

# Eliciting explanatory models of common mental disorders using the Short Explanatory Model Interview (SEMI) Urdu adaptation - a pilot study

Ilyas Mirza<sup>1</sup>, Rana Hassan<sup>2</sup>, Haroon Chaudhary<sup>3</sup>, Rachel Jenkins<sup>1</sup>

Institute of Psychiatry<sup>1</sup>, de Crespigny Park, Denmark Hill, London, Qasim Clinic<sup>2</sup>, Wazir Ali Road, Lahore, Fatima Jinnah Medical College<sup>3</sup>, Lahore.

## Abstract

The purpose of this pilot study was to describe the presenting symptoms and its explanation from the patients' perspective of GHQ (General Health Questionnaire)

positive cases attending primary care facility/a general practice in semi-urban Lahore. Fifteen consecutive attenders were screened with GHQ and 11 GHQ positive cases went on to complete an adapted questionnaire derived

from SEMI (Short Explanatory Model Interview). Though there was no consistency in the presenting symptoms of GHQ positive cases on presentation to a general practitioner, all described their problems as intense, less than 2 years on onset and on reflection located its origins in their social worlds. These findings have implications in terms of providing preliminary data for a larger study, perhaps looking at development of psychosocial interventions for treatment of mental distress in our local context as it seems to have its origins in their social worlds.

## Introduction

Anxiety and depressive disorders are the most prevalent mental disorders within the general population and are hence called common mental disorders (CMDs). These disorders pose a considerable burden for the individual and the society partly due to the cumulative effect of their associated physical and economic consequences. There is a considerable body of literature about this in the West.<sup>1</sup> Comparative data from Pakistan is relatively sparse but continues to grow.<sup>2</sup>

Explanatory models (EMs) denote the "notions about an episode of sickness and its treatment" and include beliefs about causes of illness which in turn can influence illness related behaviors, use of services and patient satisfaction. Understanding the EMs of a particular disorder in a population is important in developing effective prevention and treatment strategies for that particular population.

Qualitative literature from Pakistan indicates that people with CMDs when closely questioned about its onset, see the origins of their problems in their social world.<sup>3-5</sup> There is limited information about how people with CMDs present to the general practitioner though this has been described for faith healers and general hospital psychiatric clinics.<sup>2</sup> We decided to conduct a pilot study to examine this from the sufferers' perspective. The primary aim of the study was to field test the SEMI-Urdu adaptation to generate preliminary data on explanatory models of mental distress.

## Patients, Methods and Results

Key questions from the Short Explanatory Model

Interview (SEMI), a short interview to elicit explanatory models, were translated by consensus method.<sup>6</sup> keeping in view the conceptual and linguistic equivalence of the questions. The group consisted of two general practitioners, two psychiatrists and two psychologists. The SEMI is designed to be a simple tool for use in routine clinical practice and research. It is non-technical in language, easily translated and allows interviewers from any background to be readily trained in its use. Data from the instrument can be considered for analysis both from a qualitative and quantitative perspective.

Patients were recruited from a primary care center in Manawa, Lahore which is a semi-urban area. Fifteen consecutive patients were screened of whom 10 were men and 5 were women with a mean age of 33.8 years (median 32, mode 32) and a standard deviation of 12.025. Five were single and 10 were married.

With regard to assets, 8/15 owned a cycle, had a sewing machine and lived in a house with straw or wood roofing, 7/15 owned agricultural land, 5/15 owned cattle and had television, 3/15 had a radio at home, and 2/15 owned a motorcycle. All had electricity, water supply at home and were working in one capacity or other.

All subjects were screened using GHQ-12 (General Health Questionnaire- 12 question version). It is the most widely used screening test for common mental disorders and has been validated for use amongst Pakistani population.<sup>7</sup> Eleven fulfilled the criteria of GHQ-12 caseness set at 1/2 which has been described as an optimal cut off in Pakistani Population. GHQ-12 caseness was significantly associated with being married. The GHQ-12 cases went on to be interviewed on brief translated version of SEMI.

With regard to health and illness behaviour, 8/11 described a non-specific reason for the visit i.e. aches, discharge of air etc. 2/11 had a specific physical complaint and one presented for administrative reason.

All put the onset of their problems to events in their social world; 7/11 described their problem onset for 2 years or less.

When asked to give their problem a name, 4/11 named it in terms of body organs, 3/11 named it in non-specific terms and 2/11 named it in psychological terms.

As regards problem severity, 10/11 described their problem as very intense and one said it was variable. When asked what do you fear most about your problems, 5/11 reported serious discomfort.

With regard to activities and functioning, 5/11 reported main difficulties with their work, 2/11 with their general functioning and 1/11 with breathing difficulties. All eleven said

and 9/11 said their mood was affected. When asked specifically if any part of their body is affected, all replied yes.

### Comments

We found that all GHQ-12 cases presented to the primary care for non-specific reasons and regarded their problem as so intense that it limits their functioning at home, at work and in the social arena, although the GHQ-12 threshold adopted was relatively low. They also identified their current presenting problems arising in their social world on SEMI-Urdu adaptation.

The main limitation of our study is a small sample size, as it was a pilot exploratory study.

We found the brief version of SEMI-Urdu adaptation relatively simple to administer. Use of such an instrument helps quantify patient's view of the condition, be it a physical illness like tuberculosis or a mental illness like depression. This helps develop a shared language between the patient and the provider, which is valuable for health education, treatment (especially for promoting adherence) and research in general health care setting. Further work is required to develop culturally appropriate vignettes of mental health conditions that can be used with the general population.

### References

1. WHO. The World Health Report: 2001: Mental health: new understanding, new hope; Geneva: 2001.
2. Mirza I, Jenkins R. Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *Br Med J* 2004; 328:794-97.
3. Rabbani R. Views about women's mental health: study in a squatter settlement of Karachi. *J Pak Med Assoc* 1999; 49:139-42.
4. Tareen E. The Perception of Social Support and The Experience of Depression in Pakistani Women 2000; PhD Thesis; University of Essex.
5. Naeem S, Ali BS, Iqbal A, Mubeen S, Gul A. What probably made a difference? A qualitative study of anxious and depressed women who exhibited different levels of change after counseling. *J Pak Med Assoc* 2003; 53: 242-47.
6. Lloyd KR, Jacob KS, Patel V, St Louis L, Bhurgra D, Mann AH. The development of the Short Explanatory Model Interview (SEMI) and its use among primary care attenders with common mental disorders. *Psychol Med* 1998; 28: 1231-37.
7. Minhas FA, Mubbashar MH. Validation of General Health Questionnaire in a primary care setting of Pakistan. *J Coll Physicians Surg Pak* 1996; 6: 133-6.