

Research paper

An exploration of the explanatory models of illness amongst Pushtuun families living in the UK who are high attenders in general practice

Qulsom Fazil BSc PhD

Lecturer in Psychology, Department of Psychiatry, University of Birmingham and Queen Elizabeth Psychiatric Hospital, Birmingham, UK

Louise M Wallace FBPsS

Professor of Psychology and Health, Director, Health Services Management Centre, Coventry University, UK

Abid Hussain MBChB MRCP

Primary Care/Principal General Practitioner, Pearl Medical Centre, Birmingham, UK

ABSTRACT

This study explored the health beliefs and explanatory models of health illness in a Pakistani sub-population known as the Pushtuuns, who were high attenders at a UK general practitioner's clinic. The study interviewed five families who were amongst the top 10 highest attenders at the practice. The interview involved an in-depth exploration of health beliefs using the Self Explanatory Model Inventory (SEMI); families were also screened for anxiety and depression symptoms. The study found that these families were living in poor adverse social conditions and all the high attenders, plus five other family members, were found to have high scores above the screening threshold for clinical depression. As well as attributing illness causation to

biological and psychosocial causes, a strong divergent theme emerged in reporting by first-generation Pushtuuns who attributed illness causation to supernatural powers. Families also reported going abroad for treatment, and the main barrier in accessing services was reported as communication in the Pushtuun's own language. It is concluded that a more patient-centred approach to primary health-care is required, as well as culturally appropriate language and service provision to access mainstream secondary care services.

Keywords: explanatory models, health beliefs, Pakistani, Pushtuun, service access

Introduction

Peoples from the North West Frontier of Pakistan are known as Pushtuuns. They are a distinct cultural and ethnic group with their own language (Pushtu), and they are a subgroup of the Pakistani population. Birmingham has the largest concentration of Pushtuuns within the UK. The exact community numbers are unknown. These people have a strong

culture with unique traditions, language and identity (Khan, 1993). However, this population is seldom differentiated from Pakistanis or Southern Asians. They may even be omitted from studies, as they speak a different language from the Pakistani population. If they are included it is likely that they are classed as Pakistanis.

A literature search on the following databases: ASSIA, Medline, BIDS, Cochrane Library, and the Centre for Research in Ethnic Relations at Warwick University was carried out to identify existing studies on the Pushtuun population. Only one study by Curren (1983, 1986a,b) was identified. Curren (unpublished 1983, 1986a,b) examined concepts of mental wellbeing and ill-health in Pushtuun mothers, and the extent to which the health needs of this group of mothers and their children were adequately met by the UK NHS. She concluded that the health needs of the Pushtuun mothers were not being adequately met, due to the interplay of institutional, social and cultural barriers. With the lack of availability of female practitioners and interpreters who spoke Pushtu, the women did not visit the general practitioner (GP) alone, and therefore were routinely treated by proxy. She concluded that the low rate of reported distress amongst the Pushtuun mothers 'does indeed derive partly from cultural differences in the conception and treatment of mental illness between the Pathans and the NHS practitioners' (Curren, 1983, p. 191).

The current study arose as a result of general observations by one of the authors (AH) who is a Pushtuun GP living and working in east Birmingham. From medical records it was evident that a significant proportion of Pushtuun patients had high rates of poor health, and a significant number were high attenders who, it was observed, reported health beliefs that were likely to be putting them at a disadvantage in accessing services.

Since there is only one study of Pushtuuns living in the UK, and in order to gain an understanding of health within this group, we examined research on Pakistani populations, as Pushtuuns, if recruited for these studies, would have been categorised as Pakistanis. Two national surveys of the health of minority groups in England (Department of Health, 1999, 2004) have reported that Pakistanis in general have high rates of poor health in a number of disease areas. Pakistanis were five times more likely to have diabetes, and had 60–70% higher rates of cardiovascular disease than those in the general population. Pakistani women were found to have the highest levels of glucose/blood sugar of all the groups in the population. Pakistanis also had very high rates of long-standing illness or disability, and were three to four times more likely to rate their own health as bad or very bad. Pakistani women had been reported as being significantly higher attenders of primary care services compared with native whites and all other ethnic groups. Pakistani men were also reported to be high attenders compared to the native white population and other ethnic groups except Bangladeshi men (Department of Health, 1999, 2004). The 2004 survey also reported that the prevalence of heart attack and angina was highest in Pakistani men and Indian men and women (Department of Health, 2004).

Having established that the Pakistani population, which may contain Pushtuuns, has high rates of illness and healthcare use, we searched for studies to establish the reasons for this. However, there are no known studies examining explanatory models of illness representation and service access in general practice among frequent attenders from a Pushtuun, or indeed a Pakistani, population in the UK.

Frequent attenders have been defined in a number of studies as those patients who attended more than three times in three months, or more than seven, eight or 12 times a year, or the upper 10% of consulters (Von Korff *et al*, 1992; Karlsson *et al*, 1994). Psychological distress has been related to high attendance in previous studies of high attenders (Katon *et al*, 1990; Bellon *et al*, 1999).

The research aimed to carry out a pilot study to establish the health beliefs and healthcare-seeking behaviour of the Pathan patients who were high attenders, and their families, and to establish if high attendance is related to psychological distress in this group of frequent attenders. In order to establish health beliefs and healthcare-seeking behaviour, we aimed to examine patients' beliefs around their illness, how they perceived the severity of their illness, what they felt caused their illness, their help-seeking behaviour, and what expectations and satisfaction individuals had around the medical care they were receiving. We also wanted to identify levels of service access, in terms of which services patients were in contact with, and whether there was any evidence of seeking treatment abroad and the reasons for this. In order to explore psychological distress, we intended to screen each patient for psychological symptoms. To fulfil our aims, we explored the explanatory models of illness that play a role in health-related behaviour, through the use of Kleinman's approach of asking questions through an exploratory process of qualitative enquiry (Kleinman, 1988). Explanatory models denote the notions about an episode of sickness and its treatment by all those who are part of the clinical process. Explanatory models reveal sickness labelling and cultural idioms for expressing the experience of illness, and have been shown to influence health-seeking behaviour and health service utilisation (Fosu, 1981). Understanding local cultural perspectives is crucial in culturally sensitive healthcare for a community (Joel *et al*, 2003).

Conduct of the study

Ethical approval was sought and received from East Birmingham Ethics Committee. Five families from a Pushtuun-speaking background (20 respondents) taken from the register of AH's primary care practice were interviewed between November 2001 and May

2002. A family was selected to take part in the research if at least one member of the family frequently attended the surgery (more than eight visits in a six-month period/upper 10% of consulters). In each family, the frequent attendee was interviewed, and then three other members of the family (Box 1).

Box 1 Summary of the project

In summary we explored:

- 1 anxiety and depression symptoms
- 2 health beliefs and healthcare-seeking behaviour: what were the patients' beliefs about their health, its perceived severity, causation, expectations and satisfaction with medical care, and help-seeking behaviour of the individual and families involvement in help seeking?
- 3 level of service access and service needs: what were the services patients were in contact with? Was there evidence of seeking treatment abroad, and if so for what reasons?

We wrote to each family member inviting them to take part. The research project was a collaborative venture between the general practice and Coventry University. The researchers who interviewed the families were employed by Coventry University and were independent of the GP practice, and participants were informed of this both initially when letters went out, and at the time of the interview. The researchers arranged an appropriate time and place to visit each family. At the first visit, the members of the family household were asked to help build a family tree. This put the role of the member being interviewed into the context of the family setting, and acted as an ice breaker to introduce the family to the researchers. Each person was presented with a male or female drawn figure, and asked to indicate any areas where they had had pain in the last 30 days. This was used to ensure that all areas of pain were covered in the interview.

The Self Explanatory Model Inventory (SEMI) (Lloyd *et al*, 1998) is designed for use in primary care, to explore explanatory health belief models. It was developed for use with Asian populations (Jacob *et al*, 1998; Sumathipala *et al*, 2000; Joel *et al*, 2003). It uses simple language and contains no medical or technical words. This tool encourages participants to talk openly about their attitudes and experiences, with the aim of eliciting concepts and the relationship of these to the current situation and culture. Using the SEMI divided the interview into five sections covering the person's personal background, the nature of the presenting problem, help-seeking behaviour, interac-

tion with the physician/healer, and beliefs related to illness. Additional semi-structured questions using a similar format were added for the research reported here. These questions explored whether respondents had gone abroad for medical treatment and reasons for this, concepts of good and bad health, help seeking, and experiences with the health services. Families' beliefs about the role of the GP were also explored.

A second tool, the Self-Rated Questionnaire (SRQ), was used to screen for anxiety and depression (Harding *et al*, 1980). This questionnaire has also been widely used on Asian populations.

The SEMI with additional questions, and the SRQ, were both translated and back-translated from English into Pushtu and Urdu. Owing to respondents' resistance to being tape-recorded, records were made by the interviewers and checked afterwards. Interviews took place in either Pushtu, Urdu or English, using the translated questionnaires as necessary, and two members of the research team were present at each interview to ensure accurate response recording. The researchers were bilingual and for each interview the members of the team present at the interview went through the data and agreed on its translation content and meaning.

The SEMI data were analysed according to the SEMI manual (Lloyd *et al*, 1996), which gives coded categories for specific themes. The additional data collected were analysed with a similar method using a process of thematic content analysis, where themes emerging through the interviews were identified and categorised. The SRQ was coded in terms of 'yes' and 'no' answers, with a score of 1 for yes and 0 for no. A score of 7 or above was seen as being above the clinical threshold for anxiety and depression, and indicative of psychiatric morbidity (Harding *et al*, 1980).

Findings

Demographic data

Four of the five families lived in social housing, owned by either a housing association or the local authority. Of the 20 respondents interviewed, only two were employed, the other 18 were claiming state benefits. All five high attendees were on state benefits, and three of the families' living conditions can be described as poor and crowded, with damp walls and very sparsely furnished with old and broken furniture.

Data analysis revealed seven themes: symptoms of anxiety and depression, health and illness, perceived severity, expectations and satisfaction with medical care, seeking advice from others, treatment abroad, and accessing secondary care services, each of which is discussed below.

Symptoms of anxiety and depression

We found that 10 respondents were above the threshold score of 7 of the self-rating scale for anxiety and depression, meaning they had a clinical level of morbidity. Each family had at least one member who had a score above the threshold score of 7 (see Table 1). In the majority of cases this was the high attender. Only one person above the threshold for depression was seeing a psychiatrist.

Only four respondents reported psychological issues as problems they had faced in the year. The respondents who were high scorers on the SRQ also reported more non-specific symptoms than those who did not have high scores on the SRQ.

Health and illness

We asked respondents about their most recent visit to the GP and the reasons for this. Of the 20 respondents, 10 had visited the GP in the last two months, and six had visited the GP in the last six months; the other four had not visited the GP at all in the year. All the high attendees had visited the GP in the last two months. We asked respondents to list problems that they had

experienced over the last year. We found that the five high attendees listed a median of seven health problems about which they had visited the GP over the last year. In total, the high attendees listed 35 problems. The other 18 respondents had, on average, three problems that they had experienced in the year, i.e. 45 problems in the year for the sample. We divided the problems using the SEMI rating scale into physical complaints, non-specific (used if the presenting problem was vague), psychological, marital family problems, housing, employment, other social problems, administrative, and finally, if their visit was related to the illness of a child.

We explored whether respondents had a name for their illness, how long ago it had started, and why they thought their illness had started when it did. We explored whether there was an internal or an external cause, and if so, who or what was the cause and whether they believed in spells (see Table 2).

There were no responses in the categories for employment, housing, marital, administrative and other social problems.

The five high attendees found it difficult to identify, or were not aware of, terms for some of their illnesses;

Table 1 First-generation/second-generation/male/female depression scores

	<i>N</i>	Mean score on the self-rating questionnaire	Number above threshold for anxiety and depression
First-generation males	6	11	3
Second-generation males	4	0	0
First-generation females	6	15	6
Second-generation females	4	4	1

Table 2 Outline of the 80 problems organised into the number of problems for each category and beliefs relating to causes

Problems	Number of problems	Beliefs as to why illness occurred			
		Internal	Natural world	Social world	Supernatural world
Physical	43	36	1	–	6
Non-specific	27	4	10	–	13
Psychological	4	–	–	1	3
Children's problems	5	2	–	–	3

instead they explained their illness in descriptive terms of pain, the location of pain. One example of this is MB's explanation for her stomach pains:

'I have been taking this mixture for one year because I get pains in my stomach, my stomach burns, I also get a pain in my side ... I don't know why I get this pain it pains so much it hurts. I had tests done they found nothing.'

The five high attendees were not aware of the names of some of the medicines they were taking, and in one case a man aged 45 years thought he was taking medicine for an upset stomach and not sleeping. He was actually taking tablets for anxiety and depression. A large proportion (37%) of the 80 problems was attributed to the supernatural world, especially physical, non-specific, psychological and children's problems. Of the five high attendees, four believed in supernatural causes, and all four attributed at least one of their problems to a supernatural cause. To illustrate the types of problems and the complex nature of the perceived causes we outline below the cases of two high attendees, a female and a male who attributed a range of problems to both supernatural causes and internal causes. WJ was a 55-year-old woman who had visited the GP 38 times in the last six months before interview. She scored a maximum of 20 on the SRQ scale for anxiety and depression. She reported severe free-floating pain in her body. She had had tests that had not led to a diagnosis. She stated that some of her illnesses were due to all the problems that were happening in her family. Two of her sons were drug addicts, her husband, at the time of interview, was in Pakistan with one of the sons. He was helping his son overcome his addiction. She had four daughters; one of her daughters had only female children, and one had been unable to conceive. She explained how she believed her pains and the problems in her family were due to *nazar* (eye). She described *nazar* as a spell put on her family by members of her wider family due to reasons of jealousy. *Nazar* is a supernatural power similar to the more widely known concept of *evil eye*. It is tied to the fear of envy, jealousy and admiration in the eye of the beholder. It is not seen as a deliberate act, but as an unconscious supernatural act controlled by forces outside of human nature. Only friends, acquaintances and relations are able to cast *evil eye*. It is not within the reaches of declared enemies (Abu-Rabia, 2005). She believed that someone was jealous of her having seven sons. She stated:

'I think it is *nazar* as I have seven sons and four daughters. One of the sons got married and had a child after 25 years. My one daughter has seven female children and she miscarries the male child. Another daughter has four daughters and no male children. Another daughter is expecting twins, I hope one of these is a boy. I am always ill with these pains, I wonder why someone would do this.'

Later in the conversation she revealed further her fears about her pains:

'I am worried that I might have cancer, I get pains in my hands and in my neck, when I change my clothes I ache, sometimes I can't move my hands. I hurt so much and no one can tell me what is wrong. So I think that I might have cancer.'

In the second case IK had five children from his second marriage, and a son from his previous marriage. He had visited the GP 28 times in the last six months. His son was married. IK had a large bag full of medicines which he showed to the interviewers. He outlined five ongoing health problems: diabetes, asthma, high blood pressure, problems with his back and problems with his knees that he visited the GP for. He also visited the GP for his daughter's health. She was two months old and had a severe skin condition. He sought help for his two sons who could not sleep well at night. He attributed the causes of two of his own problems, diabetes and asthma, to internal causes related to a slowing down of the body organs. Problems with his back and his knees he reported were due to an accident he had had at work. He attributed his two sons' sleeping condition as being due to supernatural causes. He believed his first son from a previous marriage to be responsible for the supernatural activity.

Perceived severity

Of the 20 respondents interviewed, the five high attendees were found to have the highest perceived severity for their problems. Of the five high attendees, four reported that their problems were very serious, and that they might die from their illness; the remaining one felt that his illness was moderately serious and felt that his problems would lead to a more serious disability. For example, BB was a 43-year-old mother of two grown-up children. She lived with her sons and two daughters-in-law. She had been in England since she was nine years old. She was fluent in English and the interview was carried out in English. She described a very troubled background of abuse by her husband and her in-laws. She reported a series of health problems: depression, acid in her stomach, pains in the heart, asthma, pains in her joints and pains in her stomach. Her SRQ scores were indicative of clinical anxiety and depression. She stated:

'... my problems are serious, sometimes I think that my heart is beating so fast that I think that it is going to stop and that I will die.'

Expectations and satisfaction with medical care

We asked respondents what they hoped to gain from seeing the family doctor. We asked whether they had told the doctor about all the problems they had discussed with us and whether it was useful to talk to the doctor. Respondents said they went to the doctor for a variety of medical/psychological reasons. Four respondents were on antidepressants, and 14 were on a variety of other medications for various illnesses. Six were awaiting appointments at the hospital. Thirteen of the respondents said that talking to the doctor at their last visit was useful and helped put their mind at ease about their problems. For example:

'I found it useful to talk to the doctor about my operation, I asked him questions about my fertility rates. He said that I should not pick up my son for six weeks and advised that due to my ectopic pregnancy, my fertility rate had gone down.'

'The doctor reassures me about my problems, the depression is making me think I am ill. I find it useful when I talk to the doctor, I feel reassured. I turn to the doctor for comfort. When I arrive at the doctors I think I am very ill, but when I leave the surgery I have a peace of mind, I realise nothing is wrong, it is just my mind.'

We found that all the patients had discussed the problems that they mentioned to us with their doctor, and reported being satisfied with the medical care that they were receiving at present. Ten respondents from three families reported dissatisfaction with their previous doctor, and hence they had transferred to the current GP. One respondent recalled how after numerous visits to his previous GP regarding what can be described as a serious needle phobia, the previous GP advised:

'Don't worry if you are that scared of needles, you should get lots of needles then put them in your room.'

The man reported:

'That was a stupid thing to say, as I am so scared of needles if the doctor had intervened then I might have got better when this was at the early stages.'

Seeking advice from others

We asked respondents if they had asked for advice from anyone else about their problems. We found that eight respondents had visited healers, and five asked advice from friends and family. We found that first-generation respondents were not familiar with other healthcare practitioners apart from the GP that they could access, such as community nurses and osteopaths, counsellors, clinical psychologists, etc. One family was not aware of state benefits that could be claimed for incapacity.

Family members were found to be involved in each other's healthcare. They gave advice and intervened in arranging healthcare. Second-generation members of the family were involved in interpreting for their parents who were not able to speak English. However, this was problematic in two cases. Two elder first-generation respondents who had had serious operations were traumatised from these operations. They had not fully understood the need for the operation despite having second-generation members of the family present.

Families sought the help of spiritual and religious healers for their problems and the problems of others in their family. We report three accounts of visits made to a *pir* (faith healer) for three different reasons. One respondent described her visit to a *pir* after her cousin had informed her that someone 'may have done something to you'; she reports that she thinks all the time that her heart will stop.

'I saw a *pir*. He said that someone has done something to you. He said that I will take it out of you. He gave me some *taveez* [a paper with prayers and inscriptions written on it] in water and I was sick [vomited]. He said I was sick as something was inside me and it has now come out. He gave me *taveez* to put around my neck. I felt better. My mind was freer then. I felt better. I previously felt that my heart was trapped in a cage and after this session with the *pir* I felt free. I felt happy for three months, but then these people [people in the extended family] do things to you again and again.'

Another respondent reported visiting a *hakim* (a traditional healer or scholar) for his asthma:

'I went to an asthma-healing *hakim*. We went early. When we got there he gave me some rice to eat and a bucket of water, a big bucket with three feet of water in it. He said drink from this bucket till you are full. I did and then he made me smell this material and I was violently sick. I felt something come out. It was like a net material. I still have it. I put it in a bottle. He also gave me some medicine. I took the medicine but after a few days I was sick again. I think this was because I didn't follow the proper way of taking the medicine.'

Another respondent reported asking the help of a *pir* because he could not understand the behaviour of his children. He phoned the scholar in Pakistan and had a session with him on the phone. The scholar told him that his older son from his first marriage had put a spell on his children and his family.

'All night the children don't sleep, they laugh in their sleep, they destroy things, they throw everything around the room. S and T are the one that have *jin* in them. I recently took them for a blood test and the doctor informed me that T is OK but that S has the mind of a child of three. He is now being checked and referred to hospital.'

In the above example, S who is 6 years old is now under the care of community health teams after the family

changed GP and was referred by their current GP. He was not attending school at the time of interview. The child had recently been referred for assessment after they reported they could not cope with his behaviour and referred him.

Treatment abroad

Three out of the five families had at least one member who had gone abroad to Peshawar in Northern Pakistan for treatment. The types of treatment included kidney transplant, drug treatment and general routine operations such as rhinoplasty. Language, understanding the system and quicker access to healthcare were the reasons given for going abroad. An example was SKK who had had one kidney since 1963. This kidney was failing and he stated:

‘I enquired in the Pakistan hospital and they said come anytime and we will attach the kidney. A woman from my village was in dialysis for many years here in England, she went to Pakistan and had a new kidney. She told me about this and gave me the telephone number of the doctor. So I took the number and spoke to the doctor he is a Pushtuun and lives in Rawalpindi.’

When asked why he would not have the treatment here he said:

‘They don’t do this treatment here. They said we only do this if you are from age 25–50 years old. I am over 60 and so I am too old, they have said do *ghazarah* [put up] with this, if I could get this treatment here I wouldn’t go abroad ... Here when people get old there is no use for them and so they don’t get proper treatment. Two people have had this treatment in Pakistan and they are both fine, one is a man and he is now driving a taxi.’

AJ’s husband was currently in Pakistan where he had taken his son to receive drug treatment. Previously he had taken both his sons and had first tried to wean them off drugs himself by rationing the drug, then he admitted them to a clinic in Pakistan. We spoke to one of his sons who said that he was now free of drugs and stated that his father took him over there as he had more confidence in the system as he could talk to hospital staff in Pushtu.

Accessing secondary care services

We found little evidence of families accessing services outside their own GPs. Only one out of the 10 respondents above the threshold score for anxiety and depression had been referred to a psychiatrist. He had a very severe phobia of needles, and it was limiting his activities. Of the other nine, four were on antidepressants, and five were not taking any medication for their symptoms. One father told us about the constant care his daughter needed. When asked if

he had sought help he said he did not know he could get help. His six-month-old daughter had a severe skin condition and had a range of care needs for which community healthcare teams could have provided support. He was also not claiming any benefits for caring for the child.

The first-generation Pushtuuns reported language problems as a barrier to accessing services. Four of the high attendees relied heavily on their children to go with them to hospital to interpret. Two respondents reported missing appointments, as there was no one to go with them at the time. Using family members as interpreters can in itself be problematic as is clear from the case of HB. Mrs HB cried throughout much of her interview, she became upset when she started to talk about her eye operation. She described how she went into hospital to have a cataract removed from her left eye. The doctors, after carrying out tests, removed her right eye. She was convinced that the eye medicine given to her at the time had harmed her eyes. She was blind at the time of the interview, and reported that she was afraid to let doctors near her eye that needed a cataract operation.

‘They were experimenting on me and told me to put medicine in both eyes. I did this and they tricked me as this made my eye bad. I don’t understand why they did this. Why they took out my good eye? If they go back to the tests that they did they will find that there was nothing wrong with that eye.’

She describes what she was like before the operation:

‘... when I first came here [England] two years ago I could do everything, I could paint the house, I used to make sofa covers, now I cannot do anything. I am very sad. I will not go for the other eye as I am afraid that they will take it out and I don’t want them to touch me anymore.’

We asked her if someone had explained to her the reason why she had her eye removed; she said they told her stepson that it was a bad eye, but she did not believe this. She said that she had not received any counselling or rehabilitation intervention afterwards. Second-generation respondents showed a more empowered and proactive attitude to finding out information about their healthcare. An example was AB who was a second-generation female who reported that she had had an ectopic pregnancy. She was able to describe clearly what happened to her during her pregnancy. She did not feel that having an ectopic pregnancy could be blamed on anything she did. She also reported being overweight and getting severe pains in her legs. She had taken action to lose weight. Below is an account of how she went to the doctor to find out about the consequences of an ectopic pregnancy:

‘I went to the doctor so that he would explain to me the likelihood of having kids and what I needed to do such as

rest and how long for ... The doctor explained that I should keep away from lifting heavy things, he explained that they had to take out my Fallopian tube and that my fertility rate had gone down by 50%.’

‘I think the body had too much pressure on it with my weight and it is the body’s way of saying do something. So I gave up driving everywhere and have started to walk.’

Another second-generation 18 year old who had a clinically significant score on the SRQ stated that she often felt depressed. She felt that her weight was a problem, and had asked the doctor for tablets to help her to lose weight. He had asked her to start to exercise and eat less before he would consider treatment for her. She had taken his advice and was on a diet and exercise regime. Second-generation respondents reported no problems with accessing services or visiting the hospital.

We asked what kind of things families would like improved in current services. The majority of families reported they were happy with services. One mother felt that drug rehabilitation in England needed to be reassessed, as she reported that the drug rehabilitation system had failed her sons and that is the reason why their father had to take action into his own hands. Seven respondents reported that a person who could speak their language would improve communication.

Discussion

From the sample of the five Pushtuun families, we observed that these families lived in poor social housing and had diverse health, social and psychological problems. There was evidence that first-generation immigrants were not utilising mainstream healthcare services apart from local GP services. All the high attenders, and five other respondents in the families, had high scores on a screening measure for depression and anxiety. Only four of these were receiving treatment for anxiety and depression. It is not surprising that mental illness is associated with frequent attendance. This has been documented in other studies (Katon *et al*, 1990; Bellon *et al*, 1999). High attenders also reported a high perceived severity of their problems. This is also similar to findings of other studies of frequent attenders (Bellon *et al*, 1999; Berkanovic and Telesky, 1982).

Frequent attenders were also found to be lacking in knowledge about their medication, with all five high attendees not being able to name their medication, and one attendee misunderstanding the reason for their medication. This finding has serious implications for compliance with and understanding the side-effects of medication.

A strong divergent theme emerged regarding illness causation. According to the self-regulatory model

(Leventhal *et al*, 1984, 1997), a person considers illness in terms of five coherent themes. Each theme relates to a particular aspect of illness and together they form a person’s illness representation. The themes are: identifying the illness, giving it a label, outlining the cause as being either biological or psychosocial, establishing the perceived consequence on life and beliefs about whether illness can be treated/cured or controlled. In our study supernatural beliefs were seen as the cause of many illnesses. It is not possible to understand this by applying Leventhal’s self-regulatory model (1984, 1997), which only categorises causes in terms of biological and psychosocial aspects. Beliefs in supernatural causes for illnesses are not uncommon in non-western societies (Murdock *et al*, 1978; Patel, 1995; Maher, 1999). However, other studies of high attenders in primary care carried out in the UK and Spain with native white populations have not reported a perception of supernatural causation in illness (Heywood *et al*, 1998; Bellon *et al*, 1999; Neal *et al*, 2000). Murdock’s models of aetiology based on a worldwide survey of illnesses classified illness into two basic groups: natural causation such as infections and accidents, and supernatural causation which included mystical causes, animistic causes and magical causes (Murdock *et al*, 1978). The role of spirits in traditional societies is prominent in the causation of illness, and is used as an important way of explaining misfortune (Patel, 1995). However, many western quantitative questionnaires such as the IPQ-R (Moss-Morris *et al*, 2002) do not address beliefs regarding supernatural causation.

It is possible that families gave supernatural explanations for their illnesses as they lacked understanding and knowledge of the nature of their illness, or because it was culturally acceptable and/or a cultural norm to attribute supernatural causes to certain illnesses. Attributing illness causes to supernatural explanations gives families the legitimacy to turn to spiritual healers, who may provide a form of coping and a source of support. In a recent study McCabe and Priebe (2004) looked at explanatory models of illness in patients of four ethnic groups with schizophrenia: African-Caribbean, Bangladeshi, West African and UK white. They found that of the 119 total respondents in their study, 26.9% (7/30) of Bangladeshis, 28.6% (8/29) of West African and 10% (3/30) of African-Caribbeans reported supernatural causes as the primary cause of their schizophrenia, compared to none (0/30) of the UK white population. They also reported that Bangladeshis who cited supernatural causes more frequently either wanted alternative forms of treatment such as religious activities, or no treatment at all. In a study by Sulaiman *et al* (2001) on the perceptions of depression in a community sample in Dubai, it was stated that respondents advocated the most effective coping strategy for psychological distress as going to religious places and talking to religious professionals. However,

the effect of spiritual beliefs on health outcome has been found to be a negative one in two studies in London (King *et al*, 1994, 1999), which found that cardiology and gynaecology patients with stronger spiritual beliefs do less well clinically than those who adhere less strongly. In our study, none of the second-generation individuals stated there were supernatural causes for their illnesses, and they reported asking questions about the nature of their illness and requesting explanations of causes from their GP to a far greater degree than the first-generation Pushtuuns.

Families resorted to taking up medical care in Pakistan. Either they went for a general visit or they went especially to access care such as drug rehabilitation. Three of the reasons given were language barriers, better understanding of the system in Pakistan, and easier access to care. This may be due to a number of factors: healthcare is private and therefore those who pay can access healthcare; patients understand the system because they are able to communicate with healthcare providers in Peshawar in Pakistan; private healthcare is cheaper than it is in England.

All the families had at least one member who was a frequent attender at the GP surgery. Studies such as that of Heywood *et al* (1998) have shown that frequent attenders have high levels of physical and psychological ill-health, and so it was not surprising to find that the respondents in our study had poor health. What was surprising was the poor level of access to other healthcare services. Other studies on white/European populations have found that frequent attenders are usually in contact with a range of service providers (Kersnik *et al*, 2001). Awareness of services outside the general practice was found to be low. This is likely to be due to a combination of compounding factors; it is likely that these families are not assertive in their requests to be referred to other healthcare practitioners because they are not aware of what is available. Lack of access could also be attributed to the poor provision of interpreters, translated material, culturally competent practice, and culturally appropriate service provision. In previous research on Pathans (Curren, 1986a, 1986b), women were found not to visit the GP. In our study, the women we interviewed did access the GP, and mainly on their own. The main reason for this is likely to be language access with the principal GP, and a number of staff, including receptionists, at the practice able to communicate in Pushtu. Poor previous experience due to the above precipitating factors of a service is likely to lead to fear or reluctance to undertake further visits to healthcare providers. This was evident in the case of the elderly lady who was in need of cataract surgery, but a traumatising previous experience led her to avoid further visits.

The sample of respondents in this study were from one GP practice; however, it is likely that these findings are a trend in other high-attender Pathan families

in other Asian GP practices. As for Pathan families from non-Asian GP practices, it is not possible to speculate that this would be a similar pattern, as lack of language and cultural understanding may lead to poor access to GPs as well as other providers. However, it is argued that in Pathan families, where members do not speak English, an Asian GP who spoke either Pushtu or Urdu would be sought out as a primary care provider, especially in large inner-city areas with significant Asian populations and a wider range of access to GPs from diverse Asian backgrounds.

Since Pushtuuns are a subgroup of Pakistanis, it can be questioned whether this trend is likely to exist in other Pakistani subgroups such as the Mirpuris. Mirpuris are people who have originated from Mirpur in Pakistan, and they make up the largest group of Pakistanis in the UK. Since the Mirpuris are demographically from a different part of Pakistan, speak a different language, and are viewed as culturally different from the Pushtuuns in many aspects, it is not wise to speculate that this trend exists in the subgroup populations of Pakistanis such as the Mirpuris.

It is recognised that there are a number of limitations to this study. The population was drawn from one general practice. This conferred some benefits, in that patients from one practice are likely to be receiving some consistency in care. However, it is acknowledged that by including other practices, we would have been able to generalise our findings further. The research team received generally positive feedback about the services received from the GP. It is recognised that, even though it was made clear to the patients that the research team was independent of the practice, there may have been some reluctance to give unfavourable answers about services, although there is evidence from other research that frequent attenders are generally more satisfied with their GP in any case (Kersnik *et al*, 2001).

In order to help these families acquire a better understanding and knowledge of the nature and course of illnesses that are affecting them, a more patient-centred approach to healthcare is required, as well as culturally appropriate secondary care service provision. These suggestions are similar to those put forward by Curren (1983, 1986a,b) over 20 years ago. Little *et al* (2001) suggest that patients in primary care strongly want a patient-centred approach, with communication, partnership and health promotion. They suggest that doctors should be particularly sensitive to those patients who are vulnerable either psychosocially or because they are feeling particularly unwell.

This study is a small qualitative study, which has attempted to understand the health beliefs and explanatory models of illness of a subpopulation of the larger Pakistani population. From the data of the Health Survey for England (Department of Health, 1999, 2004), it is evident that the Pakistani population

as a whole has great healthcare needs. For us to gain a deeper and broader understanding of health beliefs and models of illness in the Pakistani population as a whole, a larger study is needed, which should explore explanatory models of illness in this population and the role supernatural beliefs play in different types of illness. This study raises a number of issues for practitioners and service providers. First, a lack of understanding and awareness of a patient's health beliefs surrounding their illness by a healthcare practitioner can lead to non-compliance with medication, poor self-care, and poor access to services by the person concerned. There is evidence of specific cultural beliefs that do not fit into western health models, and therefore there is a need to understand a patient's own specific health models. Second, lack of access appears to be multi-factorial, and includes a lack of knowledge of services and lack of culturally appropriate service provision with even the basic requirements such as language provision not being met. Healthcare information should be explained in the individual's preferred language, taking into account their beliefs, including sensitivity to the supernatural beliefs, and working with these to help individuals access a range of healthcare services in accordance with need. Finally, fulfilling a basic requirement such as providing interpreters is still not taking place for a number of patients. Health and social care services should be collecting data on ethnicity and preferred language spoken, in order to identify both needs in their own service provision, and to establish areas within services where there are pockets of populations who are not accessing services.

Conclusion

This study examined the health beliefs of five Pushtun families, each of which had a member who frequently attended the GP's surgery. Findings demonstrated that health inequalities persist for the most economically and socially disadvantaged, because their access to the full range of health and social care services is either restricted by patients' lack of knowledge or an inability to express their needs, or influenced by health beliefs that are not congruent with the dominant western paradigm. For this situation to change, health and social care practitioners need to address the bias inherent in their practice and actively seek out ways of providing culturally appropriate and competent care.

ACKNOWLEDGEMENT

Research was funded by Warwick West Midlands Primary Care Research Network.

REFERENCES

- Abu Rabia A (2005) The evil eye and cultural beliefs among the Bedouin tribes of the Negev, Middle East. *Folklore* 116:241–54.
- Bellon JA, Delgado A, De Dios Luna J and Lardelli P (1999) Psychosocial and health belief variables associated with frequent attendance in primary care. *Psychological Medicine* 29(6):1347–57.
- Berkanovic E and Telesky C (1982) Social networks, beliefs and the decision to seek medical care: an analysis of congruent and incongruent patterns. *Medical Care* 20:1018–26.
- Currer C (1986a) Concepts of mental well-being and ill-being: the case of Pathan mothers in Britain. In: Currer C and Stacey M (eds) *Concepts of Health, Illness and Disease; a comparative perspective*. Leamington Spa: Berg, pp. 183–98.
- Currer C (1986b) *Health Concepts and Illness Behaviour: the case of some Pathan mothers in Britain*. University of Warwick, Department of Sociology, PhD thesis.
- Department of Health (1999) *Health Survey for England: the health of minority groups*. London: The Stationery Office.
- Department of Health (2004) *Health Survey for England: health of ethnic minorities*. London: The Stationery Office.
- Fosu GB (1981) Disease classification in rural Ghana: framework and implications for health behaviour. *Social Science and Medicine* 15B:471.
- Harding TW, De Arango MV, Baltazar J *et al* (1980) Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychological Medicine* 10:231–41.
- Heywood PL, Blackie GC, Cameron IH and Dowell AC (1998) An assessment of the attributes of frequent attenders to general practice. *Family Practice* 15:198–204.
- Jacob KS, Bhugra D, Lloyd KR and Mann AH (1998) Common mental disorders, explanatory models and consultation behaviour among Indian women living in the U.K. *Journal of the Royal Society of Medicine* 91:66–71.
- Joel D, Sathyaseelan M, Jayakaran R *et al* (2003) Explanatory models of psychosis among community health workers in South India. *Acta Psychiatrica Scandinavica* 108:66–9.
- Karlsson H, Lehtinen V and Joukamaa M (1994) Frequent attenders of Finnish public primary health care: socio-demographic characteristics and physical morbidity. *Family Practice* 11:424–30.
- Katon W, von Korff M, Lin E *et al* (1990) Distressed high utilisers of medical care, DSM-III-R diagnoses and treatment needs. *General Hospital Psychiatry* 12:355–62.
- Kersnik J, Svab L and Vegnuti M (2001) Frequent attenders in general practice: quality of life, patient satisfaction, use of medical services and G.P characteristics. *Scandinavian Journal of Primary Health Care* 19:174–7.
- Khan R (1993) *The Pushtun Community in Birmingham*. Birmingham: Department of Social Services, Birmingham City Council.
- King M, Speck P and Thomas A (1994) Spiritual and religious beliefs in acute illness: is this a feasible area of study? *Social Science and Medicine* 38:631–6.
- King M, Speck P and Thomas A (1999) The effect of spiritual beliefs on outcome from illness. *Social Science and Medicine* 48:1291–9.

- Kleinman A (1988) *Rethinking Psychiatry: from cultural category to personal experience*. New York: Free Press.
- Leventhal H, Benyamini Y, Brownlee S *et al* (1997) Illness representations; theoretical foundations. In: Petrie KJ and Weinman J (eds) *Perception of Health and Illness: current research applications*. Amsterdam: Harwood Academic Publishers, pp. 19–45.
- Leventhal H, Nerenz DR and Steele DJ (1984) Illness representations and coping with health threats. In: Baum A, Taylor SE and Singer JE (eds) *Handbook of Psychology and Health*, Vol. 4. Hillsdale, NJ: Erlbaum, pp. 219–52.
- Little P, Everitt H, Williamson I *et al* (2001) Preference of patients for patient centred approach to consultation in primary care; observational study. *BMJ* 322:1–7.
- Lloyd KR, Jacob KS, Patel V *et al* (1996) *The Coding Manual for the Short Explanatory Model Interview (SEMI)*. Exeter: University of Exeter, Department of Mental Health.
- Lloyd KR, Jacob KS, Patel V *et al* (1998) The development of the Short Explanatory Model Interview and its use among primary care attenders with common mental disorders. *Psychological Medicine* 28:1231–7.
- Maher P (1999) A review of traditional aboriginal health beliefs. *Australian Journal of Rural Health* 7:229–36.
- McCabe R and Priebe S (2004) Explanatory models of illness in schizophrenia: comparison of four ethnic groups. *British Journal of Psychiatry* 185:25–30.
- Moss-Morris R, Weinman J, Petrie KJ *et al* (2002) The Revised Illness Perception Questionnaire (IPQ-R). *Psychology and Health* 17:1–16.
- Murdock GP, Wilson SF and Frederick V (1978) World distribution of theories of illness. *Ethnology* 17:449–70.
- Neal R, Heywood PL and Morley S (2000) ‘I always seem to be there’ – a qualitative study of frequent attenders. *British Journal of General Practice* 50:716–23.
- Patel V (1995) Explanatory models of mental illness in Sub-Saharan Africa. *Social Science and Medicine* 40:1291–8.
- Sulaiman SOY, Bhugra D and Silva P (2001) Perceptions of depression in a community sample in Dubai. *Transcultural Psychiatry* 38:201–18.
- Sumathipala A, Hewege S, Hanwella R and Mann AH (2000) Randomized control trial of cognitive behaviour therapy for repeated consultations for medically unexplained complaints – a feasibility study in Sri Lanka. *Psychological Medicine* 30:747–57.
- Von Korff M, Ormel J, Katon W and Lin EH (1992) Disability and depression among high utilizers of health care. A longitudinal analysis. *Archives of General Psychiatry* 49:91–100.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Qulsom Fazil, Department of Psychiatry, University of Birmingham, Queen Elizabeth Psychiatric Hospital, Mindelsohn Way, Edgbaston, Birmingham B15 2QZ, UK. Tel: +44 (0)121 678 2439; fax: +44 (0)121 678 2351; email: q.a.fazil@bham.ac.uk

Received 28 March 2006

Accepted 24 July 2006

