will face someone you have a problem with. If you leave people alone, you will feel lose your mind. If you deal with them, you find yourself in big trouble. Working in a desert negatively affected me, but the salary I got made me carry on.* (Male patient 17)

In two other cases a patient described how her duties had undermined relationships with work colleagues and someone who had worked as a project manager complained of unfairness and injustice in the workplace:

> *My best friends left me. They thought that I was reporting them to our manager. They stopped talking to me and having lunch with me as we used to do. They were avoiding me…I stopped working because my manager excluded me.* (Female patient 3)

> *I have been selected to run several companies, but I found myself in a nasty kind of competition with individuals who wanted to use the advantages of being in power to make money for themselves, and then those people bought the company. I had successfully managed to make it the best in terms of management, but they bought it very, very cheap, so that makes me hate working, especially in the public sector. At the same time I want to help, to help my country and people… I thought people who steal millions would get punished and everything would be sorted out, but surprisingly those people became managers*. (Male patient 5)

Family relationships

The impact of family relationships was reflected in the thoughts of two interviewees in relation to their mothers and one woman's views on her relationship with her husband:

> *My mother is very kind, but she cannot understand me. When I talk to her, she is just a passive listener; she does not give her opinion, suggestion, advice. I feel like I am talking to no one.* (Female patient 2)

> *I want my mum to be happy with me I am really upset when she is angry with me. When she misunderstands me I apologize. She doesn't accept that…I am a student in the university, and normally I face lots of problems…When I talk to my mum about these problems, she just listens and…says ok, she does not show me that she cares about me…I escaped to my uncle's home. I am really missing my mum, even if she doesn't want to listen to me; I would like to talk to her.* (Female patient 7)

Strains within marriages and the behaviour of spouses were also mentioned by some of the informants:

> *The other stressful thing is that my father is very rich and very generous…*
> *My father was bringing everything for my kids and for me, and my husband started*
> *to be dependent on my father. My illness and the stress that I'm living with, make me more volunteer to be depressed…I buy everything for the family, he is generous only when it comes to paying for food, or courses for his sons or daughters. Even if you have animals you will feed them. My daughter said that all of her friends were saying that their fathers bought this and that, while only she had to say that her mother bought her goods: I usually respond to this by asking, "What is the difference between Mum and Dad?", but when I'm stressed, I say what is really on my mind. I am exhausted from being responsible for everything…He has become rich, but he doesn't like to pay for anything.* (Female patient 12)

The last thing that makes me ill is that my husband bought a piece of land close to his family, and built a house. I made it clear that to think that I am going to live in it was impossible. I cannot; it is OK to go to the farm, and stay for weekends, but living there - don't even think of it. Really I feel sorry that he is living away from me, but if anyone tells me that I have to stay, I become another person. I turn into a depressed person and don't want to see anyone, or talk to anyone… You love to be there, OK, but I deserve to make an effort for myself. My kids said to me that I was the one who should make an effort, not he - that wives should follow husbands, not the opposite. (Female patient12)

In this latter regard, it was increasingly clear as I focused on the interview data pertaining to female research participants that family relationships were often shaped and mediated by patriarchal cultural practices and expectations. Given the nature of the investigation as a whole I thus explored these phenomena in more depth with regard to factors associated with depression by the interviewees.

6.2 Patriarchal hierarchies and cultural practices

An initial indication of patriarchal cultural orientations was evident in the thoughts of two women about the impact of being single on their status – a status not automatically framed in terms of autonomy:

Another problem is that I am 38 and still single; all of the people I know view this as a problem…I want to get married but no one proposed to me and I am afraid of being with someone who might not be suitable. (Female patient 2)

My father and brothers made it difficult for me to get my driving license. My father upsets me whenever I had an exam or I needed to do some documents. At that time I felt that it was essential to have a husband. It looks like they (my father and brothers) are not happy to take

any responsibility. I am a female and therefore a problem and must have a husband to get rid of me. (Female patient 2)

But it was also clear from several accounts that marriage in Libyan culture was often not an oasis of gender equality and that this had implications for feelings of well-being for a number of female informants.

Marriage

Limits to the choice and influence of women were mentioned in the course of discussions about marriage:

I got married when I was 15, and at that time I attempted suicide because of the stress I faced about getting married. I wanted to complete my studies, my sister was happy to marry her cousin but as for me, there was no one in my mind. My cousin wanted to marry me, but I was too young to decide who was the one who could be suitable for me…I remember that I got medicine to commit suicide, but later my husband announced that he would let me carry on studying. But people lie…After I got married, on the second day, I became ill for two months. (Female patient 12)

I thought that by getting married I could escape from my brother, and be happy with a normal husband.…If I left him (her husband) I would go back to the hell with my brother, my mum being unable to stand with me. I stayed with my husband five years just because I cannot live with my brother. (Female patient10)

Such restrictions even extended to mature women, as this female divorcee attested:

I got divorced nine years ago and I really still need to be with a man, despite all the hardship I lived through with my ex-husband. Two men have proposed to me. One of them is single, and

has not been married, but my brother refused, saying: "What would people say, you are divorced and he is single, a shame on you!" And the other one is a very nice guy, with a brilliant job, but my brother and my sister refused him too. My brother told me if I married him he would kill me. They both don't feel my needs, and they refused because he is black. (Female patient 10)

But male control over women, with subsequent implications for feelings of self-efficacy and control were not restricted to marital relationships.

Social control

Issues such as male influence over continuation in education and a lack of involvement in important family decisions were also cited by female interviewees:

My brother has made me stop studying since I was 12 years old, after my Dad passed away. (Female patient10)

I was abroad with my family, when my son called me and told me that his father had started building the house. But [why couldn't we] sit down together and discuss the plan? I'm concerned about every detail in the home - so why didn't we do the planning of the building together? (Female patient12)

Several female informants also drew attention to the violence they had experienced and, more particularly, the lack of appropriate protection and recourse.

Violence

This interviewee was typical with regard to the instances of violence discussed in the interviews:

Her sister also hates my uncles. My (mother's sister) always insult my uncles and her son is always hitting me for silly reasons. One day he came home and gave me an order to serve food to them all. I obeyed him and did what he asked. After we all finished eating he said to me as order to clean everything. I was so angry and I refused to do what he asked. I went to my room. He followed me and hit me on the head, until I was bleeding. None of them treat me nicely. I hate my life. (Female patient 7)

Another patient had been driven to several suicide attempts in the face of repeated violence and sexual assaults by her brother and the apparent indifference of their father:

Even when I told my Dad, I explained it in a letter. I couldn't say that face to face. I have told him that I am depressed, and [my brother] is doing such a thing, he is beating and sexually abusing me. I have told him I am thinking of committing suicide, and you know that I have tried more than once. And I will try until God takes me. He told me not to think again of this, and I will talk to him. And he did. But he didn't say to him, stop abusing your sister. He said to him not to talk to me, and not to ask me to serve him anything. He stopped abusing me for some time, and then it went back to the same story. The problem is my mum knows. I told everyone (crying). No-one did anything for me. They ask me not to go out of the room, and not to tell my Dad, but when he didn't stop I told him…I remain silent, even when he abuses me. I am weak because there is no solution. I talked in the hospital just because I hope that someone will help me. (Female patient 13)

Discussion

Summary and discussion of results

The aim of this study was to investigate culturally distinctive representations of depression within the Libyan population. Seven super-ordinate themes were identified from the data: symptoms;

stigma; social support; recognition of depression; coping with depression, perception of depression from a cultural perspective, and causes of depression. Physical and psychological symptoms emerged as symptoms of depression, and participants reported a variety of somatic features such as: lump in the throat; constipation; shaking feet and speech; losing weight; refusing to talk; losing interest in sex; and bad temper. Also, participants in this study included descriptions of the common pattern of depression as based on psychological symptoms, for example, losing one's old self was identified by many patients. Even though patients were aware of their psychological problems, they tended to report more somatic symptoms, and this extends and supports findings by Sulaiman et al. (2001). And that in turn may indicate the great cultural stigma of depression (Okasha, 2003; Al-Krenawi, 2005; Tylee & Gandhi, 2005; Ryder et al., 2008) rather than inability to distinguish between bodily and psychological symptoms (Leff, 1973). Thus it may be that physical symptoms of depression are considered more curable, and less stigmatized, while psychological ones are more stigmatized (Okasha, 2003; Al-Krenawi, 1999). Physical illnesses are more acceptable from others, as psychological problems are considered as indication of low religious faith (El-Islam, 2008). Psychological help may mean releasing details about the family like private problems and family activities to the therapist (El-Islam, 2008). The current findings in a Libyan context give further evidence in support of the view that depression is a cultural universal, with both psychological and somatic aspects, but that the way that depression is represented varies strongly between cultures. Similar views of the cultural variation of depression as a phenomenon differently represented across cultures have been expressed by (Parker et al., 2001; Arnault et al., 2006; Steptoe et al., 2007; Rong et al., 2009; Lu et al., 2010; Selim, 2010; Leff, 1973).

With no distinction being made between depression and other serious mental health problems, stigmatizing attitudes are highly associated with depression to the same extent as with all mental health problems in Libya, (Sulaiman et al., 2001; Al-Krenawi, 2005). It emerged clearly in the accounts of patients that stigma is linked with the location of treatment, because there are only 2 mental health hospitals in Libya, one in the east (Benghazi) and one in the West (Tripoli); and people

think that everyone in the hospital is critically mentally ill, to the point that the name of the hospital has been changed several times. The current data also indicated that for people with mental health problems, stigma prevents them from going to the hospital, and seeking professional help, to the extent that some of them have attempted suicide. It emerged that people tend to deny that they have been suffering from depression; refuse to seek early help, and refuse contact with the mental health services provided from the hospital, until depression has become severe, and their state is getting worse. Then, they are either forced to contact the mental health services by their relatives, or they attempt suicide. That means many people with depression receive no treatment, or contact with professional help. Also seeking help in a severe stage means that recovery from depression can be difficult. People with depression often hide their crisis from others because they fear that family members, friends, and neighbours will treat them as mad, and they will be ignored or misunderstood (Al-Krenawi, 2005). People do not ask for help from the hospital because the reputation of the hospital is so bad, and people consider the judgment of others above their own needs, and they even do not want to be seen in the hospital, so to avoid social disgrace, Libyan people may travel to outside Libya for treatment (El-Badri, 1995). Particularly for women, having depression reduces the chance of getting married (WHO, 2000; Al-Krenawi, 2000). The negative impact of stigma in present study was revealed also in the patients' own responses towards dealing with doctors.

In this study, it is highly interesting to find that there are gender differences in accounts of social support. All wives in their accounts perceived sufficient social support while all husbands did not perceive social support, and that may be due to cultural factors: Females tended to talk more openly and were thereby getting support, and in any case they are dependent on men to reach medical help. Conversely men reported that they prefer not to talk about personal problems, and anticipated that they will not get adequate support because of lack of knowledge about depression (Al-Krenawi, 2005), or that they want to keep their wives happy, or that they are afraid of being blamed for being weak. This gender difference may be understood from the theoretical perspective of social learning theories, in that the roles of female and male are determined according to the social network, and those

roles are different for each gender (Bandura (1977, Bussey, & Bandura, 1999; Martin et al., 2002). Also, this result give evidence to the argument that the gender differences in prevalence of depression may arise from it being underestimated for men, because of masked depression in men, because men tend to behave according to their roles in the social cultures (Addis, 2008; Parker & Heather, 2010). The present study also suggests that positive and close attachment is essential for receiving good support.

Among some patients with depression, good social support was perceived from family, friends, and neighbours, however some patients reported that lack of family cohesion, and distances between family members can be factors in not getting good support. Also, whilst in a depressed state, female patients reported becoming watched or disrespected by their families, especially when it comes to honour mistakes. In taking a closer look, lack of knowledge about depression may be the most significant problem that prevents family members, friends or neighbours from giving the support that is needed by patients, and this lack of knowledge negatively affects getting support in many ways. First: when depression is not recognised by others around the patient, a patient may face the difficulty of how to convince them that he/she is really in crisis. Second, people do not know how to give support in such a disorder, as there is a culturally specific way of giving support, that is, by visiting the patient's family and staying with them for long times, which may disturb the patient, specially the amount of visitors could be large number for example 10 to 15 person, some of them with kid. It is evident that people do not know about the help that can be provided, and have no idea about the support they may be able to get from professionals; some patients were under professionals care just by coming across it by chance, and this suggests there are many people who do not seek help just because they do not know where to go for help.

Depression was self-recognised by some patients, and not self-recognized by others, suggesting that many people are not likely to receive treatment for their problems. It is interesting to

find that females in the present sample insisted on using the word ill, to complain about depression, and this included those who had been told by a doctor in the past that they were depressed. According to Simon et al., (1999) reporting only physical symptoms are common on centres where patients have no personal physicians. For the Libyan context, the present results therefore favour the view of Douki et al. (2007) that physical complaint is characteristic of women rather than the view of Sulaiman et al., (2001) that gender differences are not expected to influence preferences in expressing depression as general-illness (Sulaiman et al., 2001).

From the interview data, three kinds of help-seeking were identified. First, people who do not seek any help, and are at high risk of committing suicide. Second, people who seek only professional help and were guided by well educated relatives. Third, people who seek both professional and traditional help by first going to a traditional healer or *El-Sheikh*, (Sayed, 2003; Al-Issa, 1999; El-Islam, 2008). *El-Sheikh* is widely available as an unofficial intervention in health care in Libya (Okasha, 2003), particularly, in rural areas of Libya where there is a lack of availability of professional help (Al-Issa, 1990), and because there are only two hospitals serving the whole country (Avasthi, Khan & Elroey, 1991). Usually they switch to a qualified doctor only when they do not feel any better. It is possible that people seek traditional help because they have been strongly influenced by the majority community rather than their own choice. This is not exceptional; for example a doctor was considered as the next best choice after family and friends among Nigerians, Bangladeshis and White British (Lavender, et al. 2006).

Many patients reported practising religious treatment to get relief; both males and females view religion as a key factor in the management of depression, and this conclusion was supported also by Sulaiman et al., (2001). Libyan out-patients use religious observances such as reading the Koran and praying, and they all reported that this helps to get relief, and this evidently functions as an effective distracting response technique to cope with depression (Nolen-Hoeksma, 2008). In order for anyone to pray they must make sure that their clothes and the place of prayer is clean; and they must make make Wuduh (cleaning some parts of the body). Using water may assist their mood change, and

reading from Koran citations helps them to divert their attention away from their depressed thoughts to pleasant thoughts (Nolen-Hoeksema, 2008). Also being mentally engaged with something other than their current problem may relieve unpleasant feelings of sadness. On the other hand, negative attitudes towards medicine were commonly reported by the patients. Some patients do not take medicine as prescribed; they complain of fear of addiction, with no belief in the effectiveness of treatments, and drinking alcohol also was reported as a kind of treatment.

Specific stressful life event may contribute to depression (Kendler, Thornton & Gardner, 2000; Horesh, Klomek, & Apter, 2008; You & Conner, 2009; Allam, 2011) and this is also apparent in the Libyan context. Culture and social systems may have an amplifying effect on the pattern of depression among individuals in Libya. The complex of social interrelations and interactions surrounding life events may influence people's depression. Many such factors were reported by out-patients as risk factors for depression in Libyan context, and many of those factors applied specifically to females, in that Families are strongly influenced by the patriarchal power structure in Libyan (Haj-Yahia, 2000). Men have power over wives, sisters, and daughters (Douki et al., 2007) and violence against women (Douki et al., 2007) and intimate partner violence (Golding, 1999; Pico-Alfonso et al., 2006) were identified in these accounts. Women are expected to make excessive self-sacrifice in their relationships with husbands (Haj-Yahia, 2003). Happiness is not one of the marital expectations of Libyan people, more important is what others think about marriage, and social relationships between the families, and it is a woman's responsibility to maintain the marriage (Haj-Yahia, 2000) and as shown in the accounts of Libyan out-patients, she may be trapped between her family's interest and her violent husband. In addition, poor relationships between the patient and family members were typical in the accounts of depressed out-patients. Relationships with mother, sisters, and brothers, featured as problematic relationships, and a lack of warmth and lack of expression of emotion was often mentioned. The impact of family in developing depression showed itself through a problematic family environment and resulting psychological distress, such as conflict between parents and inappropriate treatment from family members, poor daily communication a lack of time spent

together, and a lack of entertainment. In addition, married women have expressed a communication gap between themselves and their husbands, with a lack of communication of feelings and thoughts, and an unmet need to openly talk about current concerns. Also, the cultural expectation that women should obey men even at the expense of their own interests puts additional pressure on women. Both females and males mentioned discrimination or unfair of treatment due to the gender or colour; low cohesion of family relationships; and lack of sensitivity to feelings between family members.

In this study, I have found further strong, culturally specific gender differences in causes of depression. Females are of lower social status and power than men among Libyan culture, and this has negative consequences for women. Women have less control over very important decisions of their lives, and in the present sample, many basic rights were ignored by the community, such as decisions to marry, to study, to move, and to be independent. Libyan women lack control over their environment, and have lower social power compared with men. Consequently, that may lead to the tendency to engage in ruminative thinking when distressed, by repetitively and passively thinking of the symptoms and the consequences of the depressive mood instead of being active, and solving the sources of their difficulties (Nolen-Hoeksema, 1987, Nolen-Hoeksema, & Larson (1999). Generally, as Nolen-Hoeksema suggested, women may be stuck in rumination because they try to find a way to control their circumstances but they fail to do so (Nolen-Hoeksema, 2008).

In the current study, negative life events, and difficult circumstances have been identified in patient accounts as risk factors in the vulnerability to depression. For females: negative life events identified as causes of depression included rape, and being repeatedly, physically, emotionally, and sexually abused by family members with no protection against abuse. However, less extreme negative events, such as living in bad facilities in university accommodation were also mentioned as causes of depression. Also, being a single female and passing the age of marriage, or getting divorced can be a major life event leading to depression. For both male and female: loss of some kind such as loss of a

family member or friend was considered as a stressful event that can cause depression. According to participants in this study, one of the factors that can lead to depression is problems in the workplace, such as the working environment, social relations in the workplace, and corruption.

In this study, the importance accorded to the perceptions of others, may put people under pressure and place them under an obligation to others. In regard to the causes of depression from the patients' perspective, supernatural influence through sorcery was mentioned by only one patient as a potential cause of depression. This has been reported as being more widely prevalent in some previous studies such as Al-Krenawi (1999) and Al-Issa (1999) El-Islam (2008), and sub-cultural studies (comparing different groups within Libya) may be needed to explore this specific perception of depression.

In contrast to all of the previous factors that were reported by females as causes of depression in this study, it is interesting to find only two themes emerged as specific to males; taking on family responsibilities, and shortage of money. These findings reflect the fact that it is men's obligation to take on financial commitments in Libyan culture, and perhaps that these are socially acceptable pressures for males to talk about.

Strengths and limitations of the present study

This study has several strengths; the sample was varied: thus the inclusion of females with differing marital status (single, married, and divorced) gave rich detailed backgrounds to such experiences among depressed women. Also the sample of interviewees included people of different educational level, occupation, and age. It was a clinical sample, that is, it consisted of people who had been diagnosed in clinical interviews as suffering from depression rather than a self-report questionnaire study of a non-clinical sample. Although the out-patient participants came from a single general practice, and the sample is small, the findings of the present study are likely to be generalizable, and to have wider applicability, because people come to the hospital from the entire country. I believe that this exploratory study, yielded useful data about the model of depression in

Libyan culture, and illuminated the possible reasons for the higher depression scores in females in Study 1. Despite these strengths, the study has some limitations including; I did not ask about the city of residence of participants, which may have revealed further regional cultural influences that affect the participants' views. Data from males did not include divorced men and that would have been a good chance to compare the difficulties facing divorced men with those of divorced women. Data from both males and females does not include people of low socioeconomic status, so many of the difficulties may have been related to the particular social and economic level may be not reported in the current study. Data does not for example include married worker women and I expect those would suffer from different difficulties from housewives.

Conclusion

To sum up, findings from this study of Libyan out-patients provide an important record of the individual experience of depression, placing a spotlight on the cultural construction of depression. These findings have major implications for individuals who deal with patients with mood disorder, and for those who are involved in planning mental health services in Libya. The accounts of the women in this sample of the experience of depression in Libya reflected a considerable degree of female suffering and stresses from the social environment in Libyan society, and awareness of these issues should be remembered

The accounts of the informants in this study revealed a difficult journey to receiving help, and a considerable lack of understanding of depression among individuals, family members and the wider society. This suggests that more progress is needed with regards to increasing community awareness of depression. If people have poor knowledge, or stigmatizing attitudes towards common depression, then they may be even less likely to seek help. Work is thus needed to address the problems of stigma and discrimination associated with depression, also an increase of public awareness of mental illness is needed.

The identification of culturally distinctive features of depression has a practical value, specifying some of the culturally sensitive issues that may affect the delivery of psychotherapy for the Libyan population. The present study focused on Libyan culture-specific experiences of depression, and the identification of different cultural beliefs, considerations, and understandings of depression should be taken into account in the preparation, guidance and training of practice staff. Depression can be better understood in the context of a population's own perspectives.

Chapter 6

Overall Discussion

This final chapter contains an overall discussion of both study 1 and study 2; Future research; implications; and brief conclusions.

Summary of the Studies

The purpose of both studies was to investigate depression; the first study found that self-esteem emerged as a negative significant predictor of depression, and females were significantly more depressed than males among most of the BDI-II items, (gender differences in psychological and somatic symptoms) (pp. 103-99). Although this study was with a non-clinical population, studies in UK and other countries have shown that BDI scores in representative samples correlate with population prevalence of clinical depression (Chapter 2). However, Study 1 did not identify cultural risk factors that may lead to depression, nor did it identify causes of the higher BDI scores in females. Study 2 provided a possible set of answers: There are considered to be differences in males' and females' experiences of patriarchal hierarchies; cultural practices which affect marriage; and of social control, and these emerged as causal themes in individual accounts of depression in the Libyan female depressed sample. Also, levels of violence, bereavement, estrangement, loss of hope, perceptions attributed to other people, problems in the workplace and family relationships all emerged as perceived causes of depression, and the way these events and stresses showed themselves in the accounts of depressed patients is culturally specific. Study 2 thus identified the characteristic symptoms, and revealed a delayed recognition of depression, a specific pattern of treatment choices, strong perceptions of stigma, and typical sources of support as constituting a Libyan cultural model of depression (Chapter 5).

The Libyan non-clinical sample reported low overall subscale scores in suicide wishes, when they were asked to reply directly in study 1. However, the clinical sample reported many cases of

attempting suicide in study 2. Previous studies have explained the low reporting of suicidal wishes as due to the Islamic religion which condemns suicide (Al-Musawi, 2001).

Sex differences were found to be a powerful factor in two ways, in affecting depression scores and the overall symptoms of depression in Study 1, and in determining the ways of seeking help in the Libyan sample in study 2. Both studies found consistent evidence of gender differences in depression, study 1 found that Libyan females in a non-clinical sample were significantly more depressed than males. Study 2 revealed some possible reasons for gender differences in causes of depression that may also account for differences in the overall BDI-II scores of males and females in the non-clinical sample. However, contrary to the overall pattern of adverse life events and persecution in women, in Study 2, all females reported good perceptions of social support, whereas no males reported good perceptions of social support; also, men were found not to disclose depression to family members, and to hide depression from others. Thus differences in the BDI scores between men and women in the Libyan sample may also be influenced by under reporting due to social cultural factors that can be explained by Gender Schema Theory (Chapter 3). Thus, cultural factors may play a significant role in the gender differences in reporting of depression; but also the differences in depression scores may be explained by the differences in the exposure to stressful life events that apply to women more than men. Cultural conditions can put women under such stress that it leads to depression, and the findings of the current study thus are consistent with the account of social learning theory to explain the differences between women and men in depression in Libyan context (pp. 67, 68).

Qualitative evidence indicated that stigma against mental disorders remains severe in the Libyan nation; the stigmatisation of depression is one of the major problems that is facing people in Libya, and it can lead to delay in obtaining appropriate help, an added burden of shame, poorer individual functioning at best, and at worst, devastating consequences such as suicide.

As a quantitative self-report method was used to measure depression in the first study, and although this resulted in high depression scores in a non-clinical sample, it is essential to bear in mind

that stigma and the concealment of depression, as reported by the participants in the second study, may influence self-report. Therefore, it could be possible that many participants, and not only men, were unwilling to acknowledge their symptoms, and that the true extent of depression in the non-clinical Libyan sample was underestimated. Because of the influence of the negative attitudes, lack of knowledge, and the negative view of mental illness to the extent of a taboo on mentioning the location of a hospital where mental health services are available, individuals living in this society are less likely to recommend seeking help from a mental health specialist. Furthermore, the problem of accessing effective treatment is compounded by the lack of resources, and given the high workload of the mental health services, a psychiatrist may not able to allocate sufficient time in assessing and treating an individual patient as psychiatrist have to diagnose many patients within such a short time.

Although two participants who were forced to marry were identified in the present study, forced marriage is uncommon in the current Libyan culture, and in this study the reports of forced marriage and withdrawal from education were reported from women who were 40 and 37 years old, which means that it relates to the situation about 25 years ago. However, one participant, who was 25 years old, reported that she was forced to withdraw from education after only 5 years. Also, I should point out that most parents in Libya encourage their daughters to enter further education as people believe that the only insurance that can protect their daughters from remaining single or becoming divorced is a high level of education. However, Honour matters are still powerful and these factors are clearly identified in individual life stories leading to depression by younger as well as older women in the present study. Also, I should point out that poverty did not emerge in this study as a stress factor that leads to depression in Libyan context (in both genders) and these findings disagree with Steptoe et al., (2007) and Allam, (2011). Females in Libya get the same salary as men and this has been the case for many years, and for this sample it has never been otherwise.

Future research

According to the results of both studies I include in the following section of what I consider to be essential areas of future research.

First, in regard to the Libyan context, it would be important to replicate this study of depression in the Libyan context after the war of 17 February 2011 in order to do a comparison between the levels of depression before this date, by which I mean the present study, and after. Also replicating the qualitative study may reflect the influence of some political factors, or trauma arising from the conflict, that may contribute to depression. Also, it would be interesting to study depression in the current period of political and economic changes and explore how this change may contribute either to higher or lower levels of depression. Secondly, some cultural beliefs about causes and treatments may vary between different areas of Libya, and these beliefs should be more widely studied. More studies are also needed to address the cultural factors that lead to vulnerability to depression with females in Libya particularly in divorced women.

Further studies are needed regarding the development of cultural competency practice, which means knowledge of cultural practices, beliefs, and values in mental health services in relation to depression, and what are the appropriate kinds of interventions. Libya also needs to work out how to extend mental health services to apply to an entire country; this will require decisions on how mental health services should deal with issues like the social position of women with the extended and traditional roles of society (as reflected in the accounts of participants in study 2).

There is also a need to conduct longitudinal studies that would study depression with relation to some of the social and psychological related factors, such as emotional distance between family members; warmth; comfort, and love; that emerged in study 2, and to identify the right kind of support that is needed in such mood disorders. Also, more studies are essential to address the kinds of abuse that occur, and what kinds of solution can be found in the Libyan context.

Implications

These findings have implications for individuals who deal with patients with mood disorder around the world, and for those who are involved in planning mental health services in Libya. The experiences of depressed women in Libya and the higher depression scores in the non-clinical female sample appear to reflect a significant degree of female suffering and stresses from the social environment in Libyan society, and awareness of these issues should be remembered.

Because considerable lack of understanding of the experience of depression was identified in study 2, more progress is needed with regards to increasing community awareness. If people have poor knowledge, or stigmatizing attitudes towards common depression, then they are unlikely to seek appropriate help. Work is also needed to address the problems of stigma and discrimination associated with depression; also an increase of public awareness of mental illness is needed. It is essential therefore to understand why depression is widely stigmatized in many countries and in the Libyan context in particular, and to reduce the problems caused by stigmatization.

The results of the present study suggest a considerable lack of help-seeking for depression particularly by men and it may be beneficial therefore to improve general knowledge about mood disorders. Increasing public awareness of related mental illness problems using local media, school curricula, public lectures, needs to be accepted as a priority. Stigma in the Libyan context prevents many from seeking help from professionals and family, and stigmatisation was identified in Study 2 as perhaps the main problem facing patients with depression. Libyan people need some degree of knowledge about depression, and people need to be educated not to use insulting language for depressed people.

It is important to increase the knowledge through social networks about the support that can be provided both by family members, and professionals. Findings of Study 2 show a lack of awareness regarding mental health services, leading to delays in obtaining professional help. I suggest mental health services should be also improved by providing more qualified people such as psychiatrist, psychologist, nurses, and social workers. Also, because mental health services are so limited, there is a need to provide hostels and rehabilitation services in different areas in Libya, to provide manuals for doctors and to improve psychotherapy through training. The tendency to somatization as seen in the questionnaire study, may lead depressed individuals to seek help from a medical doctor for treatment of a perceived physical illness before reaching the right professional help. Traditional help providers are sought out as they are more available, and because of beliefs concerning social supernatural and religious causes. This should be taken to consideration in the design of mental health services and in the design of public education campaigns about depression.

It is a critical step to formulate a committed mental health policy that is sensitive to gender and the needs of women in particular, and this commitment should be recognised throughout the mental health system. Domestic violence was identified in the current study in the accounts of depressed women, and together with other evidence reviewed this indicates that women are at a great risk of substantial violence and abuse in Libya. Mental health regulation and policy should ensure women's safety, privacy, dignity, and provide protection for female victims. The law must provide appropriate penalties for domestic violence and perpetrators of abuse must be prosecuted. Religious leaders must condemn domestic violence and oppression against women.

The Government should have a role in developing and employing defensive strategies to reduce domestic violence and repeated victimisation. Goals should be set for reducing violence, providing a better environment for a healthy family life and improving the health care system to support women

who experience violence. Also, researches should be carried out to provide information and guidance on preventing violence against women.

Conclusion

To sum up, the field of cross-national studies is area of study which can contribute to better understanding of depression as a universal phenomenon that manifests differently in different cultures. This study has provided quantitative statistical analysis of the extent that collectivism, individualism, familism, social support, and self-esteem do or do not contribute to depression, and indicates that these variables cannot account for the differences in depression scores between females and males in a Libyan sample. Also this study draws attention to gender differences in depression and shows that they are at least as powerful in Libya as in other countries. Finally, the study has explored the experience of depression in Libyan women and men, and their understanding of its symptoms causes and treatment from their own point of view. It is hoped that this study can shine a spotlight on the understanding of depression in the Libyan context.

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Appendices

Appendix 1

Ethical Approval Form for study 1

EXPEDITED REVIEW Checklist, School Of Social Sciences, Brunel University

Effective 1 October 2007

This checklist, based on the Research Ethics Review Checklist from the ESRC Research Ethics Framework, was designed to help determine the level of risk of harm to participants' welfare entailed in a proposed study within the School of Social Sciences at Brunel University.

This checklist should be completed for every empirical research project in the School by students and staff (see note below regarding staff funding applications), that involves human participants. It is used to identify whether a full application for ethics approval needs to be submitted. If a full application is required, then the University Research Ethics Committee's full **Application Form for Research Ethics Approval** must be used. A Word version of the full Application Form for Research Ethics Approval can be downloaded from: http://intranet.brunel.ac.uk/registry/minutes/researchethics/home.shtml.

Before completing this form, please refer to the university General Ethical Guidelines and Procedures, as well as the Code of Research Ethics (both documents can be downloaded from http://intranet.brunel.ac.uk/registry/minutes/researchethics/home.shtml). The principal investigator at Brunel University (and, when the student is the principal investigator, the student's immediate supervisor at Brunel University) is responsible for exercising appropriate professional judgement in this review.

This checklist must be completed and approved before potential participants are approached to take part in any research.

Having completed this form, it is possible that we may need further information from you, and in some instances you may be required to submit your plans for addressing the ethical issues raised by your proposal using the University Research Ethics Committee's full **Application Form**. This does not mean that you cannot do the research, only that your proposal may need to be considered further and approved by the School Research Ethics Committee. Please note that answering 'Yes' or 'No' to any of questions does not in itself give rise to the possibility of having to provide a fuller description.

If you answered 'Yes' to question 11, and the research falls outside of NHS audit procedures, then you will have to submit an application to the appropriate external health authority ethics committee after you have received provisional approval from the School Research Ethics committee (please see instructions on School Ethics webpage).

It is your responsibility to follow the Code of Research Ethics, developed by the University Research Ethics Committee, as well as any relevant academic or professional guidelines in the conduct of your study. This includes providing appropriate documentation, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design or conduct over the course of the research should be notified to the School Research Ethics Officer and may require a new application for ethics approval.

Assessed work requiring research ethics approval
Undergraduate and Masters students must retain a copy of the approved form and submit it with their research report or dissertation (bound in the Appendix); MPhil/PhD students must retain a copy of the form and submit it to the Research Degrees Board with their application for Registration. For class exercises, lecturers who have set research projects on behalf of the students will be responsible for obtaining ethics approval; in such instances, students must enclose a copy of their lecturers' approved ethics forms with their work. All undergraduate and postgraduate work that is submitted without an approved ethics form may be subject to penalties; students must consult the appropriate module convenors for penalties regarding failure to submit approved ethics forms as part of research-based work in specific modules.

Staff research
Please note that all members of staff who are the primary researchers at Brunel University, whether collecting data with or without the aid of students, must submit ethics forms to the School Research Ethics Committee. If the ethics submission relates to staff research for which an application to an external funding agency will be/has been made, then please complete and submit the full University ethics submission form (see notes on School Ethics Webpage).

Submission instructions
Please submit **two copies** of this form completed and signed, to Devinder Saggi via the drop box outside MJ157 for review.

16/5/08

SCHOOL OF SOCIAL SCIENCE RESEARCH ETHICS CHECKLIST (Effective 1 Oct 2007)

If the ethics submission relates to staff research for which an application to an external funding agency will be/has been made, then please complete and submit the full University ethics submission form.

Section I: Project Details

1. Project title: Depression, Social support, Self-esteem, and Culture values Orientation in Libya and Britain

Section II: Applicant Details

2. Name of researcher (applicant):	Aisha Abuhajar
3. Status (please circle): Undergrad Student/Postgrad Student/Staff	Postgrad Student
4. Discipline (please circle): Eco & Fin/His & Pol/Psy/SAnth/Soc & Com	Psy
5. Email address:	Aisha.Abuhajar@brunel.ac.uk
6. Telephone number	07796763822

Section III: For Students Only

7. Module name and number:	PhD
8. Brunel supervisor's or module leader's name:	Dr:Stanley Gaines& Proff.Michael Wright
9. Brunel supervisor's email address:	Dr:stanely.gaines@brunel.ac.uk& michael.wright@brunel.ac.uk/

Supervisor: Please tick the appropriate boxes. The study should not begin until all boxes are ticked:

- ☑ The student states that he or she has read the Brunel University Code of Research Ethics.
- ☑ The topic merits further research.
- ☑ The student will possess the skills to carry out the research by the time that he or she starts any work which could affect the well-being of other people. He or she will be deemed to have acquired such skills on passing the relevant research skills module.
- ☑ The participant information sheet or leaflet is appropriate.
- ☑ The procedures for recruitment and obtaining informed consent are appropriate.

Please confirm the professional research ethics code that will guide the research (please circle)

ASA/BPS/BSA/Other (please state) _____

Stanley Gaines — 14 May 2008

Supervisor's signature — Date

Section IV: Research Checklist

Please answer each question by ticking the appropriate box:

	YES	NO
1. Does the study involve participants who may be particularly vulnerable and/or unable to give informed consent, thus requiring the consent of parents or guardians? (e.g. children under the age of 16; people with certain learning disabilities)	☐	✔
2a. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	☐	✔
2b. If the answer to Question 2a is Yes, then will the study involve people who could be deemed in any way to be vulnerable by virtue of their status within particular institutional settings? (e.g. students at school; disabled people; members of a self-help group; residents of a nursing home, prison, or any other institution where individuals cannot come and go freely)	☐	✔
3. Does the research involve observational/ethnographic methods?	☐	✔
4. Will the study involve discussion by or with respondents or interviewees of their own involvement in activities such as sexual behaviour or drug use, where they have not given prior consent to such discussion?	☐	✔
5. Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	✔
6. Will blood or tissue samples be obtained from participants?	☐	✔
7. Is pain or more than mild discomfort likely to result from the study?	☐	✔
8. Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	☐	✔
9. Will the study involve prolonged or repetitive testing?	☐	✔
10. Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	✔
11. Will the study involve recruitment of patients or staff through the NHS?	☐	✔
12a. Have you undertaken this study as part of your work placement?	☐	✔
12b. If your answer to Question 12a is Yes, then have the employers at your work placement conducted their own research ethics review?	☐	✔
13. Does the research involve MRI, MEG, or EEG methods?	☐	✔

Participants are random samples, public, British and Libyan, males and females, aged from 18 and over, Who they are going to complete the total packet of questionnaires .Each sample consists about 200, and would be asked about their sex, age, religion, marital status, social economic and education level. For British sample the target people who were born in the UK or British who have been in the UK for at lest 10 years. Both of the sample are given enclosed envelope, which contents the questionnaires and prepayment empty envelope, After giving some information about the current research, thus we are could motivate them to response to these questionnaires and send them to our address.

Measures: (A) Individualism, Collectivism, Familism Scale (Gains, 1997) will be used to obtain subjective report of IND,COL and FAM, this scale consist of 10 items for each. (B)Beck Depression Inventory (BDI-II) contains 21 sets of four statement Respondents are asked to indicate Which statements best characterize the way they have been feeling during the past two weeks. (C) Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet & Farley, 1988) is a brief measure will be used to obtain subjective reports of social support.

(D) Rosenberg Self-Esteem scale (RSE, Rosenberg). This scale consists of 10 items assess positive or negative evaluation of the self.

All of questionnaires are translated to the Arabic language for Libyan sample.

Name of Principal Investigator at Brunel University (please print): Aisha Abuhajar

Signature of Principal Investigator at Brunel University: _____

E-Mail Address: aisha.Abuhajar@brunel.ac.uk

Date: 02/05/08

This request for expedited review has been: (1) Approved (no additional ethics form is necessary)
~~(2) Declined (full University ethics form is necessary)~~

Signature of School Research Ethics Officer: _____

Date: 19/05/08

Appendix 2

Socio Demographic Data Sheet

1. Sex: □ Male □ Female

2. Age: □ 18-30 □ 31-40 □ 41-50 □ 51-60 □ Over 61

3. Religion: □Believer Please state……. □ Non Believer

4. Marital Status: □ Single □ with Spouse

5. Social Economic: □ High □ Middle □ Low

6. Educational Level: □ High □ Middle □ Low

7. Occupation……

8. How long have you been in Britain? ……

9. Ethnic background……..

Appendix 3

Beck Depression Inventory

Instruction:

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

No.	Statement	
1 Sadness	0	I do not feel sad.
	1	I feel sad much of the time.
	2	I am sad all the time.
	3	I am so sad or unhappy that I can't stand it
2 Pessimism	0	I am not discouraged about my future.
	1	I feel more discouraged about my future than I used to be.
	2	I do not expect things to work out for me.
	3	I feel my future is hopeless and will only get worse.
3 Past failure	0	I do not feel like a failure.
	1	I have failed more than I should have.
	2	As I look back, I see a lot of failures.
	3	I feel I am total failure as a person.
4 Loss of pleasure	0	I get as much pleasure as I ever did from the things I enjoy.
	1	I don't enjoy things as much as I used to.
	2	I get very little pleasure from the things I used to enjoy.
	3	I can't get any pleasure from the things I used to enjoy.
5 Guilty feeling	0	I don't feel particularly guilty.
	1	I feel guilty over many things I have done or should have done.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6 Punishment feeling	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
No.	Statement	
7 Self-dislike	0	I feel the same about myself as ever.
	1	I have lost confidence in myself.
	2	I am disappointed in myself.
	3	I dislike myself.
8 Self-criticalness	0	I don't criticize or blame myself more than usual.
	1	I am more critical of myself than I used to be.
	2	I criticize myself for all of my faults.
	3	I blame myself for everything bad that happens.
9 Suicidal thoughts or wishes	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.

10 Crying	0	I don't cry anymore than I used to.
	1	I cry more than I used to.
	2	I cry every little thing.
	3	I feel like crying, but I can't.
11 Agitation	0	I am no more restless or wound than usual.
	1	I feel more restless or wound up than usual.
	2	I am so restless or agitated that it's hard to stay still.
	3	I am so restless or agitated that I have to keep moving or doing something.
12 Loss of interest	0	I have not lost interest in other people or activities.
	1	I am less interested in other people or things than before.
	2	I have lost most of my interest in other people or things.
	3	It's hard to get interested in anything.
13 Indecisiveness	0	I make decisions about as well as ever.
	1	I find it more difficult to make decisions than usual.
	2	I have much greater difficulty in making decisions than I used to.
	3	I have trouble making any decisions.
14 Worthlessness	0	I do not feel I am worthless.
	1	I don't consider myself as worthwhile and useful as I used to.
	2	I feel more worthless as compared to other people.
	3	I feel utterly worthless.
15 Loss of energy	0	I have as much energy as ever.
	1	I have less energy than I used to have.
	2	I don't have enough energy to do very much.
	3	I don't have enough energy to do anything.
16 Change in sleeping pattern	0	I have not experienced any change in my sleeping pattern.
	1	a- I sleep somewhat more than usual.
		b- I sleep somewhat less than usual.
	2	a- I sleep a lot more than usual.
		b- I sleep a lot less than usual.
	3	a- I sleep most of the day.
		b- I wake up 1-2 hours early and can't get back to sleep.
17 Irritability	0	I am no more irritable than usual.
	1	I am more irritable than usual.
	2	I am much more irritable than usual.
	3	I am irritable all the time.
No.	Statement	
18 Changes in appetite	0	I have not experienced any change in my appetite.
	1	a- My appetite is somewhat less than usual.
		b- My appetite is somewhat greater than usual.
	2	a- My appetite is much less than before.
		b- My appetite is much greater than usual.
	3	a- I have no appetite at all.
		b- I crave food all the time.
19 Concentration difficulty	0	I can concentrate as well as ever.
	1	I can't concentrate as well as usual.
	2	It's hard to keep my mind on anything for very long.
	3	It find I can't concentrate on anything.
20 Tiredness or fatigue	0	I am no more tired or fatigued than usual.
	1	I get more tired or fatigued to do a lot of the things I used to do.
	2	I am too tired or fatigued to do a lot of the things I used to do.
	3	I am too tired or fatigued to do most of the things I used to do.

21 Loss of interest in sex	0	I have not noticed any recent change in my interest in sex.
	1	I am less interested in sex than I used to be.
	2	I am much less interested in sex now.
	3	I have lost interest in sex completely.

Appendix 4

The Individualism, Collectivism, and Familism Scales

Instructions:

Below is a list of statements dealing with your general feelings about yourself.

- If you strongly disagree, tick SD.
- If you disagree, tick D.
- If you are neutral, tick N.
- If you agree, tick A.
- If you strongly agree, tick SA.

No	Statement:	SD	D	N	A	SA
1	I am not to blame for other's misfortunes.					
2	I feel that I am the master of my own fate.					
3	I really feel that the "pull-yourself-up-by-bootstraps" philosophy makes a lot of sense.					
4	These days, the only person you can depend upon is yourself.					
5	I take great pride in accomplishing what no one else can accomplish.					
6	I actively resist other people's efforts to mould me.					
7	Before I can feel comfortable with anyone else, I must feel comfortable with myself.					
8	I place personal freedom above all other values.					
9	I know myself better than anyone else possibly could know me.					
10	I see nothing wrong with self-promotion.					

No	Statement:	SD	D	N	A	SA
1	I don't feel that I am a success unless I've helped other succeed as well.					
2	I want the opportunity to give back to my community.					
3	I'm the type of person who lends a helping hand whenever possible.					
4	I consider myself a team player.					
5	My major mission in life is striving for social justice for all.					
6	My heart reaches out to those who are less fortunate than myself.					
7	If another person can learn from my mistakes, I'm willing to share my ups and downs with that person so that he or she can do better.					
8	It feels great to know that others can count on me.					
9	I have an important role to play in bringing together the people of the world.					
10	I believe in the motto, "united We Stand, Divided We Fall."					

No	Statement	SD	D	N	A	SA
1	When it comes to social responsibility, blood really is thicker than water.					
2	My family always is there for me in times of need.					
3	I owe it to my parents to do well in life.					
4	I know that my family has my best interests in mind.					
5	I cherish the time that I spend with relatives.					
6	I will do all that I can to keep alive the traditions passed on to me by my parents and grandparents.					
7	Even when I'm far away from home, my family ties keep me feeling safe and secure.					
8	To this day, my parents' teachings serve as my best guide to behaviour.					
9	In my opinion, the family is the most important social institution of all.					
10	I cannot imagine what I would do without my family.					

Appendix 5

The Multidimensional Scale of Perceived Social Support

Instructions:

Below is a list of statements dealing with your general feelings about yourself.

- If you are very strongly disagree, tick VSD.
- If you are strongly disagree, tick SD.
- If you are disagree, tick D.
- If you are neutral, tick N.
- If you are agree, tick A.
- If you are strongly agreed, tick SA.
- If you are very strongly agreed, tick VSA.

No	Statement:	VSD	SD	D	N	A	SA	VSA
1	There is a special person who is around when I am in need.							
2	There is a special person with whom I can share my joys and sorrows.							
3	My family really tries to help me.							
4	I get the emotional help and support I need from my family.							
5	I have a special person who is real source of comfort to me.							
6	My friends really try to help me.							
7	I can count on my friends when things go wrong.							
8	I can talk about my problems with my family.							
9	I have friends with whom I can share my joys and sorrows.							
10	There is a special person in my life who cares about my feelings.							
11	My family is willing to help me make decisions.							
12	I can talk about my problems with my friends.							

Appendix 6

The Rosenberg Self-Esteem Scale

Instructions:

Below is a list of statements dealing with your general feelings about yourself.

- If you strongly agree, circle SA.
- If you agree, circle A.
- If you disagree, circle D.
- If you strongly disagree, circle SA.

No	Statement:	SA	A	D	SD
1	On the whole, I am satisfied with myself.				
2	At times, I think I am no good at all.				
3	I feel that I have a number of good qualities.				
4	I am able to do things as well as most other people.				
5	I feel I do not have much to be proud of.				
6	I certainly feel useless at times.				
7	I feel that I'm a person of worth, at least on an equal plane with others.				
8	I wish I could have more respect for myself.				
9	All in all, I am inclined to feel that I am a failure.				
10	I take a positive attitude toward myself.				

Appendix 7

Socio Demographic Data for Arabic Version

مقاييس الشخصي

1. الجنس: ❑ ذكر ❑أنثى

. العمر:❑ 51- 60 ❑ 41-50 ❑ 31 40 ❑ 18-30 ❑فوق 61

3. الوضع العائلي: ❑متزوج ❑أعزب

. الحالة الاقتصادية: ❑منخفض ❑متوسط ❑ عالي

5. المستوى التعليمي: ❑منخفض ❑متوسط ❑ عالي

المهنة: .....

Appendix 8

Beck Depression Inventory (Arabic Version)

التعليمات:
تتضمن هذه الورقة 21 مجموعه من العبارات، الرجاء أن تقرأ كل مجموعة من العبارات بعناية، ثم اختار من كل مجموعة عبارة واحدة والتي تصف بطريقة أفضل الطريقة التي تشعر بها خلال الأسبوعين الأخيرين بما في ذلك اليوم. ضع دائرة حول الرقم جوار العبارة التي اخترتها. ولو بدا لك أكثر من عبارة في مجموعة العبارات تنطبق عليك بطريقة متساوية، ضع دائرة حول أكبر رقم في هذه المجموعة وتأكد أنك لا تختار أكثر من عبارة في أي مجموعة بما في ذلك المجموعة رقم 16 (تغيرات في نمط النوم) أو المجموعة 18 (تغيرات في نمط الشهية).

(0)

المجال	الرقم	العبارة
1 الحزن	0	لا اشعر بالحزن.
	1	أشعر بالحزن أغلب الوقت.
	2	أنا حزين طول الوقت.
	3	أنا حزين أو غير سعيد لدرجه لا أستطيع تحملها.
2 **التشاؤم**	0	لم تفتر همتي فيما يتعلق بمستقبلي.
	1	أشعر بفتور الهمة فيما يتعلق بمستقبلي بطريقه أكبر مما اعتدت.
	2	لا أتوقع أن تسير الأمور بشكل جيد بالنسبة لي.
	3	أشعر بأنني لا أمل لي في المستقبل وانه سوف يزداد سوءا.
3 **الفشل السابق**	0	لا أشعر بأنني شخص فاشل.
	1	لقد فشلت أكثر مما ينبغي.
	2	كلما نظرت إلى الوراء أرى الكثير من الفشل.
	3	أشعر بأنني شخص فاشل تماما.
4 فقدان الاستمتاع	0	استمتع بالأشياء بنفس استمتاعي بها من قبل.
	1	لا استمتع بأشياء بنفس القدر الذي اعتدت عليه.
	2	احصل على قدر قليل جدا من الاستمتاع من الأشياء التي اعتدت الاستمتاع بها.
	3	لا أستطيع الحصول على أي استمتاع من الأشياء التي اعتدت الاستمتاع بها.
5 مشاعر الإثم (تأنيب الضمير)	0	لا أشعر بالإثم (تأنيب الضمير).
	1	اشعر بتأنيب الضمير عن العديد من الأشياء التي قمت بها أو أشياء كان يجب أن أقوم بها ولم أقم بها.
	2	أشعر بالإثم (تأنيب الضمير) أغلب الوقت.
	3	أشعر بالإثم (تأنيب الضمير) طول الوقت.
6 مشاعر العقاب	0	لا أشعر بأنه يقع على عقاب.
	1	اشعر بأنه ربما يقع علي العقاب.
	2	أتوقع أن يقع علي عقاب.
	3	أشعر بأنه يقع علي عقاب.
7 عدم حب الذات	0	شعوري نحو نفسي كما هو.
	1	**فقدت** الثقة في نفسي.
	2	خاب رجائي في نفسي.
	3	لا احب نفسي.
8 نقد الذات	0	لا أنقد أو ألوم نفسي أكثر من المعتاد.
	1	أنقد نفسي أكثر مما اعتدت.
	2	أنقد نفسي على كل أخطائي.
	3	ألوم نفسي على كل ما يحدث من أشياء سيئه.
9 **الأفكار أو الرغبات الانتحارية**	0	ليس لدي أي أفكار للانتحار.
	1	لدي أفكار للانتحار لكن لا يمكنني تنفيذها.
	2	أريد أن انتحر.
	3	قد انتحر لو سمحت لي الفرصة.
10 البكاء	0	لا ابكي أكثر مما اعتدت.
	1	أبكي أكثر مما اعتدت.
	2	أبكي أكثر من أي شيء بسيط.
	3	أشعر بالرغبة في البكاء ولكني لا أتستطيع.
11 التهيج	0	لست أكثر تهيجا أو استثارة عن المعتاد.
	1	أشعر بالتهيج والاستثارة اكثر من المعتاد.

والاستثارة	2	اهتاج واستثار لدرجة أنه من الصعب علي البقاء بدون حركة.
	3	اهتاج أو استثار لدرجة تدفعني للحركة أو فعل شيء ما.
12 فقدان الاهتمام	0	لم افقد الاهتمام بالآخرين أو بالأنشطة.
	1	اهتم بالآخرين أو بالأمور اقل من قبل.
	2	فقدت اغلب اهتمامي بالآخرين والأمور الأخرى.
	3	من الصعب أن اهتم بأي شيء.
13 التردد	0	اتخذ القرارات بنفس كفاءتي المعتادة.
	1	أجد صعوبة اكثر من المعتاد في اتخاذ القرارات.
	2	لدي صعوبة اكثر بكثير مما اعتدت في اتخاذ القرارات.
	3	لدي مشكله اتخاذ أي قرارات.
14 انعدام القيمة	0	لا اشعر بأنني عديم القيمة.
	1	لا أعتبر نفسي ذو قيمه وذو نفع كما اعتدت أن أكون.
	2	اشعر بأنني عديم القيمة بالمقارنة بالآخرين.
	3	أشعر بأنني عديم القيمة تماما.
15 فقدان الطاقة	0	لدي نفس القدر من الطاقة كالمعتاد.
	1	لدي قدر من الطاقة أقل مما اعتدت.
	2	ليس لدي طاقة كافيه لعمل العديد من الأشياء.
	3	ليس لدي طاقه كافيه لعمل أي شيء.
16 **تغيرات في نمط النوم**	0	لم يحدث لي أي تغير في نمط (نظام) نومي.
	1	أ- أنام اكثر من المعتاد إلي حد ما.
		ب- أنام أقل من المعتاد إلى حد ما.
	2	أ- أنام أكثر من المعتاد بشكل كبير.
		ب- أنام اقل من المعتاد بشكل كبير.
	3	أ- أنام أغلب اليوم.
		ب- أستيقظ من نومي مبكرا ساعة آو ساعتان ولا أستطيع العودة للنوم مره أخرى.
17 القابلية للغضب والانزعاج	0	قابليتي للغضب أو الانزعاج لم تتغير عن المعتاد.
	1	قابليتي للغضب أو الانزعاج اكبر من المعتاد.
	2	قابليتي للغضب أو الانزعاج اكبر بكثير من المعتاد.
	3	لدي قابليه للغضب أو الانزعاج طول الوقت.
18 تغيرات في الشهية	0	لم يحدث أي تغيير في شهيتي.
	1	أ- شهيتي أقل من المعتاد إلى حد ما.
		ب- شهيتي أكبر من المعتاد إلى حد ما.
	2	أ- شهيتي أقل بكثير من المعتاد.
		ب- شهيتي أكثر بكثير من المعتاد.
	3	أ- ليست لي شهية علي الإطلاق.
		ب- لدي رغبه قويه للطعام طول الوقت.
19 صعوبة التركيز	0	أستطيع التركيز بكفاءتي المعتادة.
	1	لا أستطيع التركيز بنفس الكفاءة المعتادة.
	2	من الصعب علي أن أركز عقلي على أي شيء لمده طويلة.
	3	أجد نفسي غير قادر على التركيز على أي شيء.
20 الإرهاق أو الإجهاد	0	لست أكثر إرهاقا أو إجهادا من المعتاد.
	1	أصاب بالإرهاق أو الإجهاد عن عمل الكثير من الأشياء التي اعتدت عملها.
	2	يعوقني الإرهاق أو الإجهاد عن عمل الكثير من الأشياء التي اعتدت عملها.
	3	أنا مرهق أو مجهد جدا لعمل اغلب الأشياء التي اعتدت عليها.
21 فقدان الاهتمام بالجنس	0	لم ألاحظ أي تغير في اهتمامي بالجنس حديثا.
	1	أنا اقل اهتماما بالجنس مما اعتدت عليه.
	2	أنا أقل اهتماما بالجنس الآن لدرجه كبيره.
	3	فقدت الاهتمام بالجنس تماما.

Appendix 9

The Individualism, Collectivism, and Familism Scales
(أ)

الرقم	العبارة	رافض بشدة	رافض	محايد	موافق	موافق بشدة
1	لست ملام على سوء حظ الآخرين.					
2	اشعر أنى أتحكم في مصيري.					
3	اشعر فعلا أن فلسفة كون نفسك بنفسك تحمل الكثير من المعنى.					
4	في الشخص الوحيد الذي تستطيع الاعتماد عليه هو أنت ، هذه الأيام.					
5	افتخر بشكل كبير بآني أنجزت ما لم ينجزه غيري.					
6	أقاوم الناس الذين يحاولون تسييري.					
7	قبل أن ارتاح مع أي شخص آخر يجب أن اشعر بالراحة مع نفسي.					
8	أضع الحرية الشخصية فوق كل القيم الأخرى.					
9	أنا اعرف نفسي اكثر من أي شخص آخر.					
10	لا أرى عيبا في عرض مهاراتي.					

الرقم	العبارة	رافض بشدة	رافض	محايد	موافق	موافق بشدة
1	لا اشعر بالنجاح ما لم أساعد الآخرين في تحقيق النجاح.					
2	انتهز الفرصة لرد المساعدات التي قدمها لي المجتمع.					
3	أقدم يد العون متى كان ذلك ممكنا.					
4	اعتبر نفسي لاعب جماعي.					
5	غايتي في الحياة أن أجاهد لتحقيق العدالة الاجتماعية.					
6	أشفق على الآخرين الدين هم اقل حظا مني.					
7	ارحب بإعطاء خبراتي للآخرين الدين يمكن أن يتعلموا من أخطائي.					
8	شعور رائع أن اشعر أن الأخريين يعتمدون علي.					
9	لي دور أساسي في تجميع شعوب العالم مع بعضها البعض.					
10	أنا أؤمن أن في الاتحاد قوة وفي التفرق ضعف.					

الرقم	العبارة	رافض بشدة	رافض	محايد	موافق	موافق بشدة
1	عندما يتعلق الأمر بالمسؤوليات الاجتماعية الدم لا يصبح ماء.					
2	عائلتي دائما هناك عند الحاجة.					
3	أنا أدين لوالدي فضل نجاحي.					
4	عائلتي لهم أهم مكانة في تفكيري.					
5	اقدس الوقت الذي اقضيه مع أقاربي.					
6	سأفعل كل ما أستطيع للحفاظ على العادات و التقاليد المتوارثة.					
7	حتى عندما أكون بعيدا عن البيت الروابط الأسرية تشعرني بالأمان والطمأنينة.					
8	حتى اليوم تعليمات والدي هي افضل ما يقودني.					
9	في رأيي الأسرة أهم مؤسسه اجتماعية.					
10	لا أستطيع تصور العيش بدون عائلتي.					

Appendix 10

The Multidimensional Scale of Perceived Social Support

الرقم	العبارة	رافض كليا	رافض	رافض نسبيا	محايد	موافق نسبيا	موافق	موافق كليا
1	هناك شخص معين عادة حولي عند الحاجة.							
2	هناك شخص معين أشاركه أفراحي وأحزاني.							
3	عائلتي تحاول حقا مساعدتي.							
4	احصل على دعم معنوي من عائلتي.							
5	هناك شخص معين يوفر الراحة التامة لي.							
6	يحاول أصدقائي مساعدتي كثيرا.							
7	أستطيع الاعتماد على أصدقائي عند الحاجة.							
8	أستطيع الحديث مع أسرتي عن مشاكلي الخاصة.							
9	لدي أصدقاء أشاركهم أفراحي وأحزاني.							
10	هناك شخص معين في حياتي يهتم بمشاكلي.							
11	تحاول عائلتي مساعدتي على اتخاذ القرارات.							
12	أستطيع مناقشة مشاكلي مع أصدقائي.							

Appendix 11

The Rosenberg Self-Esteem Scale

الرقم	العبارة	موافق كليا	موافق	رافض	رافض كليا
1	عموما أنا راضي عن نفسي.				
2	في بعض الأوقات اشعر أني شخص غير نافع إطلاقا.				
3	أشعر بأني عندي عدة صفات جيده.				
4	أنا قادر على أداء الأشياء بصورة جيده بنفس المستوى الذي يقوم به معظم الناس.				
5	اشعر انه ليس لدي الكثير لأفتخر به.				
6	اعتقد أني عديم الفائدة في بعض الأوقات.				
7	أشعر بأني شخص له جدارته وأني أقف على الأقل في مستوى واحد مع الآخرين				
8	أتمنى لو أني كنت اكتر احتراما لنفسي.				
9	على كل أنا أميل للشعور باني فاشل.				
10	اتجاهاتي نحو نفسي إيجابية.				

Appendix 12

Informed Consent and Debriefing forms for Study One (English Version)

INFORMED CONSENT SHEET:

Depression, Social Support, Self-esteem, and culture values orientation in Libya and Britain

The School of Social Sciences and Law at Brunel University requires that all persons who participate in psychology studies give their written consent to do so. Please read the following and sign it if you agree with what it says.

I freely and voluntarily consent to be a participant in the research project entitled "Depression, Social Support, Self-Esteem, and Culture Values Orientation in Libya and Britain" to be conducted at Brunel University, with Aisha Abuhajar as supervisor or principal investigator. The broad goal of this research program is to explore culture deference and similarities in depression. Specifically, I have been told that I will be asked to complete a questionnaire in which answer several pages of questions about themselves. The session should take no longer than 30 min to complete.

I have been told that my responses will be kept strictly confidential. I also understand that if at any time during the session I feel unable or unwilling to continue, I am free to leave without negative consequences. That is, my participation in this study is completely voluntary, and I may withdraw from this study at any time. My withdrawal would not result in any penalty, academic or otherwise. My name will not be linked with the research materials, as the researchers are interested in relationships in general - not any particular individual's relationship in particular.

I have been given the opportunity to ask questions regarding the procedure, and my questions have been answered to my satisfaction. I have been informed that if I have any general questions about this project, or ethical issues relating to the project, I should feel free to contact Aisha at Aisha.Abuhajar@brunel.ac.uk.

I have read and understand the above and consent to participate in this study. My signature is not a waiver of any legal rights. Furthermore, I understand that I will be able to keep a copy of the informed consent form for my records.

_____ _____ _____

Participant’s Signature Please Print Date

I have explained and defined in detail the research procedure in which the above-named has consented to participate. Furthermore, I will retain one copy of the informed consent form for my records.

_____ _____ _____

Principal Investigator Signature Please Print Da

DEBRIEFING FORM

Depression, Social Support, Self-esteem, and culture values orientation in Libya and Britain

The purpose of this study is to investigate a cross-cultural similarities and differences in depression, self-esteem, social support, among Libyan, British, public, samples, and whether these similarities and differences hold across age, gender, marital status, social class, and religion. Furthermore, explore whether there is significant interaction in predicting depression from social support and self-esteem and culture values orientation.

Moreover, we are inserted in (A) Culture differences and similarities in the symptoms depression (21) as tested by (BDI, II). In Libyan and British samples (B) Determine whether self-esteem mediates the relationship between social support and depression.

The following studies might be of interest to you:

- Kleinman, and Good (1985): *Culture and Depression*; University of California Press, California, United States of America.
- Clark, Beck AND Alford (1999): *Cognitive Theory and Therapy of Depression*; John Wiley and Sons Ltd, New York, United States of America
- Oyserman and Lee (2008): *Does Culture Influence What and How We Think? Effects of Priming Individualism and Collectivism*, Psychological Bulletin, vol 134, no 2, pp 311-342.

Thank you for taking part in this study.

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Appendix 13

Informed Consent and Debriefing forms for the Study

Arabic version:

نموذج (تعهد)

العوامل المساهمة فى الاكتئاب

أعتاد قسم علم الاجتماع و القانون في جامعة برونيل، أن يشترط على كل من الدارسين و الباحثين فى حالة إجراء أي

بحث ميداني في الدراسات النفسية، إقرارا من المشاركين الذين ستتم مشاركتهم فى هذا البحث، حيث يتضمن هذا الإقرار الموافقة الكتابية كمشارك. لذا، نرجو منكم التفضل بقراءة النص التالى و من ثم التوقيع فى حالة الموافقة.

ليس لدى أي مانع في المشاركة في البحث المقدم من قبل الطالبة، عائشة أبو حجر، بعنوان التعرف على العوامل المساهمة فى الاكتئاب، والمطبق في جامعة برونيل والذي من خلاله يمكن للباحثة من التعرف على العوامل المختلفة، والتي من شأنها أن تساهم في عملية الاكتئاب، وذلك في وقت لا يتعدى 30 دقيقة.

وأن مشاركتي قد تتمثل في الاجابة على بعض الاسئلة من الباحثة، لقد قيل لي ان ردودي على هذه الاسئلة ستعامل بسرية تامة، وايضا لي الحرية التامه في الانسحاب دون اي عواقب وهذا يعني ان مشاركتي طوعية بالكامل، وانه لن يتم الاشارة الى اسمي نهائيا وان اهتمام البحث بالعلاقات بين عوامل الاكتئاب بشكل عام وليس بين افراد معينين، أيضا ستعطى لي الفرصة لعرض أسئلتي والحصول على ردود من قبل الباحثة عائشة ابو حجر، ايضا اذا كان لدي
اي اسئلة اخرى يمكنني التواصل مع الباحثة عن طريق. Aisha.Abuhajar@brunel.ac.uk
لقد قرأت وفهمت ماذكر اعلاه واقر موافقتي على المشاركة في هذه الدراسة، وأن توقيعي لن يستخدم لأي اغراض قانونية علاوة على ذلك يمكنني الاحتفاظ بنسخة من هذا الاقرار في سجلاتي الخاصة.

الاسم	التوقيع	التاريخ
.....	.....	.....

لقد شرحت بالتفصيل غرض وطبيعة الدراسة للمذكور اعلاه الذي أقر بالمشاركة في البحث، أيضا يمكنني الاحتفاظ بنسخة من هذا الاقرار في سجلاتي الخاصة.

الاسم	التوقيع	التاريخ
.....	.....	.....

خلاصة

الهدف الأساسي من هده الدراسة هو التحقق من الاختلافات الثقافية في الاكتئاب. آخذا في الاعتبار العوامل الهامة التي من شانها إحداث الاكتئاب والتي من ضمنها الدعم الاجتماعي و مفهوم الذات و الروح الفردية والروح الجماعية والعائلية . و ذلك من خلال أخذ عينة عشوائية من فئات مختلفة من المجتمعين "الليبي والإنجليزي". ومعرفة ما إذا كانت هذه الاختلافات تتأثر بالعمر والجنس والحالة الاجتماعية والاقتصادية والدين. بالإضافة إلى دراسة الاختلافات الثقافية في علامات الاكتئاب, كما عرضت في قائمة "بيك" للاكتئاب.

ولمزيد من المعلومات يمكنك الاطلاع على الدراسات التالية:

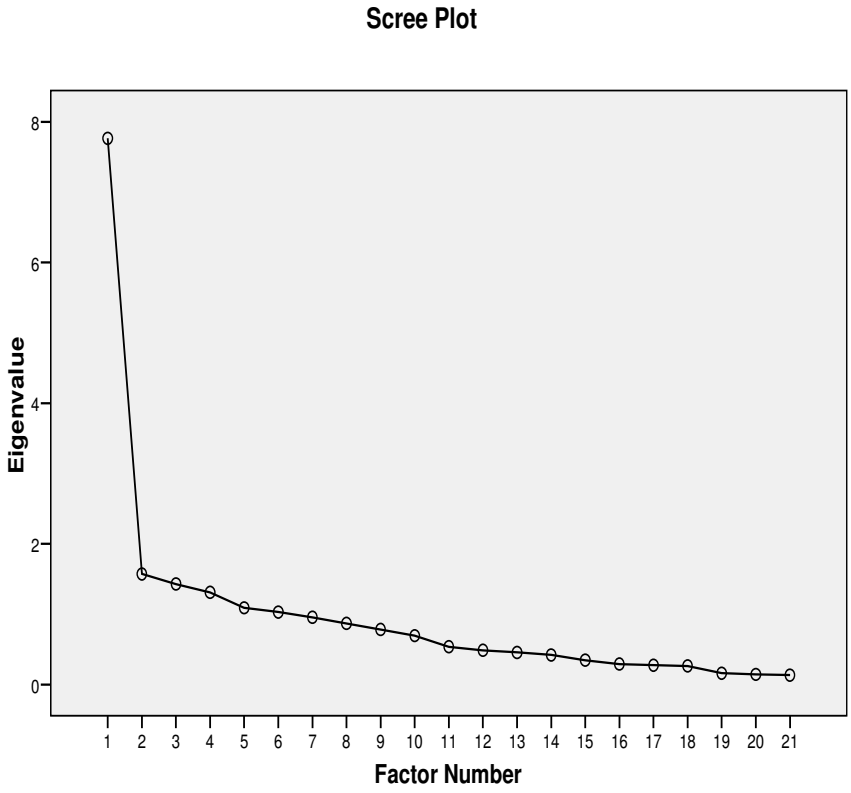
- Kleinman, and Good (1985): *Culture and Depression*; University of California Press, California, United States of America.
- Clark, Beck AND Alford (1999): *Cognitive Theory and Therapy of Depression*; John Wiley and Sons Ltd, New York, United States of America
- Oyserman and Lee (2008): *Does Culture Influence What and How We Think? Effects of Priming Individualism and Collectivism*, Psychological Bulletin, vol 134, no 2, pp 311-342.

شكرا على تعاونكم

Appendix 14

Figure (1)

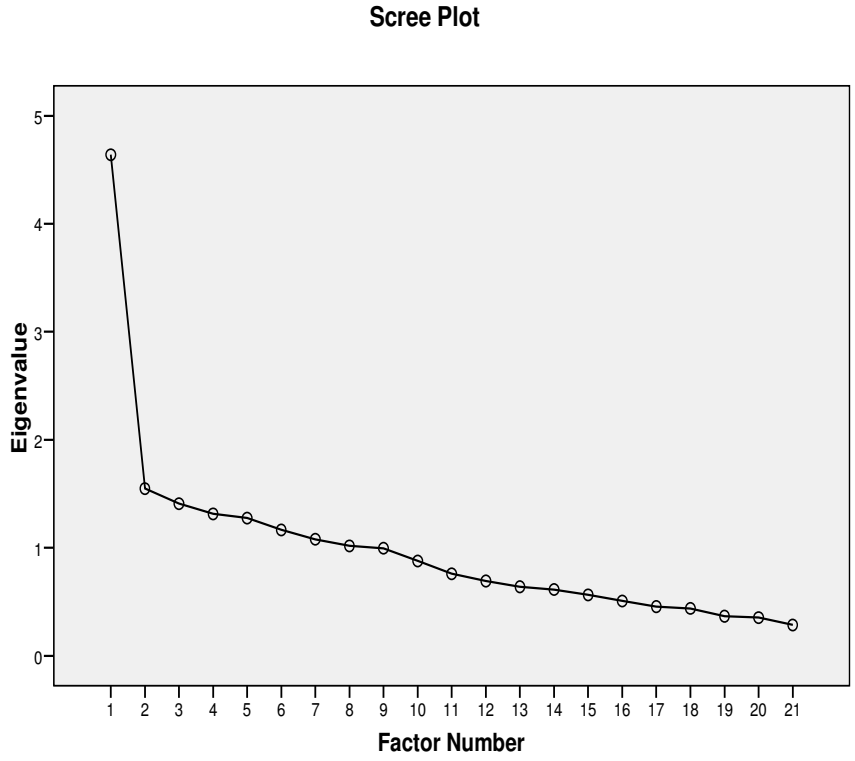
Scree Plot of depression items for British Sample



Appendix 15

Figure (8)

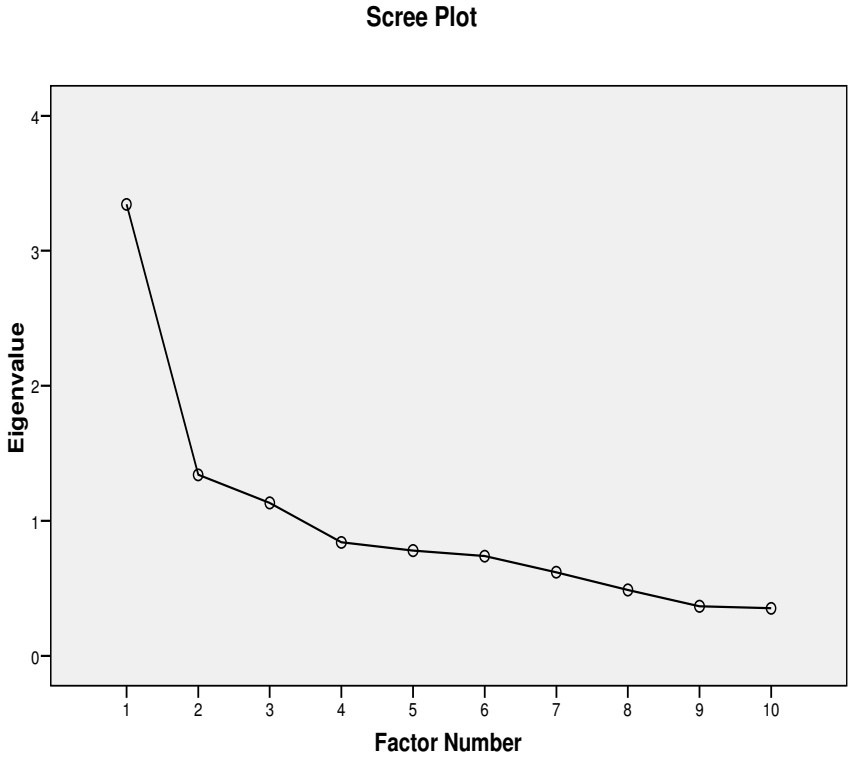
Scree Plot of Depression Items for Libyan Sample



Appendix 16

Figure (2)

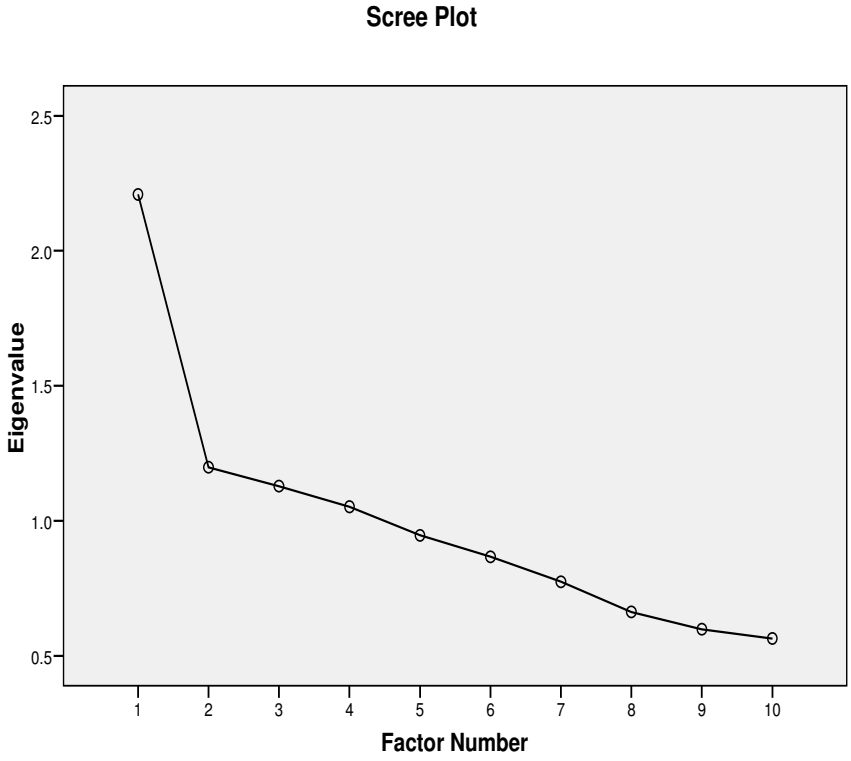
Scree Plot of Individualism items for British Sample



Appendix 17

Figure (9)

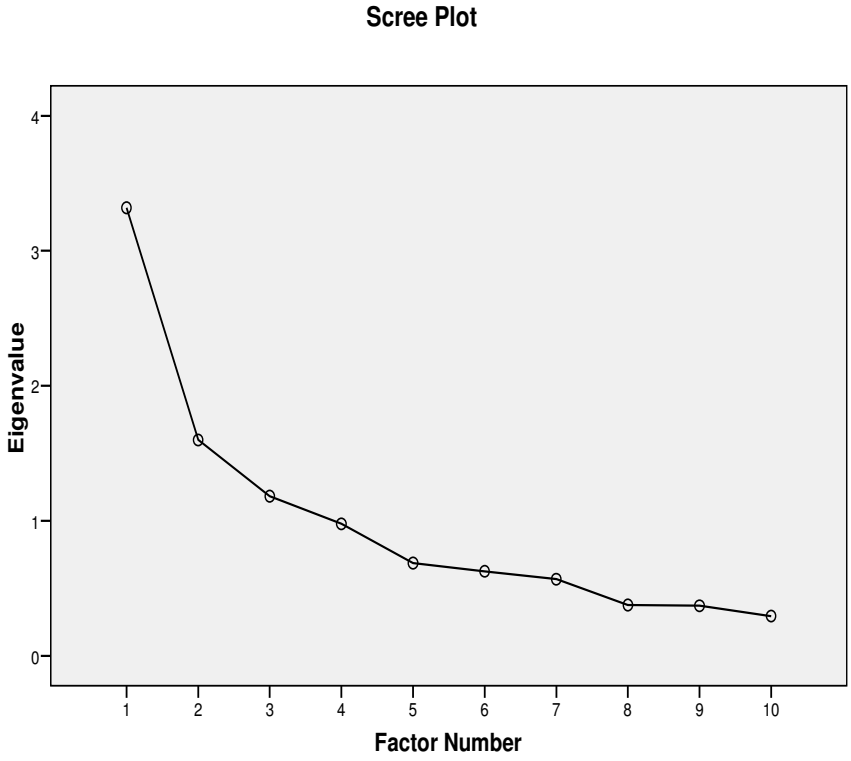
Scree Plot of Individualism Items for Libyan Sample



Appendix 18

Figure (3)

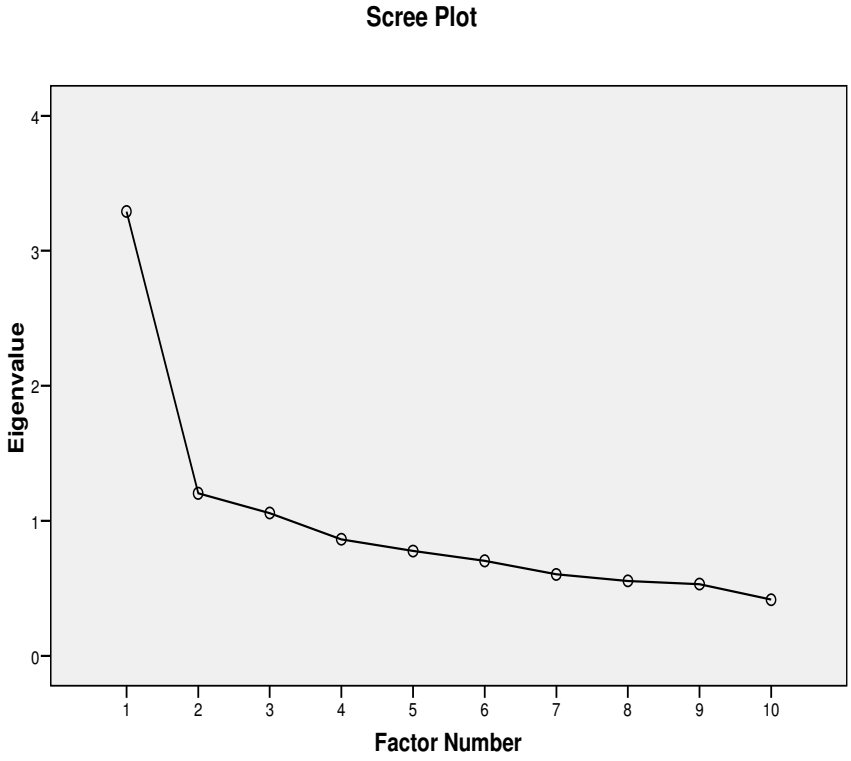
Scree Plot of collectivism items for British Sample



Appendix 19

Figure (10)

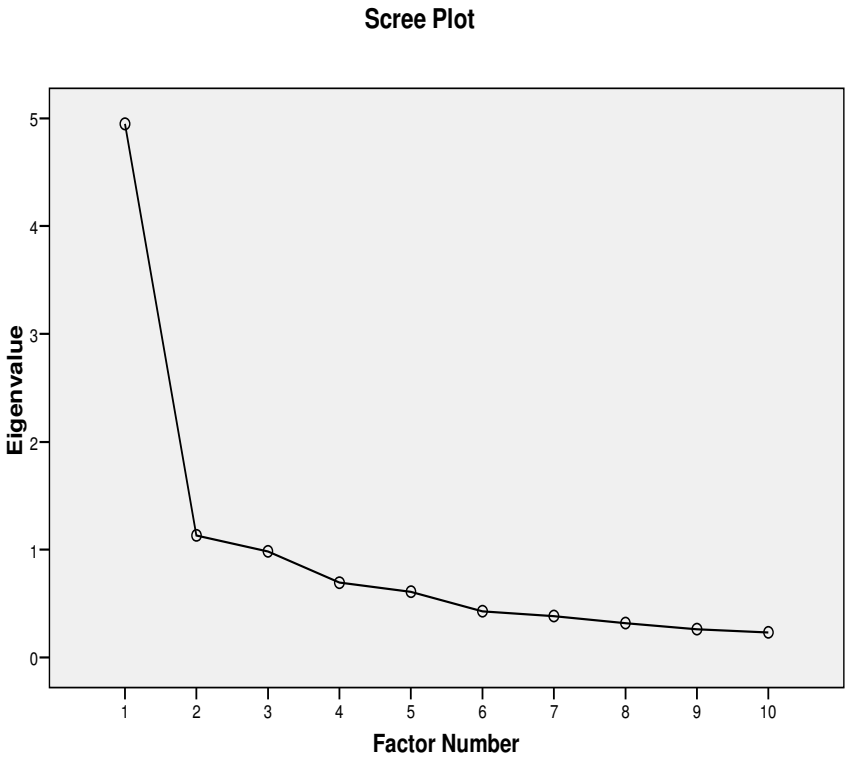
Scree Plot of Collectivism items for Libyan Sample



Appendix 20

Figure (4)

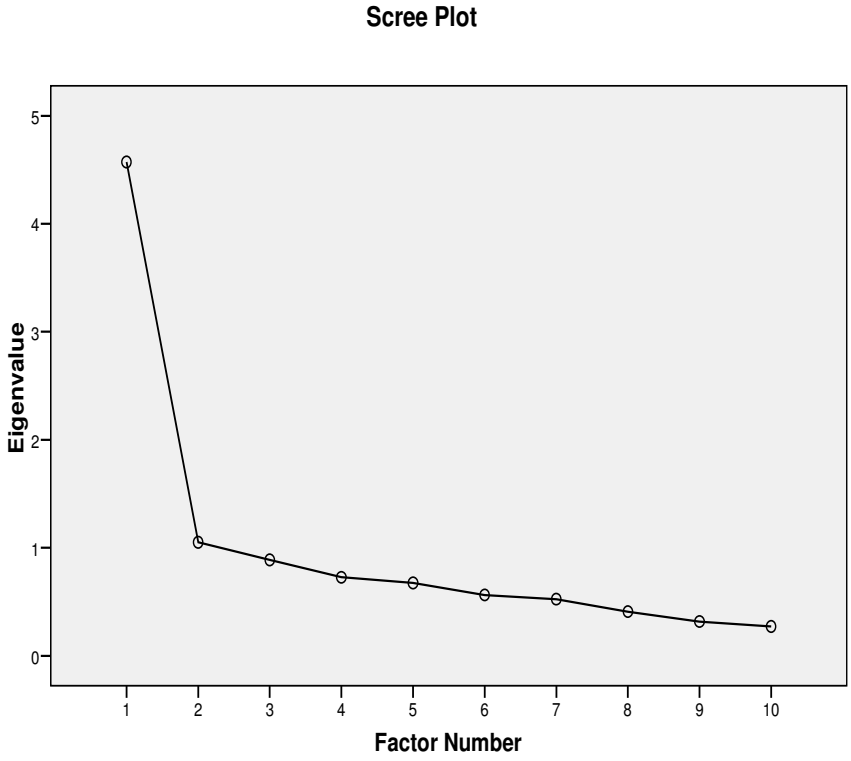
Scree Plot of familism Items for British Sample



Appendix 21

Figure (11)

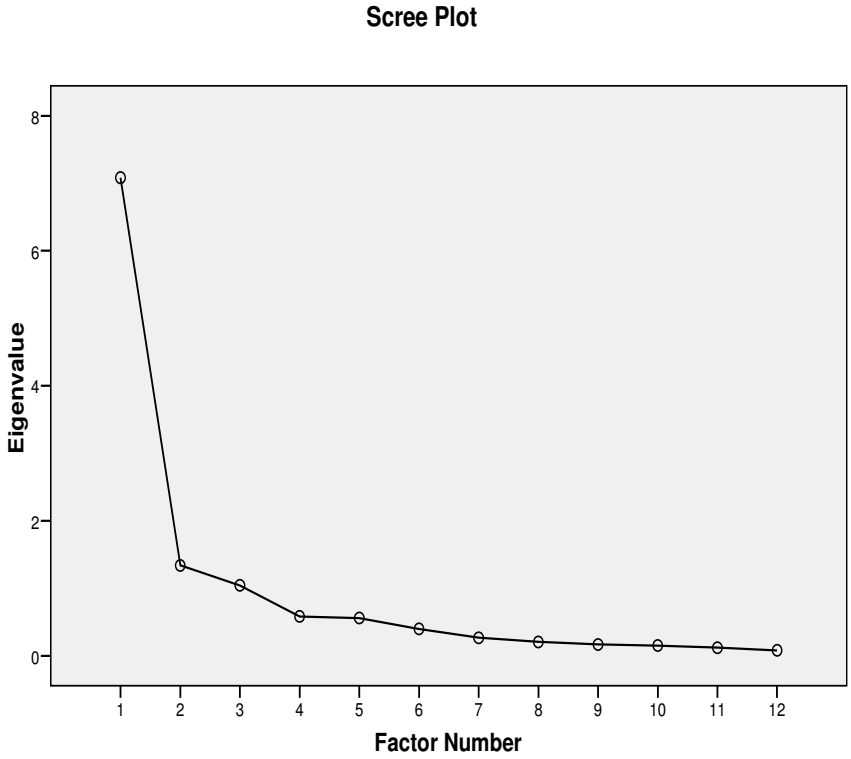
Scree Plot of Familism items for Libyan Sample



Appendix 22

Figure (5)

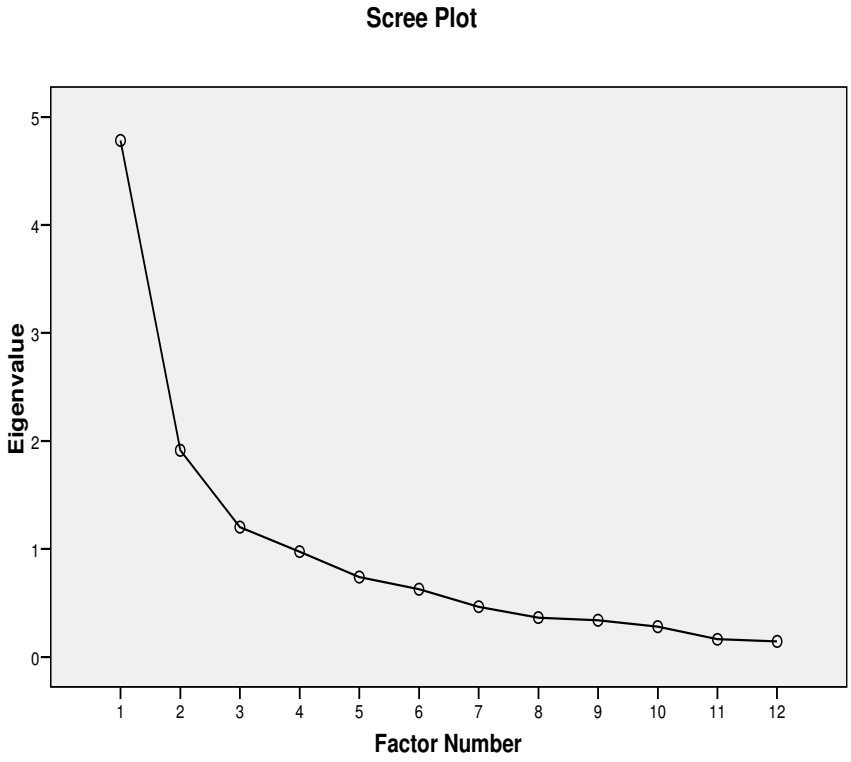
Scree Plot of Social support for British Sample



Appendix 23

Figure (12)

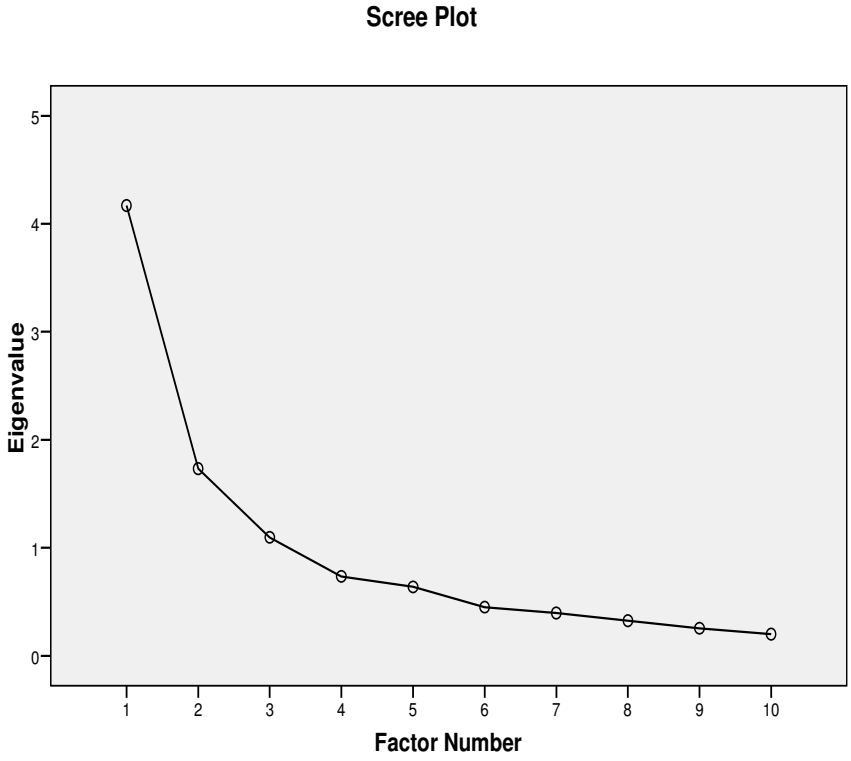
Scree Plot of Social support items for Libyan Sample



Appendix 24

Figure (6)

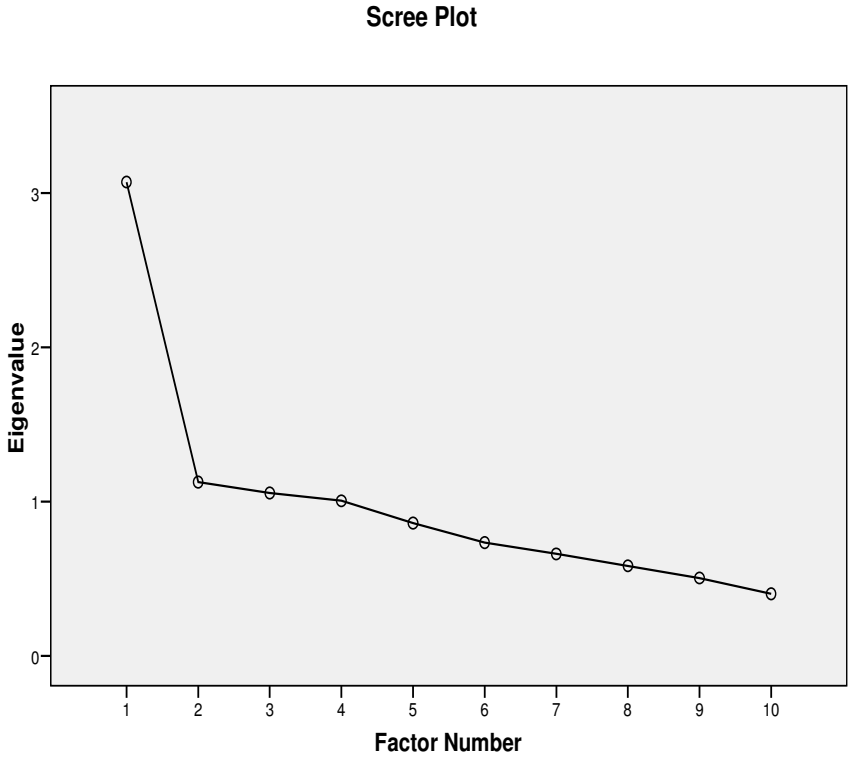
Scree Plot of self-esteem items for British Sample



Appendix 25

Figure (13)

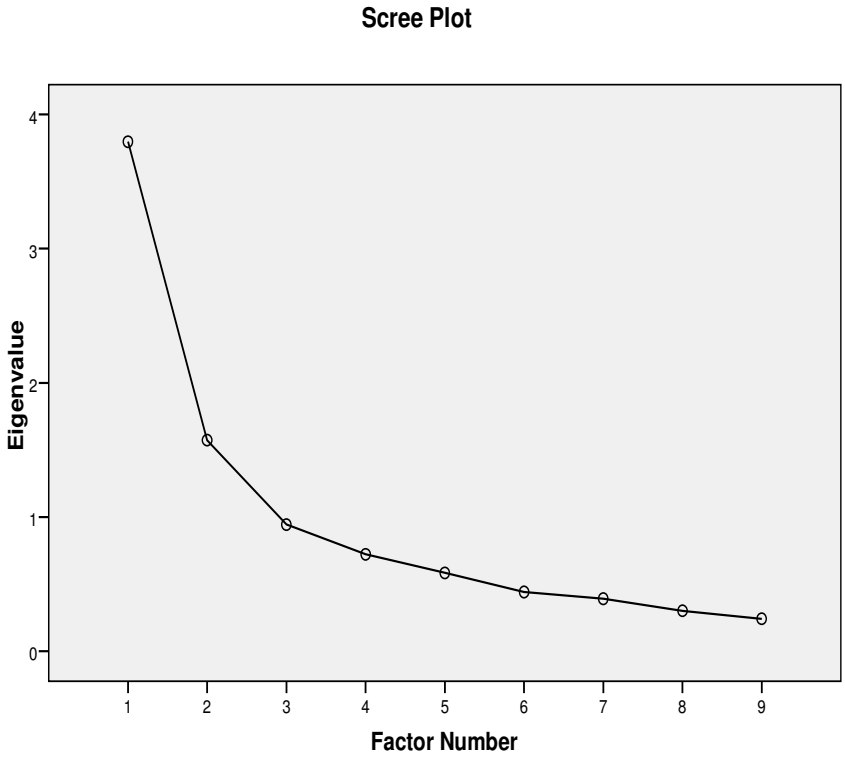
Scree Plot of Self-esteem items for Libyan Sample



Appendix 26

Figure (7)

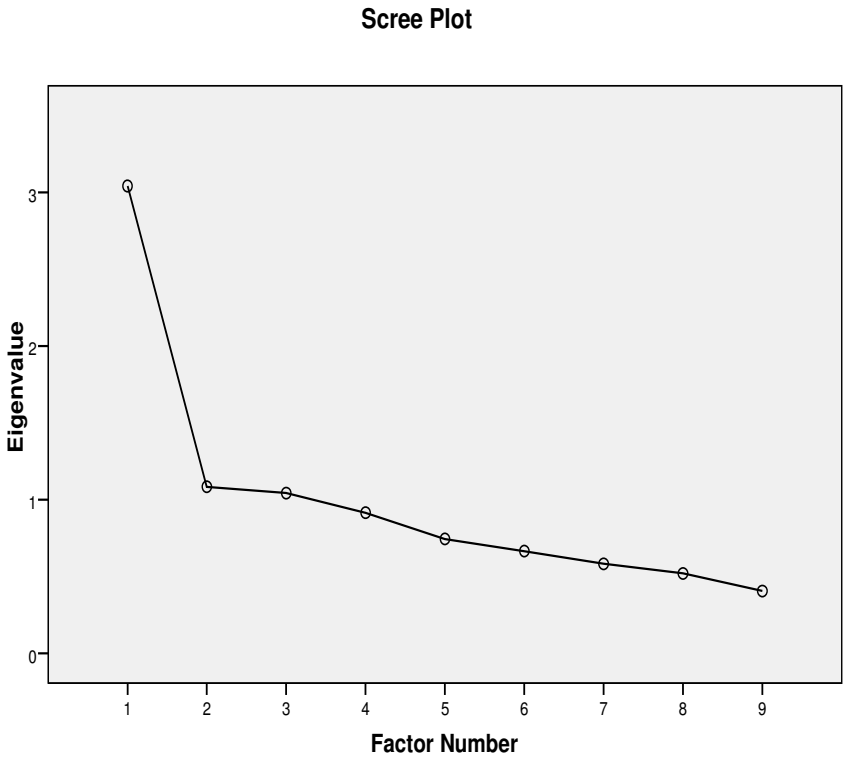
Scree Plot of self-esteem items for British Sample after excluding item 3



Appendix 27

Figure (14)

Scree Plot of Self-esteem items for Libyan Sample after item 3 was excluded



Appendix 28

Demographic Details of the Participants

S.N	Sex		Age	Marital Status			Years of Education	Socio-economic status		Occupation
	M	F		Single	Married	Divorced		High	Middle	
J1	M		48		/		14yers		/	Teacher
N2		F	38	/			16y		/	Unemployed
F3		F	34	/			12y		/	Nursery
A4	M		41		/		15	/		Businessman
A5	M		43		/		17	/		Project Manger
K6	M		25	/			11		/	Full time student
R7		F	20	/			11	/		Full time student
H8		F	20	/			11		/	Full time student
K9		F	43			/	16		/	Teacher
N10		F	40			/	6		/	housewife
S11		F	27			/	13		/	Communication
W12		F	37		/		8	/		Housewife
K13		F	27	/			5			Housewife
A14		F	31		/		14		/	Employee
M15	M		37	/			14		/	Receiving salary
H16		F	25	/			16			Teacher
F17	M		40	/			9		/	Mechanic
A18		F	18	/			14		/	Full time student
M19	M		31	/			12		/	Businessman
W20		F	38	/			11			Housewife
K21		F	51		/		8		/	Housewife
M22		F	55		/		Illiterate		/	Housewife

Appendix 29

Frame Work for the Interviews

- **Demographics**
    - Gender
    - Age
    - Marital Status
    - Socio-economic status
    - Educational Level
    - Occupation

    - **Questions**

- The general question. How does culture affect the experience of depression in Libyan context?

- The concept of depression. What does depression mean to you?

  How do you define it in your own words?

- The symptoms of depression. Do you see yourself as depressed? How do you feel

  When you get depressed?

- The causes of depression. What do you think are the causes of depression?

  Prompt: social support, self-esteem, social life, work, finance issues,

- Dealing with depression. How do you deal with depression? What do you do to get

relief?

- The Kinds of treatment people seek for help. What kind of treatment do you seek for treatment?

  Prompt: Professional help, traditional help, informal help, formal help.

Evaluation or appraisal of her/his own worth. How do you feel about yourself?

Appendix 30

Informed Consent and Debriefing Forms (Study 2)

EXPEDITED REVIEW CHECKLIST, Department of Psychology, Brunel University

Effective November 2009

This checklist, based on the Research Ethics Review Checklist from the ESRC Research Ethics Framework, was designed to help determine the level of risk or harm to participants' welfare entailed in a proposed study in the Department of Psychology at Brunel University.

This checklist should be completed for every research project by Psychology students or staff (see note below regarding staff funding applications), that involves human participants. It is used to identify whether a full application for ethics approval needs to be submitted. If a full application is required, then the University Research Ethics Committee's full **Application Form for Research Ethics Approval** must be used. A Word version of the full Application Form for Research Ethics Approval can be downloaded from: http://intranet.brunel.ac.uk/registry/minutes/researchethics/home.shtml.

Before completing this form, please refer to the University General Ethical Guidelines and Procedures, as well as the Code of Research Ethics (both documents can be downloaded from http://intranet.brunel.ac.uk/registry/minutes/researchethics/home.shtml). The principal investigator at Brunel University, or student supervisor, is responsible for exercising appropriate professional judgement in this review, and ensuring that correct ethics procedures are followed.

This checklist must be completed and approved before any participants are approached to take part in any research. Having completed this form, it is possible that we may need further information from you, and in some instances you may be required to submit your plans for addressing the ethical issues raised by your proposal using the University Research Ethics Committee's full **Application Form**.

If you answered 'Yes' to question 11, and the research falls outside of NHS audit procedures, then you will have to submit an application to the appropriate external health authority ethics committee after you have received provisional approval from the PsyREC (please see further instructions on the PsyREC webpage).

It is your responsibility to follow the Code of Research Ethics, developed by the University Research Ethics Committee, as well as any relevant academic or professional guidelines in the conduct of your study. This includes providing appropriate documentation, and ensuring confidentiality in the storage and use of data. Any significant change in the question, design, or conduct over the course of the research should be notified to PsyREC, and may require a new application for ethics approval.

Assessed work requiring research ethics approval
Undergraduate and Masters students must retain a copy of the approved form and submit it with their research report or dissertation (bound in the Appendix); MPhil/PhD students must retain a copy of the form and submit it to the Research Degrees Board with their application for Registration. For class exercises, lecturers who have set research projects on behalf of the students will be responsible for obtaining ethics approval. All undergraduate and postgraduate work that is submitted without an approved ethics form may be subject to penalties; students must consult the appropriate module convenors for penalties regarding failure to submit approved ethics forms as part of research-based work in specific modules.

Staff research
Please note that all Psychology staff leading a project at Brunel University, whether collecting data with or without the aid of students, must submit ethics forms to PsyREC. If the ethics submission relates to staff research for which an application to an external funding agency will be/has been made, then please complete and submit the full University ethics submission form (see notes on PsyREC Webpage).

Risk Assessment and Criminal Record Bureau Checks (CRB)
A Risk Assessment (RA) may be necessary for your proposed research. See PsyREC website for further details, and attach the RA to this submission if applicable.

If your research involves vulnerable persons in any way, you are required to follow University guidelines for CRB checks.

Submission instructions
Please submit **two copies** of this form completed and signed, and one copy of any necessary supporting material to Devinder Saggi via the drop box outside MJ157 for review.

DEPARTMENT OF PSYCHOLOGY RESEARCH ETHICS CHECKLIST

(Effective November 2009)

If the ethics submission relates to staff research for which an application to an external funding agency will be/has been made, then please complete and submit the full University ethics submission form.

Section I: Project Details

1. Project title: **The Conception of depression in Libyan context**

Section II: Applicant Details

2. Name of researcher (applicant): Aisha Abuhajar
3. Status (please circle): Postgrad Student
4. Discipline (please circle): Psychology
5. Email address: Aisha.Abuhajar@brunel.ac.uk
6. Telephone number: 07796763822

Section III: For Students Only

7. Student number: 0631500
8. Module name and number: PhD
9. Brunel supervisor's or module leaXder's name: Dr:Stanley Gaines& Proff.Michael Wright
10. Brunel supervisor's email address: Stanely.Gaines@brunel.ac.uk& Michael.Wright@brunel.ac.uk

To be completed for *all* research by the principal investigator, member of staff leading the research, or student supervisor.

- [C] If applicable, the student states that he or she has read the Brunel University Code of Research Ethics.
- [ ] The topic merits further research.
- [ ] If applicable, the student will possess the skills to carry out the research by the time that he or she starts any work which could affect the well-being of other people. He or she will be deemed to have acquired such skills on passing the relevant research skills module.
- [ ] The participant information sheet or leaflet is appropriate.
- [ ] The procedures for recruitment and obtaining informed consent are appropriate.

Please confirm the professional research ethics code that will guide the research (please circle)

ASA/BPS/BSA/Other (please state) _____

[ ] Yes [C] No Is a CRB check necessary for researchers/students working on this project?
If yes, please confirm by ticking this box that appropriate CRB procedures will be followed [ ]

[ ] Yes [ ] No Is a *new* Risk Assessment required for this research?
If yes, please consult the information on the Psychology Ethics webpage, and attach the Risk Assessment to this submission.

PI/Staff/Supervisor signature _____ Date 10 May 2010

Section IV: Research Checklist

Please answer each question by ticking the appropriate box:

	YES	NO
1. Does the study involve participants who may be particularly vulnerable and/or unable to give informed consent, thus requiring the consent of parents or guardians? (e.g. children under the age of 16; people with certain learning disabilities)	☐	√
2. Will all participants be age 18 and over?	√	☐
3a. Will the study require the co-operation of a gatekeeper for initial access to the groups or individuals to be recruited?	√	☐
3b. If the answer to Question 2a is Yes, then will the study involve people who could be deemed in any way to be vulnerable by virtue of their status within particular institutional settings? (e.g. students at school; disabled people; members of a self-help group; residents of a nursing home, prison, or any other institution where individuals cannot come and go freely)	☐	√
4. Does the research involve observational/ethnographic methods?	☐	√
5. Will the study involve discussion by or with respondents or behaviour or drug use, where they have not given prior consent to such discussion?	☐	√
6. Are drugs, placebos or other substances (e.g. food substances, vitamins) to be administered to the study participants or will the study involve invasive, intrusive or potentially harmful procedures of any kind?	☐	√
7. Will blood or tissue samples be obtained from participants?	☐	√
8. Is pain or more than mild discomfort likely to result from the study?	☐	√
9. Could the study induce psychological stress or anxiety or cause harm or negative consequences beyond the risks encountered in normal life?	☐	√
10. Will the study involve prolonged or repetitive testing?	☐	√
11. Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?	☐	√
12. Will the study involve recruitment of patients or staff through the NHS?	☐	√
13a. Have you undertaken this study as part of your work placement?	☐	√
13b. If your answer to Question 12a is Yes, then have the employers at your work placement conducted their own research ethics review?	☐	√
14. Does the research involve MRI, MEG, or EEG methods?	☐	√

Give a brief description of participants and procedure (methods, tests used etc) in up to 150 words

The general aim of this study is to explore and describe the Libyan people's perception of depression: their understanding of the symptoms and causes, how they typically deal with it, and what kinds of help-seeking behaviour do they display. The Overall research question for this study would be: How does culture affect the experience of depression in a Libyan context? Three qualitative methods studies with semi-structured interviews would be conducted, using thematic analysis to analyse data, for reliability I will use the judgment of multiple viewers. The first study will consist of 20 public females and males who experienced relative or close friend's depression. The second study consists of Libyan clinically depressed participants, who have already been diagnosed as depressed; those participants will only be recruited from Tripoli Psychiatric Hospital and the Noor Alghad Clinic of Counselling. The third study will consist of 10 psychological and psychiatric participants from Tripoli Psychiatric Hospital and the Noor Alghad Clinic of Counselling only. The interviews will be conducted individually in the same Hospital and Clinic mentioned above, and I will be assisted by one of the staff from the Hospital and the Clinic.

Name of Principal Investigator at Brunel University (please print): Aisha Abuhajar

Signature of Principal Investigator at Brunel University: _____

E-Mail Address: Aisha.Abuhajar@brunel.ac.uk

Date: 10/05/2010

This request for expedited review has been: ☑ **Approved** (no additional ethics form is necessary)

☐ **Declined** (full University ethics form is necessary)

Signature of PsyREC Officer: _____

Date: May 11, 2010

نموذج (تعهد)

دراسة نوعية عن مفهوم الاكتئاب في المجتمع الليبي

اعتاد قسم علم النفس في جامعة برونيل، ان يتطلب من جميع الاشخاص المشاركين في الدراسات النفيسة اقرار كتابي حيث يتضمن هذا الاقرار الموافقة الكتابية كمشارك.
لذا نرجو منكم التفضل بقراءة النص التالي ومن ثم التوقيع في حالة الموافقة.
اقر أنه ليس لدي اي مانع في المشاركة في البحث المقدم تحت اشراف الباحثة عائشة ابو حجر، بعنوان مفهوم الاكتئاب في المجتمع الليبي والمطبق في جامعة برونيل والذي من خلاله يمكن للباحثة التعرف على مفهوم وعلامات واسباب الاكتئاب من خلال الثقافة المحلية للمجتمع الليبي وذلك من خلال اجراء مقابلات مع المشاركين في البحث. لقد قيل لي أن هذه المقابلات قد تتراوح مابين 30 الى 60 دقيقة وأن مشاركتي قد تتمثل في الاجابة على بعض الاسئلة من خلال المقابلات مع الباحثة، لقد قيل لي ان ردودي على هذه الاسئلة ستعامل بسرية تامة، وايضا لي الحرية التامه في الانسحاب دون اي عواقب اكاديمية او غيرها، وهذا يعني ان مشاركتي طوعية بالكامل، وانه لن يتم الاشارة الى اسمي نهائا أيضا ستعطى لي الفرصة لعرض أسئلتي والحصول على ردود من قبل الباحثة اي اسئلة اخرى يمكنني التواصل مع الباحثة عن طريق. Aisha.Abuhajar@brunel.ac.ukعائشة ابو حجر، ايضا اذا كان لدي إذا كان لدي اي مخاوف أو شكاوي بشأن الطريقة التي يتم بها إجراء البحث يمكنني الاتصال بمكتب مدير لجنة اخلاقيات البحث في علم النفس(Taeko Wydell)
عبر البريد الالكتروني taeko.wydell@brunel.ac.uk
لقد قرأت وفهمت ماذكر اعلاه واقر موافقتي على المشاركة في هذه الدراسة، وأن توقيعي لن يستخدم لأي اغراض قانونية علاوة على ذلك يمكنني الاحتفاض بنسخة من هذا الاقرار في سجلاتي الخاصة.

الاسم التوقيع التاريخ
....

لقد شرحت بالتفصيل غرض وطبيعة الدراسة للمذكور اعلاه الذي أقر بالمشاركة في البحث، أيضا يمكنني الاحتفاض بنسخة من هذا الاقرار في سجلاتي الخاصة.

الاسم التوقيع التاريخ
....

استمارة استخلاص المعلومات (الكتئاب والثقافة)

ان الغرض من هذه الدراسة هو التعرف على مفهوم الاكتئاب من خلال المجتمع الليبي وفهم الاعراض والاسباب وكيفية تعامل المجتمع مع هذه الاعراض.
استنادا الى الدراسات السابقة، ان معايير الاكتئاب المستخدمه في العالم العربي هي معايير غربية وان هذه المعايير الغربية قد لا تتواقف مع ثقافتنا العربية الليبية بما في ذلك التقرير التشخيصي السنوي الامريكي (النسخة الرابعة والخامسة) لان لكل ثقافة خصوصية معينة قد تؤثر في تشكيل مفهوم واعراض واسباب الاكتئاب وايضا كيفية استجابة الافراد لهذه الاعراض.
بناءا على ذلك يمكننا القول انه يمكننا تجنب التشخيص الخاطئ للاكتئاب اذا اخذنا بعين الاعتبار الثقافة المحلية لكل مجتمتع، لذلك ينبغي اقامة دراسات تبين الاختلافات الثقافية في الاكتئاب. ان هذا البحث يهدف الى دراسة الاكتئاب من خلال المجتمع الليبي المحلي، ايضا كيف تؤثر الثقافة في الاكتئاب في المحيط الثقافي الليبي.
اذا كان لديك اي اهتمام بموضوع البحث يمكنك دراسة المراجع التالية

Beck, A. T. & Alford, B, A. (2009). *Depression: Causes and Treatment*; Edition 2, Pennsylvania: University of Pennsylvania Press.

Kleinman, A., & Good, B. (1985): *Culture and Depression*. California, United States of America: University of California Press.

Thakker, J., Ward, T., & Strongman,T. (1999). Mental Disorder and Cross-Cultural Psychology: A Constructivist Perspective. *Clinical Psychology Review*, 19, 7, 843-874.

نشكركم على التفضل بالمشاركة في هذا البحث