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Cross culture gender differences on evaluation of women's psychological needs

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The University of Arizona, 1987

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CROSS CULTURE GENDER DIFFERENCES ON EVALUATION OF WOMEN'S PSYCHOLOGICAL NEEDS

by

Nefissa Mohamed Abdel Kader

A Dissertation Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

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THE UNIVERSITY OF ARIZONA
GRADUATE COLLEGE

As members of the Final Examination Committee, we certify that we have read the dissertation prepared by Nefissa Mohamed Abdel Kader entitled Cross-Culture Gender Differences on Evaluation of Women's Psychological Needs and recommend that it be accepted as fulfilling the dissertation requirement for the Degree of Doctor of Philosophy.

Merle Mosher	August 24, 1987
Margarita Kay	August 24, 1987
Kenneth R. Pelletier	Aug 24, 1987
Jerry L. Miller	Aug 24, 1987
Frank Wilcher	Aug. 24, 1987

Date

Final approval and acceptance of this dissertation is contingent upon the candidate's submission of the final copy of the dissertation to the Graduate College.

I hereby certify that I have read this dissertation prepared under my direction and recommend that it be accepted as fulfilling the dissertation requirement.

Merle H. Mosher	August 31, 1987
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SIGNED: Nefissa Abdel Kader

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ABSTRACT

The central purpose of this study was to investigate the impact of the devaluation of women's psychological problems upon the recognition of women's behavior as deviant and the subsequent impact of both variables upon the recognition of women's need for psychological treatment. A secondary purpose was to determine whether culture and gender influenced each concept in this study.

The study utilized a mathematical correlational design with a causal modeling approach to test a three-stage theory. The convenience sample selected for the study consisted of 80 subjects: 20 Arabic males; 20 Arabic females; 20 Anglo American males; and 20 Anglo American females living in a southwestern city. A three-scale instrument (each scale contains two subscales) was constructed to index the theoretical concepts. Reliability and validity estimates were conducted to determine the psychometric properties of the instrument. The theory was tested using correlational, analysis of variance, and multiple regression statistical techniques.

The traditional orientation of the Arabic culture appears to account for the differences found in the data. Along with cultural influences, gender also appeared to impact upon two of the concepts in the neurotic level, devaluation of neurotic behavior (B = -.64) and recognition of the need for treatment of neurotic behaviors (B = .22), with males evidencing a lower level of sensitivity to women's psychological problems. Gender interacted with culture for

two concepts, devaluation of neurotic behavior (B = -.28) and recognition of neurotic behavior as deviant (B = -.27), and Arabic males were the least sensitive group.

Both culture and gender did not have an impact upon devaluation of psychotic behavior and recognition of the need for treatment of psychotic behavior. However, there were cultural differences in the recognition of psychotic behavior as deviant. Arabic subjects probably evaluated some of psychotic behaviors as religious rather than considering them as psychiatric disorders.

Only the variable, devaluation of women's psychological problems was found to be a predictor of recognition of women's need for treatment. Also the variable, devaluation of women's psychological problems, had an impact upon recognition of women's behavior as deviant.

CHAPTER I

INTRODUCTION

Evidence of the existence of sex-role stereotypes, that is, highly consensual norms and beliefs about the differing characteristics of men and women, are abundantly present in the literature (Anastasi & Foley, 1949; Fernberger, 1948; Komarovsky, 1950; McKee & Sherriffs, 1957; Seward, 1946; Seward & Larson, 1968; Wylie, 1961; Rosenkrantz, et al., 1968). Similarly, the differential evaluations of behaviors and characteristics stereotypically ascribed to men and women are well established in any culture (Kitay, 1940; Lynn, 1959; McKee & Sherriffs, 1957; Rosenkrantz, et al., 1968; White, 1950; Saadawi, 1980).

Stereotypically masculine traits are often perceived as more socially desirable than are attributes that are stereotypically feminine. The literature indicates that the social desirability of behaviors is positively related to clinical ratings of these same behaviors by psychotherapists in terms of "normality-abnormality" (Cowen, 1961), "adjustment" (Wiener, et al., 1959), and "health-illness" (Kogan, et al., 1957).

Thus it seems reasonable to expect that clinicians will maintain parallel distinctions in their concepts of what behaviorally is healthy or pathological when considering men versus women. More specifically, particular behaviors and characteristics may be thought indicative

of pathology in members of one sex, but not pathological in members of the opposite sex.

Social reaction to mental illness depends to some extent on one's sex. Standards of normality for females are reported to be lower than standards for males, and females are apparently less stigmatized for symptoms of mental incompetence (Howell & Bayes, 1981).

Mental illness in males seems to be detected earlier and treated at greater length in special inpatient facilities (Tudor, Tudor & Gove, 1977). Since, as Loftus (1960) notes, the basis of psychiatric diagnosis is "social, cultural, economic and sometimes legal" in nature, there is considerable room for the play of subjective factors in diagnosis formulation. Some of the facts which may influence the diagnostic process are generalized expectations and sex stereotypes.

This study focuses on the possibility that differences in culture and gender (male versus female) might influence the evaluation of women's psychological needs by investigating the impact of culture and gender as predictor variables on the concepts under study (i.e., devaluation of women's psychological problems, recognition of behavior as deviant, and recognition of the need for treatment). This study provides initial information about factors that may impact on the recognition of women's need for psychiatric treatment cross-culturally.

The need for this study is important due to the limited number of scientific cross-cultural comparisons that explore the effect of gender and cultural differences on the evaluation of women's psychological needs.

Even though there are some differences in women's situations, status, liberation and dependency as well as male domination cross-culturally, there still is a need for studying the effect of such differences upon women's psychological conditions cross-culturally. In addition, the information gleaned from such a study could be used to educate the community in terms of early recognition, treatment, and intervention. Also, the data could be used in developing and planning for needed services for the population under consideration.

This study also explores if there is a difference of women's valuation and differences in dealing with women's psychological problems across the two cultures (Arabic versus American). This will enhance therapeutic understanding of the influence of culture and gender on the appraisal of women's psychological need for treatment.

Statement of the Problem

Many authors have speculated that there are several social control and cultural processes which contribute to the different pathways into psychiatric treatment.

Psychiatry has focused on abnormal behavior as an illness and has emphasized medical (psychiatric) treatment for management. The designated social force for alleviating psychological distress is the mental health system. Even though there is a serious question as to whether this system can recognize and respond to women's need for treatment when women are victims of stereotyping sex bias, devaluation, and institutional discrimination (Horwitz, 1977). When attitudes and treatment practices reflect these biases, practitioners will be

unsympathetic to their clients' complaints against the status quo. Moreover, many women who have been in treatment report that the mental health system is primarily engaged in adjusting women to the existing social reality.

Two major areas have been discussed in the literature as possibly influencing the evaluation of women's need for treatment. The areas are the degree to which women's psychological problems are devalued and the degree to which women's symptomatology is perceived to be deviant by clinicians. The two areas are mainly derived from sociological theories, more specifically social labeling theory and symbolic interaction perspective. Symbolic interaction perspective predicts that in any culture that is male-dominated, the dominance is passed from one generation to another partly through symbolic systems, including language and religion, as well as mass media. Stockard & Johnson (1980) state that not only does male-dominance pervade our language, religion, and media, it also influences the every day interactions of males and females. They add, sex segregation and the devaluation of women appear in every day life, at home, at work and in organizations. This involves social roles and individuals' actions in social groups based on the expectations of others in that group. For example, women are likely to spend more hours of their lives than men performing roles with a high tolerance for mental aberrations, and socially they are more likely to be defined in terms of household roles which are less rigid, less visible, lower in status, and more poorly defined. It has been argued that these attributes

of traditional feminine roles create higher levels of distress among women resulting in higher rates of mental illness (Tudor et al., 1977).

If the role of the housewife is more conducive to mental illness, this role is also more tolerant of mental disturbances when they do occur. In addition, the role is tolerant of the behavioral abnormalities which signal such disturbances because disturbances are less public and less visible in this role than in occupational roles outside the home (Gove & Tudor, 1973). As Scheff (1974) states, visibility is an important factor in the decision to hospitalize the mentally ill. If the housewife becomes incapacitated, her husband and children may assist her or even take over the running of the home. A poor performance by a wife does not threaten the family in the way a husband's incapacitation would and is more likely to be tolerated (Gove & Howell, 1974; Hammer, 1964).

The same processes of women's devaluation exist in Arabic societies. Saadawi (1980) states that Arabic society does everything it can to convince a woman that she is only a body and that special care must be taken of everything that concerns the purely physical shell. Divesting a woman of her natural positive traits is equivalent to divesting her of her responsibilities as a human being. She adds, femininity, or femaleness, means weakness, naivety, negativeness, and resignation. Masculinity, maleness, on the other hand, is supposed to be distinguished by qualities that are the absolute opposite; qualities such as mastery, strength, determination, initiative and boldness.

According to Saadawi (1980), the source of some of the emotional problems that Arab women suffer is related to mental, sexual and psychological suppression. They have no other alternative than to sacrifice action because it is men who take action and it is the women's role to await the action of men. The passivity observed in Arabic women is therefore not an inherent or inborn characteristic but has been imposed on them by society. Many girls or women end up with psychological disorders due to the severe restrictions to which they are exposed. Moreover, women have been subjected to a great deal of discrimination which causes them to be victims of a very marked degree of mental and psychological suppression (Saadawi, 1980).

Thus, the underlying processes of identifying mental illness are similar cross-culturally, but the specific content of labeled mental illness varies between cultural groups. In this theme, Scheff (1966) suggests that cultural stereotypes tend to produce uniformity of symptoms within the cultural groups and enormous differences in the manifestation of symptoms of mental disorder between societies. Such differences among cultures might include differences regarding the evaluation of women's psychological problems as deviant as well as differences in recognition of women's need for treatment.

Purpose of the Study

The major purpose of this study is to investigate the recognition of women's need for treatment as a health care outcome and the

major factors believed to impact on the evaluation of women's need for treatment.

The specific purposes of this study are: a) to investigate the impact of devaluation of women's psychological problems and recognition of behavior as deviant on the recognition of women's need for treatment; and b) to investigate whether devaluation of women's psychological needs is culturally bound or due to gender differences. The specific aims of the study will be presented in Chapter II after the description of the stages of the theoretical framework underlying the study.

Significance of the Study

Several studies reviewed in the literature indicate that women experience a greater delay between their initial psychiatric problems and their first admission for inpatient treatment and show that women spend fewer weeks in the hospital than men (Mishler & Scotch, 1965). This means that mental disorders among women are likely to be defined as less disruptive than similar disorders among men, and that societal reaction to women's incompetence is more sluggish and less severe. The problems such women might have in dealing with the world they face might thus be defined as less important.

Moreover, women consistently have been found to have higher rates of untreated mental illness than men, as operationally defined by the most commonly utilized screening scales, i.e., Langer, Hos, GWB (Fox, 1980; Gove & Tudor, 1973; Link & Dohrenwend, 1980a; Veroff, et al., 1981a). Inclusive definitions of treated mental illness,

however, generally show that males have a higher overall treatment rate than females (Gove, 1980; Link & Dohrenwent, 1980b; National Institute of Mental Health (NIMH), 1981; Veroff, et al., 1981b).

Few studies have dealt with how women cope with their psychiatric problems before they seek professional help. Instead, most studies in psychiatric sociology focus on the epidemiological differences in rates of untreated and treated symptoms among social groups (Dohrenwend & Dohrenwend, 1969). The process mediating between the development of symptoms and the actual entry into treatment have, for the most part, been neglected. Many studies have not distinguished the effect of sex on the development of symptoms from its effect on the use of psychiatric treatment (Horwitz, 1977). As anticipated in the literature, it has been found that sex differences do exist in evaluating the seriousness of women's psychological problems, recognition of deviancy, as well as recognition of their need for treatment.

Since little is known about the effect of culture and/or gender on the concepts investigated in this study, their impact on the concepts under study are not hypothesized. Instead, six research questions are posed:

1. Is the devaluation of women's neurotic behavior culture bound or due to gender differences existing cross-culturally?
2. Is the devaluation of women's psychotic behavior culture bound or due to gender differences existing cross-culturally?

3. Is recognition of women's neurotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
4. Is recognition of women's psychotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
5. Is recognition of the need for treatment of women's neurotic behavior culture bound or due to gender differences existing cross-culturally?
6. Is recognition of the need for treatment of women's psychotic behavior culture bound or due to gender differences existing cross-culturally?

Three more research questions addressing testing the model are:

1. Do gender, culture or an interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence recognition of the need for treatment?
2. Do gender, culture or an interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence the degree of recognition of behavior as deviant?
3. Do gender, culture or an interaction of gender and culture, devaluation of women's neurotic or psychiatric behavior, and recognition of behavior as deviant influence the degree of recognition of the need for treatment?

The significance of this study is in its attempt to seek information that leads to a greater understanding of the factors that

influence women's accessibility to treatment. This study provides initial information about the factors that might impact on the recognition of women's need for psychiatric treatment cross-culturally. By knowing which factors are positively and negatively associated with recognition of women's need for treatment, the community mental health nurse is able to intervene by educating and guiding women to pathways of professional help.

Summary

It has been found that the greater status and power of men provide them with greater access to mental health facilities, and that their problems are more often channelled into professional hands. In addition, it has been documented in the literature that sex differences can affect the degree of evaluation of women's psychological problems and their need for treatment. This study investigates the influence of culture and gender, on the concepts of devaluation of women's psychological problems, recognition of behavior as deviant, and recognition of the need for treatment. The theoretical framework of the study and the specific aims will be presented in Chapter II. The methodology will be described in Chapter III.

CHAPTER II

THEORETICAL FRAMEWORK

This chapter includes the description of the theoretical model and derivation of the theory for each concept under study. It also includes the literature review and research supporting each concept as well as the expected theoretical relationships among the concepts under consideration.

The theory underlying this study is illustrated in the theoretical model in Figure 1. The model is in a causal modeling format drawn from the works of Asher (1976) and Blalock (1964, 1969).

Description of the Theoretical Model

The theory, shown in Figure 1, is represented by a three stage causal model showing the relationships at the concept level. The stages represent the causal sequence of the concepts. The arrows depict the hypothesized causal relationships with the signs on the arrows indicating whether a relationship is positive or negative (Asher, 1976; Blalock, 1964, 1969).

The three concepts comprising the theory are: 1) devaluation of women's psychological problems; 2) recognition of behavior as deviant; and 3) recognition of women's need for treatment. The first two concepts, devaluation of women's psychological problems and recognition of behavior as deviant, are the predictor variables and

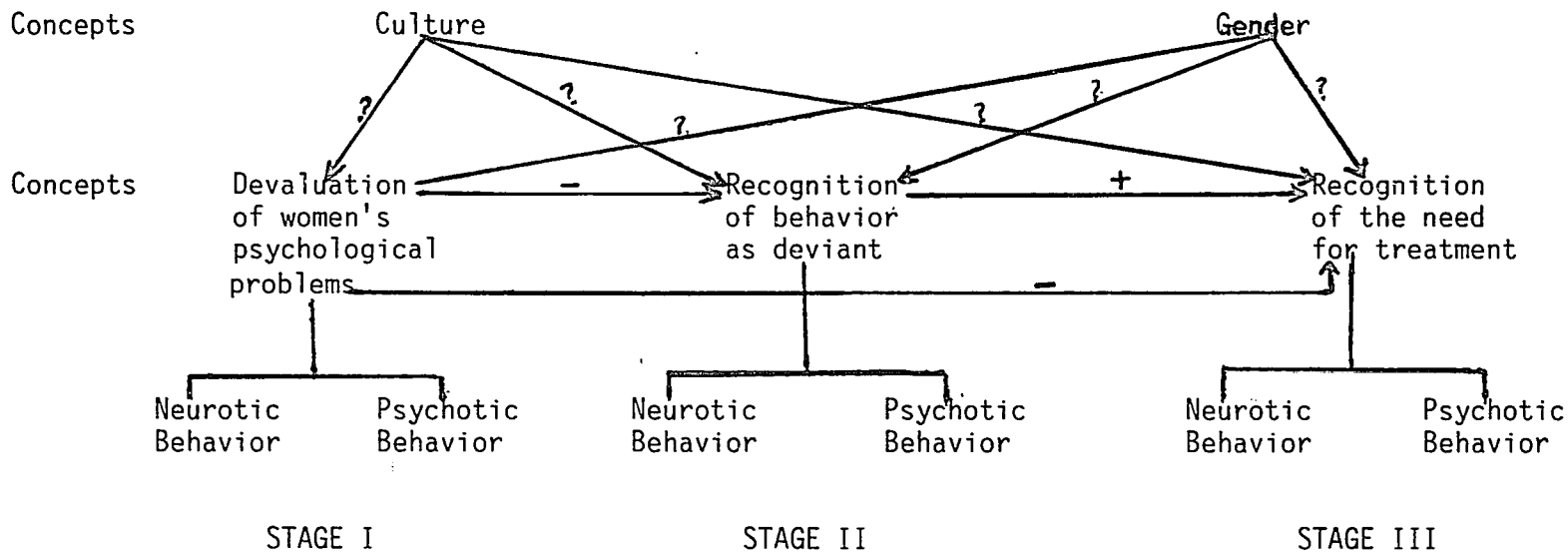


Figure 1. Theoretical Model: Cross-Cultural Gender Differences on Evaluation of Women's Psychological Need for Treatment

recognition of women's need for treatment is the outcome variable. Ethnicity (culture) and gender are variables acting as predictor variables on every concept under study. The unit of analysis of the theory is Arabic and American men and women.

Derivation of the Theory

This section includes a discussion of the derivation of the theory for each concept under study, followed by the theoretical assumptions underlying the theory as well as the theoretical relationships and concept definition.

The theory was derived from sociological theory and a social interaction perspective which provided the definition of the concepts and sources from which the concepts under study were obtained.

Devaluation of Women's Psychological Problems

The concept "devaluation of women's psychological problems" (Stage I) was derived from the psychosocial explanations which suggest that the source of women's devaluation is derived from social conditioning and incorporation of society's expectations (Fooden, 1983).

One of the explanations is based upon learned helplessness theory (Seligman, 1974). It is argued that women learn to act helpless as a result of social conditioning in the face of stress when there is a need to act assertively as in decision making or conflict resolution. Guttentag, Salasin & Belle (1980) stated that the findings of the learned helplessness experiments of Seligman (1974, 1975) have

been extrapolated to apply to the social status of women and certain aspects of the theory have described the situation of women. They added women's roles and occupations are seldom evaluated honestly. Therefore women, because of their roles, are predisposed to feelings of learned helplessness. Women are susceptible to loss because they generally depend more than men upon social status. Therefore, women may have less of a sense of control over their lives, and greater feelings of helplessness and loss which may lead to more powerlessness of women's roles in society and devaluation.

Society's expectations are a major component of Bem's (1980) gender schema theory. Bem suggests that children internalize a gender schema, and all the behavioral information is guided by the schema already internalized. Cultural biases, sex-stereotyping practices, educational and childrearing practices, family systems, and other socio-cultural systems provide the information of women's lower status as well as devaluation. Therefore, the culture or the society is the origin of misconceptions of women's status.

From a socio-political point of view, society and its practices have been identified as the generating mechanism, with specific groups being victims. Many feminist writers, using a Marxist analytic framework have viewed women either as a minority group in a majority society or as a subjugated economic class (Fooden, 1983). As a result, these inequities lead to legal and economic helplessness, dependency on others, chronically low self-esteem, low aspiration and ultimate devaluation of their emotional problems (Howell & Bayes, 1981).

Guttentag, Salasin & Belle (1980) added that socially conditioned and stereotypical images produce in women a cognitive set against assertion, which is reinforced by societal expectations. Young girls learn to be helpless during their socialization and thus develop a limited response when under stress. These self images and expectations are internalized in childhood so that the young girl comes to believe in the stereotype of femininity, especially its emphasis on youthfulness, beauty and passivity, and is expected to be valued and normative.

The same process of women's status and devaluation has been discussed by Arabic feminist writers. Saadawi (1980) emphasized that according to scientific theories about the economic, social and cultural structure of society and its relation to human nature, the tendency toward passivity and obedience in women and the tendency to aggression and dominance in men are not an intrinsic part of their nature. These behaviors are time-bound phenomena related to history, and civilization, where environmental and socialization processes play a major role. These qualities which are considered as intrinsic to men or women have in fact been acquired from society, the environment and various socialization and educative processes.

Saadawi (1980) adds, femininity means weakness, passivity, obedience and negativeness. These are all qualities that fit in well with the role imposed by society on women, the role of a wife devoted to the service of her husband and her children. Femininity requires women to share the same characteristics laudable in obedient and efficient servants and well adapted and resigned to their inferior

position. Masculinity, on the other hand, is distinguished by qualities of a master, of strength, dominance, determination, and initiative. Saadawi (1980) concluded the women's low status and inequities between men and women have led to a lack of recognition of women's psychological problems and needs.

Recognition of Behavior as Deviant

The concept "recognition of behavior as deviant" (Stage II) was derived from a social interaction perspective (Tudor, et al., 1977). One of the central premises of the societal reaction perspective of deviant behavior is that the labeling of a person as deviant effects not only his/her behavior but also the way others respond to him or her (Becker, 1963). The status attributes of the individual actor and the social context in which behavior occurs are important contingencies in the reaction. Behavior influences societal reaction and the reaction is not solely a function of social role and social context (Rushing, 1979).

Rushing (1979) emphasized that when behavior is extremely bizarre, disorganized and unpredictable, as among individuals who are severely impaired mentally, the effects of their sex are weak or non-existent. However, different behavior by members of the same sex whether male or female, evokes different societal reactions and modifies the effects of differences in sex roles and sex related behavior.

Horwitz (1978) added that the initial recognition and response to mental illness generally occurs among the lay community. Official

agencies rarely are the first parties to apply a label of mental illness but instead usually ratify a label already made by community members or by self definitions. Studies of the lay responses to mental illness have been generally limited to the nuclear family and have ignored the role of the wider social network in dealing with mental illness (Gove & Howell, 1974).

Tudor, et al. (1977) report that the reaction to deviance is closely linked to institutionalized sex role expectations within the family and economy. They argue that since the typical role of male is performed outside the home and that of the female (housewife) inside the home, behavioral abnormalities (among females) which signal mental disturbances are less public, less visible and less recognized. Inadequate (housewife) role performances are less easily identified, and they are less likely to result in loss of status. A poor performance by a wife does not threaten the family in the way a husband's loss of job would, and is thus more likely to be tolerated and less recognized. Tudor, et al. (1977) added, role expectations for males are less tolerant of behavior to which mental illness commonly gives rise and that deviance has more serious consequences when the deviant actor is male. Consequently, sex stereotypes of traditional roles provide the basis for the recognition and the societal reaction to women's psychological problems.

Saadawi (1980) holds the position that when the individual is socially defined as "mentally ill", behavior is reinterpreted as reflecting the characteristics which the culture ascribes to the mentally ill. The meaning attached to mental illness is shared by the

members of the community at large and became internalized by the person as ill, as part of his socialization into the dominant culture. She added that Arab women, as members of the society, are victims of oppression and exploitation because of sex-role stereotypes that govern their societies. This makes them suffer more than anyone else in society and affects the recognition and visibility of their psychological problems.

Recognition of the Need for Treatment

The concept "recognition of the need for treatment" (Stage III) was derived from socio-political explanations (Guttentag, et al., 1980; Howell & Bayes, 1981). In any society, men and women are systematically trained, practically from birth on, to fulfill different social roles. An adjustment notion of health, plus the existence of different norms of male and female behavior, automatically leads to a double standard of health (Howell & Bayes, 1981).

For a woman to be healthy from an adjustment viewpoint, she must adjust to and accept the behavioral norms for her sex, even though these behaviors are generally less socially desirable and considered to be less healthy for the generalized competent mature adult (Broverman, et al., 1968). Acceptance of an adjustment notion of health, then, places women in the conflictual position of having to decide whether or exhibit those positive characteristics considered for men and adults and thus have their "femininity" questioned, that is, be deviant in terms of being a woman; or to behave in the prescribed

feminine manner, accept second class adult status (Howell & Bayes, 1981).

Based on the previous socio-cultural explanations, service providers may have biases that are rooted in sex-role stereotypes and that may affect both the treatment process of and outcome expectations for women. Some research suggests that clinical service providers, both men and women, may judge the characteristics of mentally healthy males and females differently, typically in a manner consistent with sex-role stereotypes (Aslin, 1974; Broverman, Broverman, Clarkson, Rosenkrantz & Vogal, 1970; Fabrikant, 1974). In these studies, clinicians are usually asked to characterize males and females in general. It is inferred that these characterizations are in operation during treatment. Guttentag, et al. (1980) added that feminists assert that psychotherapeutic treatment too often reiterates the negative self-image of women and perpetuates problems of women suffering symptoms arising from their life situations.

Robson & Edwards (1980) supported the idea that most psychological theories have been proposed, developed, and practiced by men. For this reason, psychotherapeutic treatment has been sexist, either in theory (e.g., Freud believed women inferior to men), or in practice (the therapist was usually a powerful male who told the female patient she should be happy as a wife and mother). As a result, the emotional responses that women demonstrate are seen as expected gender appropriate behaviors. Offer & Sabshin (1975) emphasize that the psychiatrist is trained to recognize abnormal behavior, although he or she has problems with recognizing normal behavior. Definitions of normality

for women are closely linked with stereotypes such as men are more tough, self-confident, and dominant than women, and women are more nurturant, dependent and self-devaluating than men (Alberti & Emmons, 1974; Hollandsworth & Wall, 1977). Consequently, there is generally little attempt to clinicians to reinterpret women's individual distress as a product of socio-psychological factors related to role and gender stereotypes and women's need for treatment (Hollandsworth & Wall, 1977).

The same process is reported in the Arabic literature by Saadawi (1980). She reported that men represent the vast majority in the medical profession as in most professions. A rigid and backward attitude towards most women's problems and in particular, towards women's emotional and sexual problems predominates in the medical profession that affects the recognition of women's need for treatment.

In summary, this section contained a description of the theoretical model underlying this study and derivation of the theory. Each concept under the theoretical model was derived and explained by a sociological perspective.

Theoretical Assumptions Underlying the Theory

Three major theoretical assumptions underlie the study. They are described as follows:

1. A function of society is to recognize and treat behavior labeled as deviant.
2. Human behavior is reflective of the socio-cultural background.

3. The individual's evaluation of a situation represents the socio-cultural perspective.

Theoretical Relationships and Definitions

The theoretical relationships in the model shown in Figure 1 are described by stages at the concept level. The three stages represent the hypothetical causal sequence of the concepts of the theory. Definitions of the concepts are presented in Table 1.

This section presents the literature review and research supporting each concept and the expected theoretical relationships among the concepts under consideration.

Stage I

The Stage I concept, Devaluation of Women's Psychological Problems, was defined as a process of reducing the value of their problems to a minimum. Value refers to the significance attached to women's psychological problems. Culture and gender were predicted to have a direct impact on Stage I concept devaluation of women's psychological problems.

Regarding Arabic culture, Saadawi (1980) discussed the effect of culture and gender role on Arabic women's social status which generally leads to women's inferior and devalued position in the society. Saadawi (1980) holds the position that the first devaluation experienced by the female child in society is the feeling that people do not welcome her coming into the world. She added, in some families, and especially in rural areas, this "coldness" may go even further, and become an atmosphere of depression and sadness, or even lead to

Table 1. Definitions of Concepts in Theoretical Model

Concepts	Theoretical Definitions	Operational Definitions
Concept Level I		
Culture	Culture consists of whatever it is one has to know to believe in order to operate in a manner acceptable to its members (Goodenough, 1957: 167).	Indication of the kind of culture whether it is Arabic or American.
Gender	A composite of behavior influenced by social, psychological, cultural as well as biological factors (Vergrugge, 1985).	The classification of sex into male or female.
Concept Level II		
Devaluation of Women's Psychological Problems	Devaluation is a process of reducing the value of their problems to a minimum. Value refers to the significance attached to women's psychological problems.	Rating the degree of existence and concern about the selected problems.
Recognition of Behavior as Deviant	Appraisal of behavior as varying from the expectation of the group. The extent of deviation is determined not only by the behavior but also by the norms used by the definer in making his judgment (Gove, 1980).	Rating the degree to which a selected problem is recognized as deviant.
Recognition of the Need for Treatment	Evaluation of the need for therapeutic activities that are deliberate and intended to affect the individual to which they are directed, to alter the condition toward the group expectation.	Rating the necessity of treatment and checking supportive therapeutic activities for the selected problems.

the punishment of the mother with insults or blows or even divorce. Saadawi (1980) also emphasizes that male dominated civilization discriminates between male and female children. The male child is taught from the very beginning how to project his personality and how to prepare for a man's life involving strength, responsibility, authority, and a positive attitude in the face of difficulties. A girl, on the other hand, is trained and educated right from the start to shrink into a corner, to withdraw and to hide her real self because she is female and is being prepared for the life of a woman, a life where she must be passive and weak, and must surrender to the domination of the man and be dependent on him. Saadawi (1980) states that circumcision of girls is an example of aggression against the female child as well as another kind of exploitation and devaluation of females. Saadawi (1980) adds, "amputation of the clitoris and sometimes even of the external genital organs goes hand in hand with brain washing of girls, with a calculated merciless campaign to paralyze their capacity to think, to judge, and to understand" (p. 130). She firmly concluded that the reasons for oppression, exploitation, devaluation, and lower status of women in Arab societies and the lack of opportunities for progress afforded to them, are due to certain economic, political, cultural, and religious forces.

A similar argument was reported by Guttentag, et al. (1980) related to women's status in western culture. They reported that women are mentally sick because society makes them sick, because each day the life conditions they are forced to endure demands more from them, in breadwinning and childcaring and offers only powerlessness

in return. It is likely to get worse as women's lives become more complex and diverse and more demanding. The same argument is presented by Taylor (1985). She argued that discrimination against women clearly has tangible effects on their minds. Statistics from all over the world indicate that women are twice as likely as men to suffer the kind of distress which is known as mental illness due to their social status in their societies (Taylor, 1985).

In the theory underlying this study, devaluation of women's psychological problems was predicted to have a direct negative impact on the Stage II concept, recognition of behavior as deviant, as well as a direct negative effect on the Stage III concept, recognition of the need for treatment. The relationships between devaluation of women's psychological problems, recognition of behavior as deviant, and recognition of the need for treatment were based on findings and arguments from several investigators.

A support for the direct negative relationship between devaluation of women's psychological problems and recognition of behavior as deviant was provided by Saadawi (1980). She reported that many women are suffering from neurotic or psychiatric disorders due to their devalued status and their desperate desire to fulfill the norms of society and femininity imposed upon them. As a result of their social status, their psychological problems are less visible and recognized. Additional support for the direct negative relationship between devaluation of women's psychological problems and recognition of behavior as deviant is provided by Howell & Bayes (1981). They reported that women's psychological problems may be neglected or seen

as individual and intra-psychic without awareness of the massive societal forces that women face due to their lower status. Similar support was supplied by Rosenfield (1982) who found that societal reactions to mental illness are affected by social status of the deviant. That is, mental illness (deviance) is recognized as more serious for male than females.

The direct negative relationship between devaluation of women's psychological problems and recognition of the need for treatment was supported by Chesler (1972). She documents that the psychiatric treatment of women is characterized by oppression, exploitation and infantilization. For additional support, a cited study by Broverman, et al. (1970) shows that a double standard of mental health and treatment exists for men and women which parallels sex-role stereotypes in the society and within which women are essentially devalued. Similar findings of sex-role bias by counselors for treating women were found by Maslin & Davis (1975) and Abramowitz, et al., 1973). Stricker (1977) provided additional support of sex bias among male and female counselors in treating women's psychological problems.

Stage II

The Stage II concept, Recognition of Behavior as Deviant, was defined as appraisal of behavior as varying from the expectation of the group (i.e., rating the degree to which a selected problem is recognized as deviant). This definition was adapted from Gove's (1980) definition of deviant behavior which he described as the behavior that varies from the expectation of the group to trigger group

strategies aimed at coping with the deviance. The extent of deviation is determined not only by the behavior of the individual, but also by the norms used by the definer in making his judgment.

In the theory underlying this study, culture and gender were predicted to have a direct impact on the Stage II concept, recognition of behavior as deviant. A direct support for this relationship was provided by Saadawi (1980) in relation to Arabic culture. She reported that many Arab women end up with some form or other of psychological problems because of the severe cultural contradictions to which they are exposed. As a result of this exploitation, oppression, devaluation and lower status, their emotional problems are less recognized and visible. Visibility of their problems depends on family's inability to control the disruptive behavior.

Other support was provided by Howell & Bayes (1981) for the impact of culture and gender on recognition of behavior as deviant in relation to western culture. She reported that gender bias in the mental health profession affects diagnostic labeling, practice, and the use of descriptive terminology for males or females.

Additional support was provided by Guttentag, et al. (1980). They argue that the major factor in the labeling of mental illness (deviance) is the sex of the individual patient. The Broverman, et al. (1970) study of clinicians' evaluation of mental health documented the existence of sex-role stereotypes among mental health professional in diagnosis of mental illness. The existence of such stereotypes has led to speculation that the diagnosis of mental illness is a labeling category applied selectively to women. Szasz (1970) also holds

that a diagnosis of mental illness (deviance) tends to produce conformity to society's standards. Also, feminist critics have been intense in their assertions that psychiatric diagnosis is a male oriented label (Guttentag, et al., 1980).

In the theory underlying this study, recognition of behavior as deviant was predicted to have a direct positive impact on the outcome concept in Stage III, recognition of the need for treatment. Support for this relationship was reported by Franks & Rothblum (1983). They reported that fuller understanding and recognition of women's mental health problems will contribute to clinicians' understanding of women's need for treatment. Similar support for this relationship was found. Tudor, et al. (1977) reported that deviancy in mental illness is less tolerated in males; more mentally ill males are hospitalized than females and mental illness in males is detected earlier and treated longer in inpatient facilities (i.e., the more recognition of behavior as deviant, the more the deviant person is channelled into psychiatric treatment). Additional support for this relationship was reported by Rushing (1979) in regard to pathological behavior and psychiatric dispositions, Rushing found that men who exhibit neurotic or depressive types of symptoms were hospitalized more often than women with these disorders.

Additional support for the direct positive effect of the concept recognition of behavior as deviant on the concept, recognition of the need for treatment, was provided by Robson & Edwards (1980). They reported that problems which are evaluated as minor are neglected until they are uncontrollable.

Bizarre behavior is evaluated as requiring treatment. Similar findings were reported by Rushing & Jackesco (1977) who found that the more extreme one's behavior, the more apt one is to be troublesome to others and come to the attention of legal authorities and social control agencies which then leads to psychiatric hospitalization. They added extremely bizarre, unpredictable, and uncontrollable behavior typically associated with psychoses in men and women, is more apt to elicit formal community psychiatric health services than less bizarre and more predictable and controllable behavior.

Stage III

The Stage III concept, Recognition of the Need for Treatment, was defined as evaluation of the need for therapeutic activities that are deliberate and intended to affect the individual to which they are directed to alter the condition toward the group expectation (i.e., rating the necessity of treatment and checking supportive therapeutic activities for the selected problems). In the theory underlying this study, culture and gender were predicted to have an impact on the outcome concept (Stage III), the recognition of the need for treatment.

Support for gender impact on the outcome concept, Recognition of the Need for Treatment (Stage III), was supported by sociologists. They have compared the treatment of men and women patients and found that the male-dominated medical profession is biased against women; women are treated more harshly and receive poorer care (Barrett & Roberts, 1978; Corea, 1977; Ehrenreich & English, 1979; Scully, 1980; Scully & Bart, 1973). A number of critics (Franks & Burtle, 1974)

assert that the mental health practice continues to support stereotyped roles for women by concentrating on women in relationship to their love objects--men--as fathers or spouses. They say that psychotherapy places a woman in a passive stance as a patient, encouraging expressiveness and a transference of trust to the psycho-analyst.

Similar findings were obtained in case studies and experimental studies pointing out sex discrimination and sexual preoccupation in therapy (Masling & Harris, 1964). Observations of testing sessions have indicated that male mental health professionals extended their treatment sessions for females and used more sexual romantic projective tests and discussions with women (Barocas & Vance, 1974).

Support was found for the impact of culture on the recognition of the need for treatment. Psychotherapy and psychiatric treatment are susceptible to the effect of cultural forces and the biases within which it operates (Baran, 1959; Breggin, 1975; Szasz, 1960, 1970). An example that exemplifies the influence of culture on evaluation of men and women's mental health was provided by Broverman, et al. (1970). The result of their study of clinical judgments about the characteristic of healthy adult women, healthy adult men, healthy adults, sex unspecified, indicate a double standard of mental health for the sexes, the standard for men being equivalent to the standard for persons, and the standard for women being quite the contrary (Broverman, et al., 1970). If the service providers do perceive the mental health of males and females differently, then different treatment expectations based on sex and the societal status of the client are possible, as are different perceptions of what constitutes

successful treatment. Additional findings of the prevalence of gender role bias in mental health services were provided by Fabrikant (1974) who reported that male therapists agreed that women can be satisfied and fulfilled solely through the wife and mother role, while female therapists significantly disagreed with this contention. Other support was found in relation to the impact of culture on the concept, recognition of the need for treatment, by Meleis (1983). Meleis (1983) reported that the Middle Easterners resist seeking help from psychiatrists because of the stigma associated with mental illness. Families tend to conceal the fact that a member is a psychiatric patient for fear that their daughters' prospects for marriage will be jeopardized (Racy, 1977). By the time psychiatric help is finally sought, a person may be very sick.

Additional findings supporting the double standard of mental health for men and women were provided by Tudor, et al. (1977) and Rushing (1979) in their investigations of the number of males and females in mental institutions and their relative length of stay. Tudor, et al. (1977) generally argue that individuals with higher status are reacted to more severely for mental illness than those with lower status. Because the performance of those in higher status positions is more socially valuable, their nonperformance of appropriate roles is more visible and is perceived as more threatening than nonperformance among individuals of lesser status. According to this argument, Tudor, et al., reason that men, being in a higher status group relative to women, are judged more harshly for residual deviance. Further, both Tudor, et al. and Rushing suggest that the

double standard of mental health applied to males and females as demonstrated by Broverman, et al.'s (1970) contributes to this sex differential in societal reaction.

Specific Aims

The specific aims of this study were to determine whether: 1) devaluation of women's psychological problems had a direct negative impact on the recognition of behavior as deviant and had a direct negative impact on the recognition of the need for treatment; 2) recognition of behavior as deviant had a direct positive impact on the concept recognition of the need for treatment; and 3) whether culture and gender had a direct impact on each concept under study.

Summary

The theory underlying this study was presented in a three-stage theoretical model. The theory was constructed in an attempt to predict the key concepts accounting for the variance in the recognition of women's need for treatment. The Predictor concepts included devaluation of women's psychological problems in Stage I, recognition of behavior as deviant in Stage II. Recognition of the need for treatment in Stage III was the outcome concept of the theory. Culture and gender were discussed as influencing the predictor and outcome concepts.

CHAPTER III

METHODOLOGY

This chapter addresses the research design of the study, the population, sample, and setting. The instrument section addresses the scaling methodology, instrument used to measure the variables and the reliability and validity assessment of the instrument. Also included in this chapter are the pilot study, the data collection procedure, the data analysis plan, protection of human subjects and the limitations of the study.

Research Design

This study utilized a correlational design with a causal modeling methodology. Likert scaling was used as the major scaling methodology. A causal modeling methodology is used in theoretical model testing when cause and effect relationships are investigated in settings in which experimental designs cannot be implemented due to lack of control over the setting (Hinshaw, 1984a). In the causal modeling methodology, the three conditions of causality; i.e., covariation and time ordering of the variables, and controlling or accounting for all extraneous variables, are met through theoretical assumptions and control principles. The condition of covariation is met through specification of major variables and their relationships within the theoretical framework. Time ordering of the variables is satisfied by staging the variables in the framework. The condition of controlling

or accounting for all extraneous variables is met by closing the model and assuming that all major variables are included in the theoretical model (Asher, 1976; Blalock, 1964; Hinshaw, 1984a).

Population, Sample Criteria and Setting

The population for this study consisted of 80 subjects (20 Arabic males, 20 Arabic females, 20 Anglo American males, and 20 Anglo American females). A convenience sample of Arabs and Americans living in a southwestern city were chosen as representatives of both cultures. All subjects met the following criteria:

1. Adult, age 20 or older.
2. Willingness to participate in the study.
3. At least secondary school educational level (some high school).
4. Married.
5. Living less than two years in the USA.
6. Ethnicity - Anglo American or Arabic.

Anglo (White American) was specified as one of the criteria to control for cultural factors which Saunders (1975) points out may influence subject's responses. Length of time in the United States was specified as one of the criteria to control for enculturation factors which might influence Arabic subject's responses. Married subject was specified as one of the criteria to increase group homogeneity and to decrease variability in the factors which may influence subjects' responses. The demographic form is shown in Appendix A. The data describing the sample are presented in Chapter IV.

Instrumentation

One major instrument was used to collect the data for this study. The instrument contains three scales constructed specifically for this study to measure the concepts of devaluation of women's psychological problems, recognition of behavior as deviant, and recognition of the need for treatment. Each scale contains two subscales.

Likert scale measurement was selected as the scaling methodology to underlie the instrument constructed for this study based on four criteria. The instruments would: 1) allow the assignment of numbers to individual's attitude; 2) allow for the presentation of a set of stimuli to evoke the attitudinal responses; 3) allow discrimination between high and low scores; and 4) provide the highest possible level of measurement of the attitudinal responses (Hinshaw, 1978; Nunnally, 1978).

Description of the Instrument

The instrument consisted of two sets of nine vignettes (see Appendix B for a copy of the instrument). The first set of vignettes contained situations commonly encountered by women during their daily life situations and centered around daily life psychological problems (neurotic behaviors). The second set of vignettes consisted of situations describing classic psychiatric problems (psychotic behavior).

Vignettes are short compact descriptions which exemplify the concepts under consideration. Anthropologists have used vignettes to give form to discussions with informants in the field when there is reluctance to or sanction against discussion of certain topics

(Herskovits, 1950), or to elicit a diagnosis and prognosis from folk healers (Weaver, 1970). In each case, the content of the vignettes was hypothetical but in accordance with the prevalent patterns of the culture. Experimental research in social psychology has made use of vignettes in studies of simulated jury decision making (McGlynn, Megas & Benson, 1976), and the assignment of responsibility to a person for a crime or accident (Johnes & Aronson, 1973). In these cases, different aspects of the content of vignettes were changed to determine the effect on respondent's judgments.

Vignettes have been used by a large number of researchers. Chen (1977) assessed the perception of mental illness by using four case vignettes of mental disorders (adapted from those of Star, 1955). Vignettes have also been used in studies of the perception of mental illness and attitudes toward mental illness in different cultures (Cumming & Cumming, 1957, Fandetti & Gelfand, 1978; Karno & Edgerton, 1969; Arenas, Cross & Willard, 1980). In nursing, Flaskerud (1980, 1984) used vignettes as a tool for comparing the perception of problematic behavior by psychiatric professionals and minority groups.

Instrument Construction

The first set of vignettes consisted of nine situations identified from the investigator's inductive work and the literature. The vignettes were constructed based on two approaches. 1) The deductive work was based on an extensive literature review about women's mental health and their problems, and specifically about attitudes and reactions toward women's mental health problems. 2) The inductive work

was based on interviews with Arabic and American women to gather stories of their daily psychological difficulties. The initial step involved an exploratory study of a group of 16 female respondents from Arabic and American cultures who were asked open-ended questions concerning specific situations perceived as stressful. Sixteen informants, eight from each culture (Arabic and American) living in one area of University family housing were chosen as representative of both cultures. The interviews centered on daily stressful situations as perceived by the informants, their reactions and the behaviors associated with these situations. Each informant was asked to talk about the daily life situations which caused psychological difficulty, and to describe her actions and reactions towards the events and how others behaved toward her problems. In addition, each informant was asked to list some of her suggestions about the proper action that should be taken in such a situation, either by herself or others.

Criteria of Arabic women selected to participate in development of these vignettes were: 1) respondents were born in an Arabic culture (i.e., Egypt, Saudi Arabia, Sudan, Iraq, and Syria); and 2) respondents agreed to participate voluntarily in the study. Their ages ranged from 20 to 32, they were non-permanent residents in the United States, accompanying their husbands who were studying at the university. They were all unemployed, college graduates, and married with children.

Another group of eight American women from the same area (University family housing) were chosen from a list provided by the University Family Housing Office. Criteria of American women selected to participate in development of these vignettes were: respondents

1) were born in the US; and 2) were over 20 years old. Two respondents were unemployed, two were graduate students and four respondents were employed and had at least high school education level. Two respondents were divorced, two were single. The remaining four were married and had children.

The interviews were conducted in a two week period of time. The data were collected during one hour interviews arranged at times and places convenient to the respondent. The interviews took place in the respondents' homes. All interviews were tape recorded with the respondents' permission for research purposes and analysis of information. The general nature of the study and the time required for interviewing were explained to the respondent so each could make a free choice to participate in the study.

The transcripts of the taped interviews of Arabic respondents were translated into English by the investigator. All the transcripts of the taped interviews of both groups were analyzed into four content areas after inspection of the data. For each interview, the content areas were: 1) the problem; 2) the woman's feelings toward this problem; 3) the behavior associated with the problem; and 4) others' reactions toward the problems. The transcript of the taped interview based on the four content areas were then written into vignette form using every day language to describe the problematic behavior. From the 16 interviews, six vignettes were written by the investigator and evaluated by an expert (in psychiatric nursing and research) to determine if the vignettes represented common problematic situations for women in both cultures (Arabic and American). The reported

situations that did not meet the criteria of the four content areas or that mostly represented problems of only one culture (for example, problems of women who were not wearing a veil, problems relating to owning a car and a house, and other problems related to sex which were uneasy matters to discuss with Arabic men and women) were eliminated. The other three vignettes for the first set of stimuli were developed based on actual case histories of neurotic problems among women published in Arabic periodicals by experts in community mental health and illness. These three cases were translated into English and written into vignette format using every day language to describe the problem.

The first vignette is a description of the stressful situation associated with a woman's divorce. The second describes the situation of a woman experiencing infertility. The third vignette describes a problematic relationship between a wife and her mother-in-law. The stressful situation in the fourth vignette describes a woman's difficulty fulfilling her role as a new mother. The fifth vignette describes a mother's problem in dealing with her three year old child. The sixth vignette describes a woman's problem with an acquaintance who continually criticizes her in public. The seventh vignette describes a woman's difficulty in interpersonal relationships with others. The eighth vignette describes a problematic marital relationship. The ninth vignette describes a woman who lacks the self-confidence to initiate a relationship.

In the second set of vignettes, the stimuli content and degree of seriousness were changed to reflect serious psychological difficulty

The set of nine vignettes describe behaviors typical of mental illness. Six of these vignettes were adapted from Flaskerud (1980) who developed the vignettes based upon a literature review and hospital records. Flaskerud (1979) reports support for the content validity of the vignettes.

The first vignette describes a woman with paranoid and violent behavior who is delusional and homicidal. The second vignette concerns a woman with hallucinatory and delusional behaviors. The third vignette describes a woman with spiritual hallucinatory behaviors. The fourth vignette describes a woman with promiscuous and hysterical behaviors who is extremely dependent, child-like and insecure. The fifth vignette describes a reclusive girl with labile and hallucinatory behaviors. The other three vignettes were developed based on actual cases written by Saadawi (1983). These cases were translated into English and written into vignette form using common language to describe the problems. These three vignettes represent classic cases of mental illness in the Arabic culture. The first vignette describes a woman with a delusional and phobic behaviors. The second vignette describes a woman with delusional and paranoid state. Vignette three describes a woman with obsessional and violent behavior.

Constructing Scale Items

Following each vignette, five items (questions) were developed to elicit the individual's attitudinal response toward specific stimuli. These items operationally index the concepts under study. The devaluation concept is indexed by two items: "I think this person's

situation is a problem to be concerned about" and "I think this person has a psychological problem". These two items were constructed to reflect the definition of devaluation, the degree of existence and concern about the presence of selected problems.

The concept, Recognition of Behavior as Deviant, is indexed by one item: "I think this person's situation is serious", which refers to recognition of the extent to which behavior deviates from the group norm, thus is problematic.

The third concept, Recognition of the Need for Treatment, is indexed by two items: "I think this person should seek some help for the problem", and the second item asking for a checking of select treatment activities (Appendix B).

Four items are scaled by using a Likert four-point format. Subjects were asked to respond to each statement (item) in terms of their degree of agreement or disagreement by selecting one response ranging from strongly agree, agree, disagree, to strongly disagree.

The instrument has three scales, each with two subscales. The first scale, the devaluation scale, has two subscales, each addressing a vignette set containing stimuli of different intensity. The first subscale is devaluation of neurotic behavior based on the first set of vignettes and the second subscale is devaluation of psychotic behavior based on the second set of vignettes. The devaluation scale has two items repeated through the 18 vignettes (total 36 items). Devaluation of psychological problems scale is scored in the direction of devaluation, the total score ranges from 36 to 144.

The second scale, the recognition of behavior as deviant, has two subscales, each addressing a vignette set containing stimuli of different intensity. The first subscale is the recognition of neurotic behaviors as deviant based on the first set of vignettes. The second subscale is the recognition of psychotic behaviors as deviant based on the second set of vignettes. This scale has one item repeated for the 18 vignettes (total 18 items). Recognition of behavior as deviant scale is scored toward recognition of deviance, scores range from 18 to 72.

The third scale is the recognition of the need for treatment, has two subscales, each addressing a vignette set containing stimuli of different intensity. The first subscale is the recognition of the need for treatment of neurotic behaviors (problems) based on the first set of vignettes. The second subscale is the recognition of the need for treatment of psychotic behaviors based on the second set of vignettes. Recognition of the need for treatment scale has one item (Likert format) repeated for the 18 vignettes (total 18 items). This scale is scored toward recognition of the need for treatment (scores can range from 18 to 72). This scale also has a second item repeated for the 18 vignettes (which is checking activities that are appropriate for the selected problems). Scoring item five, checking of appropriate activities, will be accomplished by determining a proportion of supported activities. The proportion will be the number of activities that each subject considers appropriate divided by the total number available. The proportion will be multiplied by the

person's score in item four and summed over the situations (i.e., to get an index for need for treatment for neurotic and psychotic subscales) (Miller, 1986).

The instrument was subject to content validity estimation, translation and pilot testing before using in collecting the actual study data.

Instrument Translation Technique

Translation is necessary in the formulation of instruments for cross-cultural research. In review of translation problems and techniques, Chapman & Carter (1979) pointed out that the researcher might use one or more of the following techniques: 1) back translation which is the most appropriate method of checking the accuracy of translation; 2) bilingual technique which is having bilingual subjects take a test in both languages so that items yielding discrepant responses can be easily identified (Prince & Mombour, 1967); 3) committee approach which is a group of bilingual experts who translate from the source to the target language; and 4) pretest procedures which is field testing for translation to insure that future subjects will comprehend all questions.

The most common and highly recommended procedure for verifying the translation of a questionnaire or test is the back translation procedure. In this procedure, the instrument is: 1) rendered into the second language by one translator; 2) the resulting version is then translated back into the original language by another translator;

3) items with apparent discrepancies between the two translations are then modified and a second back translation conducted.

Brislin, Lonner & Thorndike (1973) stated some suggestions to provide adequate translation: 1) write a translatable form of instrument; 2) secure competent translators familiar with the content involved in the source language materials; 3) instruct one bilingual person to translate from the source to the target language and another to blindly translate back from the target to the source; 4) have several raters examine the original, target, and/or the back translated versions for errors that lead to differences in meaning; 5) when no meaning errors are found, pretest the translated materials on target language-speaking people; and 6) to finally demonstrate translation adequacy, administer the materials to bilingual subjects, some who see the English versions, some who see the translation, and some who see both.

The investigator used and followed the back translation procedure for verifying the translation of the instrument for this study. In this procedure: 1) the investigator translated the instrument (English format) into Arabic language; 2) rendered same English format to bilingual expert for more verification of the translation of the Arabic format; 3) the resulting version translated back into the original language (English format) by another bilingual expert; and 4) minor discrepancies in the content of vignettes were found and necessary modifications were done.

Reliability and Validity

A pilot study was conducted prior to the conduct of this investigation. The purposes of the pilot test were to: 1) test the instrument for clarity and content; 2) identify potential problems that could arise in carrying out the full study; and 3) provide preliminary estimates of instrument reliability and validity.

The same subject criteria, instrument, and data collection procedures were followed for the pilot study as have been described for this study. A sample size of 20 subjects (five males and five females from each culture) was used for the pilot study.

Reliability Assessment

Initial reliabilities were obtained in the pilot study of this instrument. Table 2 provides the reliability estimates calculated from the pilot study data. Internal consistency for the three scales and their subscales was assessed by computing Cronbach's alpha. Cronbach's alpha (a) is a conservative estimate of reliability based on the assumptions that each item in a scale is a parallel item measuring one concept (Zeller & Carmines, 1980). The criterion level for alpha was set at .70 or greater for each scale, since the instrument was considered an immature instrument (Nunnally, 1978). Internal consistency for each subscale met the criterion level of Cronbach's alpha ranging from .76 to .91 (standardized alpha, Table 2).

Pearson's correlation coefficients were used for assessing internal consistency for item to subscale and subscale to subscale correlations for each of the three scales (devaluation of psychological

Table 2. Reliability Estimates: Cronbach's Alpha Coefficient for Women's Psychological Needs Scales (Pilot Study N = 20)

Scales	Cronbach's Alpha	
	Unstandardized	Standardized
I. Devaluation of Women's Psychological Problems Scale		
A. Neurotic Behaviors Subscale	.75	.77
B. Psychotic Behaviors Subscale	.90	.91
II. Recognition of Behavior as Deviant Scale		
A. Neurotic Behaviors Subscale	.81	.82
B. Psychotic Behaviors Subscale	.86	.87
III. Recognition of the Need for Treatment Scale		
A. Neurotic Behaviors Subscale	.81	.81
B. Psychotic Behaviors Subscale	.74	.76

problems, recognition of behavior as deviant and recognition of the need for treatment). Estimates of internal consistency through item to subscale were based upon a criterion of correlation of .50 or greater and subscale to subscale were based upon a criterion of correlation of .40 to .65 (Hinshaw & Phillips, 1985).

For the item to subscale correlation all subscales met the criterion level of .50 or greater except for the devaluation of neurotic problems subscale (Table 3).

For subscale to subscale correlations for each of the three subscales, based upon a criterion correlation of .40 to .65, all the subscales met the criterion level of .40 to .65 except for the correlation of the recognition of neurotic behaviors as deviant and recognition of psychotic behaviors as deviant subscales (Table 3).

Preliminary findings from the reliability analysis, item to subscale, subscale to subscale, and Cronbach's alpha estimation suggest that this instrument could form a viable instrument and that it is possible to use as an immature scale.

Validity Assessment

Content and face validity were previously determined before using the instrument for this proposed study. An extensive review of literature was conducted to judge whether the content domain under consideration was sufficiently defined. This estimate was difficult to obtain since the literature which supported the concepts under study did not explicitly define that domain. A group of six experts who have published research or presented research at conferences in

Table 3. Reliability Estimates: Internal Consistency of Women's Psychological Needs Scales (Subscale to Subscale and Item to Subscale Correlations) (Pilot Study N = 20)

Scale	Subscale	Subscale to Subscale (Criterion of .40-.65)	Item to Subscale (Criterion of > .50)
Devaluation of Psychological Problem	Devaluation of Neurotic Behavior (DNB)	r = .68 (Subscales 1 & 2)	5/18
	Devaluation of Psychotic Behavior (DPsyB)		18/18
Recognition of Behavior as Deviant	Recognition of Neurotic Behavior as Deviant (RNBD)	r = .39 (Subscales 3 & 4)	8/9
	Recognition of Psychotic Behavior as Deviant (RPsyBD)		9/9
Recognition of the Need for Treatment	Recognition of the Need for Treatment of Neurotic Behavior (RTxNB)	r = .67 (Subscales 5 & 6)	7/9
	Recognition of the Need for Treatment of Psychotic Behavior (RTxPsyB)		7/9

the area of mental health and illness as well as research in general, plus two graduate nursing student specialists in psychiatric nursing reviewed the instrument for content validity, clarity of scale instructions and items. The 18 vignettes were sent to the experts with a letter introducing the investigator, describing the research project and asking them to judge the vignettes as representing true cases of problematic behavior as well as represent true cases of typical mental illness behaviors. The results of the review were: 1) the scale item adequately reflected the domain of evaluation of women's psychological needs; and 2) editorial changes (i.e., language) offered by reviewers to increase clarity of vignettes. Following the review process, both forms (Arabic and American) of the instrument were pilot tested.

Construct Validity

Construct validity generally can be estimated through theoretically derived hypotheses concerning the relationships of the concepts which are being measured (Zeller & Carmines, 1980). In the proposed investigation, construct validity will be addressed by comparing how consistent the empirical measurement outcomes are with the hypotheses derived from the conceptual framework for testing the model.

According to Nunnally (1978), methods of estimating construct validity involve correlations. If the empirical correlation between two concepts is as substantial as theorized, this generates initial support for an instrument's construct validity. In addition, to examine the correlations between the major study variables, construct validity

may be also assessed through correlations between subscales of the instrument. Correlations among subscales of the three scales can function to support construct validity if performance is consistent with theoretical predictions.

Initial support for the construct validity of the proposed instrument was found in the pilot data by the correlation between subscales. As shown in Table 4, the first subscale, devaluation of neurotic behaviors correlated significant with all the other subscales. The second subscale, devaluation of psychotic behaviors correlated significantly with all the other subscales except with the recognition of neurotic behavior as deviant subscale ($r = -.17$, $p = .48$). The third subscale, recognition of neurotic behavior as deviant, did not correlate significantly with any of the other subscale except with devaluation of neurotic behaviors subscale (first subscale). The fourth subscale, recognition of psychotic behaviors as deviant, correlated significantly with all the other subscales except with the recognition of neurotic behavior as deviant subscale. The fifth subscale, recognition of the need for treatment of neurotic behaviors, correlated significantly with all the other subscales except with the recognition of neurotic behavior as deviant subscale. The same correlations were found with the sixth subscale, recognition of the need for treatment of psychotic behaviors.

Findings resulting from the pilot data of the instrument did support most of the theoretically predicted relationships (Figure 2). The negative correlation between the subscales (devaluation of

Table 4. Construct Validity Estimation for Women's Psychological Needs Scales (Correlations Among the Subscales) (Pilot Study N = 20)

Subscale	DNB	DPsyB	RNBD	RPsyBD	RTxNB	RTxPsyB
Devaluation of Neurotic Behavior (DNB)	1.00	.68***	-.52*	-.55*	-.76***	-.53*
Devaluation of Psychotic Behavior (DPsyB)		1.00	-.17	-.81***	-.63**	-.83***
Recognition of Neurotic Behavior as Deviant (RNBD)			1.00	.39	.43	.37
Recognition of Psychotic Behavior as Deviant (RPsyBD)				1.00	.49*	.72***
Recognition of the Need for Treatment of Neurotic Behavior (RTxNB)					1.00	.67***
Recognition of the Need for Treatment of Psychotic Behavior (RTxPsyB)						1.00

* $p < .05$
** $p < .01$
*** $p < .001$

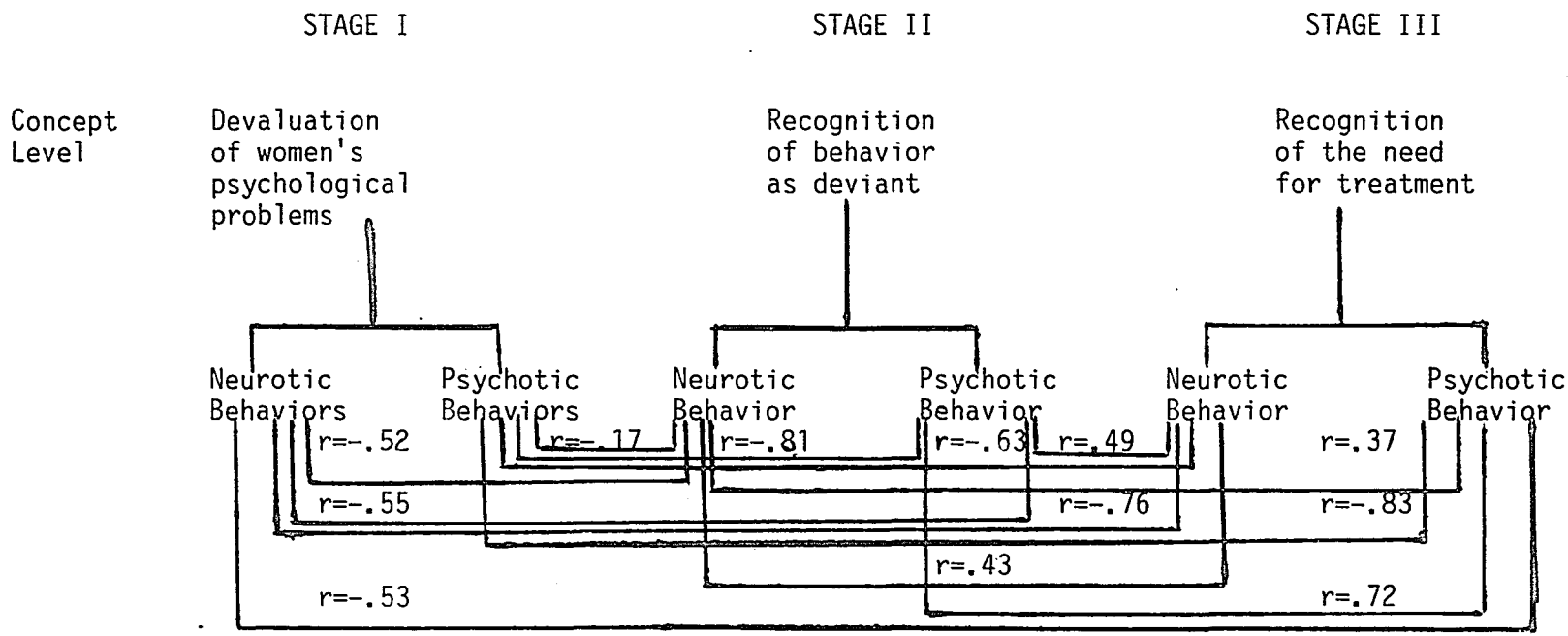


Figure 2. Empirical Model: Cross-Cultural Gender Differences on Evaluation of Women's Psychological Needs for Treatment (Pilot Test N = 20)

neurotic behaviors and devaluation of psychotic behaviors) and the subscales (recognition of neurotic behavior as deviant and recognition of psychotic behavior as deviant) did support the theoretical negative relationship between the two concepts (devaluation of psychological problems either neurotic or psychotic and recognition of behaviors as deviant whether neurotic or psychotic behavior), i.e., the more the devaluation of psychological problems the less the recognition of behavior as deviant. The same negative correlation between the subscales (devaluation of neurotic and psychotic behaviors) and the subscales (recognition of the need for treatment of behaviors, either neurotic or psychotic) did support the theoretical negative relationship between the two concepts devaluation of psychological problems and recognition of the need for treatment (i.e., the more the devaluation of psychological problems the less the recognition of the need for treatment). The positive correlation between the subscales (recognition of behavior (neurotic or psychotic) as deviant) and the subscales (recognition of the need for treatment of neurotic or psychotic behaviors) did support the predicted positive relationships between the two concepts (recognition of behavior as deviant and recognition of the need for treatment, i.e., the more the recognition of behavior as deviant, the more the recognition of the need for treatment).

In summary, initial findings from the pilot data support the construct validity of the instrument based upon correlations among the subscales of the three scales. The empirical inter correlations

among the subscales were found to be consistent with the theoretical predictions.

Data Collection Procedure

A southwestern city was chosen as one area for conducting the study. Arabic and American males and females living in this area were chosen as representatives of both cultures. A convenience sample consisted of 80 subjects (20 males and 20 females from each culture). Those who met the criteria and were interested in participation in the study were asked to select a convenience interview time and place.

Data were collected by interviewing respondents at their home, work, or school. The interviewer as an Arabic woman found it difficult to interview Arabic male subjects. Therefore, the data from Arabic male subjects were obtained by having their wives give the questionnaire to their husbands to complete. The investigator randomized the order of presentation of vignettes (questionnaire) for every subject to eliminate any tendency of response bias in answering the questionnaire. Interviews were conducted at the most convenient time for the subject. Before the interview the investigator presented the disclaimer form (Appendix C) to the subjects describing the study and assuring subjects' anonymity and ability to withdraw from the study at any time. The time required for answering the questionnaire was 45 minutes.

Data Analysis Plan

The data analysis plan consisted of: 1) analysis of the demographic data; 2) analyses to assess reliability and validity of the instrument; and 3) analysis of data to test the theoretical model relationships. Demographic data for the subjects as a total group (N = 80) and as four groups were analyzed using descriptive statistics.

Analysis of theoretical model relationships consisted of two approaches. The first approach used a two-way ANOVA with gender and culture as independent variables and each concept in the model as the dependent variable. Since each concept has two levels, i.e., neurotic and psychotic, each level was considered as the dependent variable in a separate analysis. In the two-way ANOVA, gender and culture each have two levels, creating four groups. The second approach consisted of regression analysis to test the theoretical model allowing the possibility of a main effect for gender or culture or an interaction effect of gender crossed with culture. Multiple regression analysis formed the basis for testing the predicted relationships of the theoretical model.

To address the research questions on the influence of gender or culture on the model variables, a series of six two-way ANOVAs were done addressing each level of the three major dependent variables (devaluation of psychological problems, recognition of behavior as deviant, and recognition of the need for treatment). The research questions that are addressed in this approach are:

1. Is the devaluation of neurotic behavior culture bound or due to gender differences existing cross-culturally?

2. Is the devaluation of psychotic behavior culture bound or due to gender differences existing cross-culturally?
3. Is recognition of neurotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
4. Is recognition of psychotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
5. Is recognition of the need for treatment of neurotic behavior culture bound or due to gender differences existing cross-culturally?
6. Is recognition of the need for treatment of psychotic behavior culture bound or due to gender differences existing cross-culturally?

Based upon the results of the ANOVA, if a main effect was found for gender or culture in any analysis, then the variable was effect coded and entered into the regression equation for testing the model. If a significant interaction was found for any variable, then the interaction term was entered into the regression equation. When the pattern or results of the ANOVA on gender and culture were different for the neurotic or psychotic levels of a concept this indicated that groups responded differently to neurotic or psychotic behaviors in terms of the focal concept, thus separate tests for the model were done for neurotic and psychotic behaviors.

Regression Equations

1. Do gender, culture or an interaction of gender and culture influence devaluation of women's neurotic or psychotic behavior?

   DNB = b(C) + e
   or b(G)
   or b(I)

   DNB = Devaluation of Neurotic Behavior

   b(C) = Culture or gender or interaction term

   or b(G)
   or b(I)

   e = error term

2. Do gender, culture or an interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence recognition of the need for treatment?

   RTxNB = b(C) + b(DNB) + e
   or b(G)
   or b(I)

   RTxNB = Recognition of the need for treatment of neurotic behavior

   b(C) = Culture or gender or interaction term
   or b(G)
   or b(I)

   b(DNB) = Devaluation of neurotic behavior

   e = error term

   RTxPsyB = b(C) + b(DPsyB) + e
   or b(G)
   or b(I)

   RTxPsyB = Recognition of the need for treatment of psychotic behavior

b(C) = Culture or gender or interaction term
or b(G)
or b(I)

b(DPsyB) = Devaluation of psychotic behavior

e = error term

3. Do gender, culture, interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence the degree of recognition of behavior as deviant?

RNBD = b(C) + b(DNB) + e
or b(G)
or b(I)

RNBD = Recognition of neurotic behavior as deviant

b(C) = Culture or gender or interaction term
or b(G)
or b(I)

b(DNB) = Devaluation of neurotic behavior

e = error term

RPsyBD = b(C) + b(DPsyB) + e
or b(G)
or b(I)

RPsyBD = Recognition of psychotic behavior as deviant

b(C) = Culture or gender or interaction term
or b(G)
or b(I)

b(DPsyB) = Devaluation of psychotic behavior

e = error term

4. Do gender, culture, interaction of gender and culture, devaluation of women's neurotic or psychotic behavior, and recognition of behavior as deviant influence the degree of recognition of the need for treatment?

RTxNB = b(C) + b(DNB) + b(RNBD) + e
or b(G)
or b(I)

RTxNB = Recognition of the need for treatment of neurotic behavior

b(C) = Culture or gender or interaction term
or b(G)
or b(I)

b(DNB) = Devaluation of neurotic behavior

b(RNBD) = Recognition of neurotic behavior as deviant

e = error term

RTxPsyB = b(C) = b(DPsyB) + (RPsyBD) + e
or b(G)
or b(I)

RTxPsyB = Recognition of the need for treatment of psychotic behavior

b(C) = Culture or gender or interaction term
or b(G)
or b(I)

(DPsyB) = Devaluation of psychotic behavior

b(RPsyBD) = Recognition of psychotic behavior as deviant

e = error term

The significance level of $p \leq .05$ was used for the standardized beta regression coefficients and for the adjusted R^2s which indicated the amount of explained variance for the variable. The multiple regression analysis described above was originally planned to be computed using the data from Arabic and American samples. The results of the analysis are presented in Chapter IV.

Protection of Human Subjects

Approval from the Human Subjects Committee of the College of Nursing was obtained for this investigation (Appendix D). Prior to data collection the subject read the disclaimer form (Appendix C), assuring the rights of the subjects.

Limitations of the Study

External validity of the study was affected by using a convenience sample as well as a small sample size. Findings of the theoretical model test could only be generalized to the theory and population under study.

The investigator, as a woman, found it difficult to interview Arabic male subjects due to cultural limitations. The data upon Arabic male subjects were obtained by having their wives give the questionnaire to their husbands to complete.

Another major limitation is simulation model versus observation and sampling of actual behavior. This problem indicates that no assurances can be made that the subjects' responses to the simulation cases (vignettes) match the real behavior in actual cases.

Summary

Chapter III presented the methodology. The study utilized a causal modeling approach. One major instrument consisting of three scales, each having two subscales, and a demographic data form were used to collect the data. The major scaling methodology was Likert scale format constructed for the purpose of measuring the three concepts under investigation. Results of the reliability and validity

assessment from pilot data were presented. The subject criteria and data collection protocol and analysis procedures employed in this study were also presented in this chapter along with the major limitations of the study.

CHAPTER IV

RESULTS OF DATA ANALYSIS

Introduction

The central purpose of this study was to investigate the impact of the devaluation of women's psychological problems upon the recognition of women's behavior as deviant and the subsequent impact of both variables upon the recognition of women's need for psychological treatment. A secondary purpose was to determine whether culture and gender influenced each concept in this study. A description of the sample, results of the data analysis to test the theoretical model, as well as reliability and validity estimates of the study instruments, are presented in this chapter.

Description of the Sample

The sample for this study consisted of 80 subjects: 20 Arabic males, 20 Arabic females, 20 Anglo American males, and 20 Anglo American females. A convenience sample of Arabs and Americans living in a southwestern city were chosen as representatives of both cultures. All subjects who met the criteria for the sample agreed to participate in the study during the three month data collection period. However, not all the Arabic subjects met the criterion of living less than two years in the United States. This criterion was modified to enable the investigator to obtain the designated sample size. Eighty percent (80%) of the subjects were interviewed at home, work or school by

the investigator. The data from the Arabic male subjects, representing 20% of the total sample, were obtained by having their wives give them the questionnaire to complete. The interviews were conducted at times considered most convenient for the subjects.

Demographic data on the 80 subjects indicated that the age of respondents ranged from 24 to 49 years, with a mean of 33 years and a median age of 33 years. The educational level of respondents ranged from 11 to 28 years of education, with a mean of 17.30 years and a median educational level of 16.11 years, indicating that the subjects were well educated. Only one subject (1%) had not completed high school. The highest level of education (over 16 years) for 33 subjects (39%) was graduate or professional degrees. Eight respondents (10%) had a high level of income, 60 respondents (75%) had a moderate income, and 12 respondents (15%) had a low income level. Twenty-seven subjects (34%) were working full time while 20 (25%) worked part time. Thirty-three subjects (41%) were not working outside the home. Twenty-eight subjects (35%) were full time students, nine (11%) were part time, while 43 subjects were not students. Forty subjects (50%) were moslems, while 28 (35%) were christians. Twelve (15%) subjects represented other religions. Forty subjects (50%) were English speaking, while 40 (50%) were Arabic speaking. All subjects were married.

Comparison of Demographic Characteristics: Arabic Sample Versus American Sample

Differences among the subjects by gender and culture on the demographic variables of age, years of education, income, work, and school were estimated using four groups for comparisons: all female

samples versus all male sample, Arab females versus American females, Arab males versus American males, and Arab sample versus American sample. The t-test was used to determine differences in age and years of education. The chi-square statistic was used to determine if differences existed among the groups due to income, work, and school.

In the comparison of male to female subjects, significant mean differences were found between male and female subjects on age ($t = -4.11$, $df = 78$, $p \leq .000$) and years of education ($t = -3.2$, $df = 78$, $p \leq .002$). Male subjects were older and had more years of education than female subjects.

In the comparison of American female to Arabic female, no difference was found between the two groups on age ($t = -1.9$, $df = 30.6$, $p \leq .07$), but a significant difference was found between these two groups on years of education ($t = -2.7$, $df = 38$, $p \leq .01$). American females had more years of education ($\bar{x} = 17.1$) than Arabic females ($\bar{x} = 14.8$).

In the comparison of American male to Arabic male, no differences were found due to age ($t = -1.64$, $df = 25.3$, $p \leq .113$) or years of education ($t = 1.4$, $df = 31.8$, $p \leq .19$).

In the comparison of American male to American female, a significant difference was found due to age ($t = -2.3$, $df = 38$, $p \leq .03$) with American males older than American females, but there was no significant difference due to years of education ($t = -.42$, $df = 38$, $p \leq .68$).

In the comparison of Arabic male to Arabic female, significant differences were found relative to age ($t = -4.9$, $df = 38$, $p \leq .000$)

and years of education ($t = -5.4$, $df = 38$, $p \leq .000$), males were older and had more years of education.

In the comparison of American to Arabic subjects, a significant difference was found due to age ($t = -2.3$, $df - 63.3$, $p \leq .03$) with American subjects older than Arabic subjects, but there was no significant difference due to years of education ($t = -.22$, $df = 78$, $p \leq .83$).

A chi-square test was used to determine significant differences among males and females (either Arabic or American) relative to income, work, and school.

No significant differences were found on income between males and females ($X^2 = 1.9$, $df = 2$, $p \leq .4$) but significant difference was demonstrated on work ($X^2 = 6.2$, $df = 2$, $p \leq .04$). More males than females were working full time. No significant difference due to full or part time school was found between males and females ($X^2 = 3.5$, $df = 2$, $p \leq .17$).

In the analysis of differences between American females and Arabic females relative to income, work, and school, significant differences were found due to income ($X^2 = 10.3$, $df = 2$, $p \leq .006$) and due to work ($X^2 = 13.8$, $df = 2$, $p \leq .001$). Only the American females had full time work. Only 20% of American females were unemployed while 65% of Arabic females were unemployed outside of the home. No significant difference was found between the two groups on full time or part time school ($X^2 = 5.4$, $df = 2$, $p \leq .07$).

In the analysis of differences between American males to Arabic males on income, work and school, no significant difference was found due to income (X^2 = 3.6, df = 2, $p \leq .16$). While a significant difference was found due to work (X^2 = 34.7, df = 2, $p \leq .000$) and school (X^2 = 32.9, df = 2, $p \leq .000$). American males had more full or part time work as contrasted with Arabic males. More Arabic males were either full or part time students as compared with American males.

In the analysis of differences between American males and females on income, work, and school, no significant difference was found due to income (X^2 = 2.13, df = 2, $p \leq .34$. However, significant differences were found on work (X^2 = 9.8, df = 2, $p \leq .008$) and school (X^2 = 9.8, df = 2, $p \leq .008$) with males having a higher frequency of work, and females having a higher frequency of full time study.

In the analysis of differences between Arabic males and females on income, work, and school, no significant differences were found on income (X^2 = 1.03, df = 2, $p \leq .6$) or work (X^2 = 1.13, df = 1, $p \leq .3$). However, a significant difference was found on school (X^2 = 26.7, df = 2, $p \leq .000$) with more Arabic males enrolled in full time study than Arabic females.

In the analysis of differences between American subjects versus Arabic subjects on income, work, and school, significant differences were found on income (X^2 = 13.1, df = 2, $p \leq .001$), on work (X^2 = 46.1, df = 2, $p \leq .000$), and on school (X^2 = 6.5, df = 2, $p \leq .04$). The American sample more frequently rated their income as high, and had a higher frequency of full or part time work, while Arabic subjects had a higher frequency of full time study.

A summary of the differences between the groups indicate that males were older, had more years of education, worked full time more frequently than females.

In the comparison of American to Arabic females, American females had higher income, more years of education, and more full or part time work than Arabic females. More American males had either full or part time work as contrasted with Arabic males and more Arabic males had full or part time study.

In the comparison of American males to females, American males were older, had a higher frequency of work and a higher frequency of full or part time school. Arabic males were older, had higher years of education and had more full time study than Arabic females.

In the comparison of American to Arabic subjects, American subjects were older, more frequently rated themselves as having a high income and having more full or part time work, while the Arabic subjects rated themselves as having higher frequency of full time study. As a result, most of American and Arabic subjects were upper-middle class and highly educated, especially the male subjects. Thus, these findings are limited to the Arabic and American sample under this study.

Reliability of the Instrument

The scales indexing the major study variables were evaluated for internal consistency using Cronbach's alpha coefficient. Additional estimates of internal consistency were computed using Pearson Correlation Coefficients for item to subscale and subscale to subscale

correlations for each of the three scales (devaluation of women's psychological problems, recognition of women's behavior as deviant and recognition of the women's need for treatment of psychological problems). Each scale contains two subscales; one subscale measuring neurotic behaviors and another for psychotic behaviors for each concept under study, totaling six subscales. The criterion for an adequate level of internal consistency through item to subscale correlation was a correlation of .50 or greater and for subscale to subscale correlation, the criterion was a correlation of .40 to .65 (Hinshaw & Phillips, 1985).

The criterion level for alpha was set at .70 or greater for each scale, since the instrument was considered an immature instrument (Nunnally, 1978). Five subscales met the criterion level for internal consistency as all alpha levels ranged from .76 to .85 (see Table 5). The one subscale which did not satisfy the criterion for internal consistency was "recognition of women's need for treatment of psychotic behaviors", which had an alpha level of .64.

For item to subscale correlations, four of the subscales met the criterion level of .50 or greater. Two of the subscales (the devaluation of psychotic behaviors and the recognition of the need for treatment of psychotic behaviors subscales) (Table 5) did not meet the criterion level. Seven of 18 (40%) item to subscale correlations did not meet the criterion level of correlation (.50 or greater) for the subscale devaluation of psychotic behaviors. Five of nine (50%) item to subscale correlations did not meet the criterion level

Table 5. Reliability Estimates: Cronbach's Alpha Coefficient for Women's Psychological Needs Scales (N = 80)

Scales	Cronbach's Alpha	
	Unstandardized	Standardized
I. Devaluation of women's psychological problems scale		
A. Neurotic behaviors subscale	.85	.85
B. Psychotic behaviors subscale	.80	.80
II. Recognition of behavior as deviant scale		
A. Neurotic behavior subscale	.83	.76
B. Psychotic behaviors subscale	.83	.76
III. Recognition of the need for treatment scale		
A. Neurotic behaviors subscale	.78	.78
B. Psychotic behaviors subscale	.63	.64

of correlation (.50 or greater) for the subscale recognition of women's need for treatment of psychotic behaviors.

In the subscale to subscale correlations for the six subscales, based upon a criterion correlation of .40 to .65, four of the subscales did not meet the criterion level. Only the correlation of the devaluation of neurotic behavior subscale with devaluation of psychotic behavior subscales met the criterion level of r = .40 (Table 6). The correlation of the subscales recognition of neurotic and psychotic behaviors as deviant was moderate r = .39. The correlation was about the same for the subscales recognition of the need for treatment of neurotic and psychotic behaviors (r = .34) which was expected since they refer to two related yet different levels of behavior.

The findings from the reliability analysis, item to subscale, subscale to subscale, and Cronbach's alpha estimation indicated that this proposed instrument demonstrates adequate reliability with the reliability of recognition of the need for treatment scale still being questionable.

Construct Validity of the Instrument

Substantial correlations among study instruments as theoretically predicted provide one piece of evidence for construct validity of an instrument (Carmines & Zeller, 1979:23). Support for the construct validity of the proposed instruments was found in the correlation among subscales consistent with theoretical predictions.

As shown in Table 7, the first subscale, devaluation of neurotic behaviors correlated significant with the other subscales (criterion

Table 6. Reliability Estimates: Internal Consistency of Women's Psychological Needs Scales (Subscale to Subscale and Item to Subscale Correlations) (N = 80)

Scale	Subscale	Subscale to Subscale (Criterion of .40-.50)	Item to Subscale (Criterion of > .50)
Devaluation of Psychological Problems	- Devaluation of Neurotic Behavior (DNB)	r = .40	$\frac{11}{18}$
	- Devaluation of Psychotic Behavior (DPsyB)	(Subscales 1 & 2)	$\frac{7}{18}$
Recognition of Behavior as Deviant	- Recognition of Neurotic Behavior as Deviant (RNBD)	r = .39	$\frac{9}{9}$
	- Recognition of Psychotic Behavior as Deviant (RPsyBD)	(Subscale 3 & 4)	$\frac{7}{9}$
Recognition of the Need for Treatment	- Recognition of the Need for Treatment of Neurotic Behavior (RTxNB)	r = .34	$\frac{8}{8}$
	- Recognition of the Need for Treatment of Psychotic Behavior (RTxPsyB)	(Subscales 5 & 6)	$\frac{5}{9}$

Table 7. Construct Validity Estimation for Women's Psychological Needs Scales (Correlations Among the Subscales) (N = 80)

Subscale	DNB	DPsyB	RNBD	RPsyBD	RTxNB	RTxPsyB
- Devaluation of Neurotic Behavior (DNB)	1.00	.40**	-.63**	-.38**	-.71**	-.19
- Devaluation of Psychotic Behavior (DPsyB)		1.00	-.22	-.73**	-.35*	-.76**
- Recognition of Neurotic Behavior as Deviant (RNBD)			1.00	.39**	.47**	.13
- Recognition of Psychotic Behavior as Deviant (RPsyBD)				1.00	.32*	.53**
- Recognition of the Need for Treatment of Neurotic Behavior (RTxNB)					1.00	.34*
- Recognition of the Need for Treatment of Psychotic Behavior (RTxPsyB)						1.00

* Significant at $p \leq .05$

** Significant at $p \leq .001$

of being < .05) except for the recognition of the need for treatment of psychotic behavior subscale ($r = .19$, $p \leq .083$). The second subscale, devaluation of psychotic behavior correlated significantly with the other subscales except for the recognition of neurotic behavior as deviant subscale ($r = -.22$, $p \leq .05$). The third subscale, recognition of neurotic behavior as deviant, correlated significantly with the other subscales except for recognition of the need for treatment of psychotic behavior subscale ($r = .13$, $p \leq .24$). The fourth subscale, recognition of psychotic behavior as deviant and the fifth subscale, recognition of the need for treatment of neurotic behavior, correlated significantly with all the other subscales. The sixth subscale, recognition of the need for treatment of psychotic behavior correlated significantly with all subscales except for the devaluation of neurotic behavior subscale ($r = -.19$, $p \leq .083$) and the recognition of neurotic behavior as deviant subscale ($r = .13$, $p \leq .24$).

The devaluation of neurotic behavior and the devaluation of psychotic behavior subscales, as theorized, have negative and substantial relationships with the subscales recognition of neurotic behavior as deviant and recognition of psychotic behavior as deviant. This correlation supported the theoretical negative relationship between the two concepts (devaluation of psychological problems either neurotic or psychotic and recognition of behavior as deviant whether neurotic or psychotic behavior), i.e., the more the devaluation of women's psychological problems the less the recognition of behavior as deviant. The subscales devaluation of neurotic and psychotic behavior did, as predicted, correlate negatively with the subscales recognition

of the need for treatment of neurotic or psychotic behaviors. This correlation supported the theoretical negative relationship between the two concepts devaluation of women's psychological problems and recognition of the need for treatment (i.e., the more the devaluation of women's psychological problems the less the recognition of the need for their treatment). The subscales, recognition of behavior (neurotic or psychotic) as deviant did, as predicted, have a positive correlation with the recognition of the need for treatment of neurotic and psychotic behaviors. This correlation supported the predicted positive relationship between the two concepts, recognition of behavior as deviant and recognition of the need for treatment, i.e., the more the recognition of neurotic or psychotic behavior as deviant, the more the recognition of the need for treatment of neurotic and psychotic behaviors.

Findings resulting from the construct validity estimation of the proposed instrument based upon correlations among the subscales of the three scales did support most of the theoretically predicted relationships and provided initial support for the construct validity of the instrument. However, the subscale, recognition of the need for treatment of psychotic behaviors did not hold with the theoretical predictions, thus questions exist concerning how well the subscale adequately represented the concept of recognition of the need for treatment.

Test of the Theoretical Model

Analysis of the theoretical model relationships consisted of two approaches. The first approach used a two-way ANOVA with gender and culture as independent variables and each concept in the model as the dependent variable. Since each concept had two levels, i.e., neurotic and psychotic, each level was considered as the dependent variable in a separate analysis.

In the two-way ANOVA, gender and culture each had two levels, creating four groups. Based upon the results of the analysis of variance, a second approach consisted of regression analysis for testing the predicted relationships of the theoretical model for total group and for each subgroup.

Analysis of Variance

To test the influence of gender or culture on the model variables as stated in research questions one to six, a series of six two-way ANOVAs were done addressing each level of the three major dependent variables (devaluation of psychological problems, recognition of behavior as deviant, recognition of the need for treatment). The research questions that are addressed in this approach are:

1. Is the devaluation of neurotic behavior culture bound or due to gender differences existing cross-culturally?
2. Is the devaluation of psychotic behavior culture bound or due to gender differences existing cross-culturally?

3. Is recognition of neurotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
4. Is recognition of psychotic behavior as deviant culture bound or due to gender differences existing cross-culturally?
5. Is recognition of the need for treatment of neurotic behavior culture bound or due to gender differences existing cross-culturally?
6. Is recognition of the need for treatment of psychotic behavior culture bound or due to gender differences existing cross-culturally?

Results of applying the ANOVA technique to test the first research question indicated a significant interaction effect of culture with gender on devaluation of neurotic behavior ($F = 11.13$, $p \leq .001$) (Table 8).

Results of applying the ANOVA technique to test the second research question indicated no significant effect of culture and gender on devaluation of psychotic behaviors ($F = .17$, $p \leq .0845$) (Table 9).

Results of the ANOVA for testing the third research question indicated a main effect for both culture ($F = 31.14$, $p \leq .001$) and gender ($F = 33.55$, $p \leq .001$) on recognition of neurotic behavior as deviant (Table 10).

Table 8. Analysis of Variance: Devaluation of Neurotic Behavior by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	1378.63	2	689.31	30.01	.001
Culture	9.11	1	9.11	.397	.531
Gender	1369.51	1	1369.51	59.62	.001
Culture X Gender	255.61	1	255.61	11.13	.001***
Error	1745.65	76	22.97		
Total	3379.89	79	42.78		

*** $p \leq .001$

Table 9. Analysis of Variance: Devaluation of Psychotic Behavior by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	9.13	2	4.56	.169	.845
Culture	5.51	1	5.51	.204	.653
Gender	3.61	1	3.61	.134	.716
Culture X Gender	27.61	1	27.61	1.021	.315
Error	2054.75	76	27.04		
Total	2091.49	79	26.48		

Table 10. Analysis of Variance: Recognition of Neurotic Behavior as Deviant by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	648.3	2	324.13	32.34	.001
Culture	312.05	1	312.05	31.14	.001***
Gender	336.20	1	336.20	33.55	.001***
Culture X Gender	12.80	1	12.80	1.28	.262
Error	761.70	76	10.02		
Total	1422.75	79	18.009		

*** $p \leq .001$

Results of the ANOVA for testing the fourth research question included a significant main effect for culture ($F = 14.68$, $p \leq .001$) on recognition of psychotic behavior as deviant (Table 11).

Results of applying the ANOVA to test the fifth research question indicated a significant main effect for gender ($F = 39.48$, $p \leq .001$) on the recognition of the need for treatment of neurotic behavior (Table 12).

Results of the ANOVA for testing the sixth research question indicated no significant effect for culture or gender on recognition of the need for treatment of psychotic behaviors ($F = .080$, $p \leq .923$) (Table 13).

Multiple Regression Analysis (Second Approach)

Multiple regression analysis was used to compute regression coefficients between variables in the theoretical model (Figure 3). The regression coefficient indicates the direction and magnitude of the direct influence of a variable hypothesized as the cause of another variable, the effect variable (Asher, 1976). Standardized regression coefficients (betas) were used since they provide the same scale of measurement for the variables (Pedhazur, 1982). The adjusted R^2 obtained from the regression analysis was used as the measure of explained variance for the effect variables. The adjusted R^2 adjusts for the number of independent variables in the regression equation, for the number of cases and it is a more conservative estimate than the R^2 (Nie, Hull, Jenkins, Steinbrenner & Bent, 1975). The

Table 11. Analysis of Variance: Recognition of Psychotic Behavior as Deviant by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	201.13	2	100.56	8.63	.001
Culture	171.11	1	171.11	14.68	.001***
Gender	30.01	1	30.01	2.58	.113
Culture X Gender	17.11	1	17.11	1.47	.229
Error	885.75	76	11.66		
Total	1103.99	79	13.98		

*** $p \leq .001$

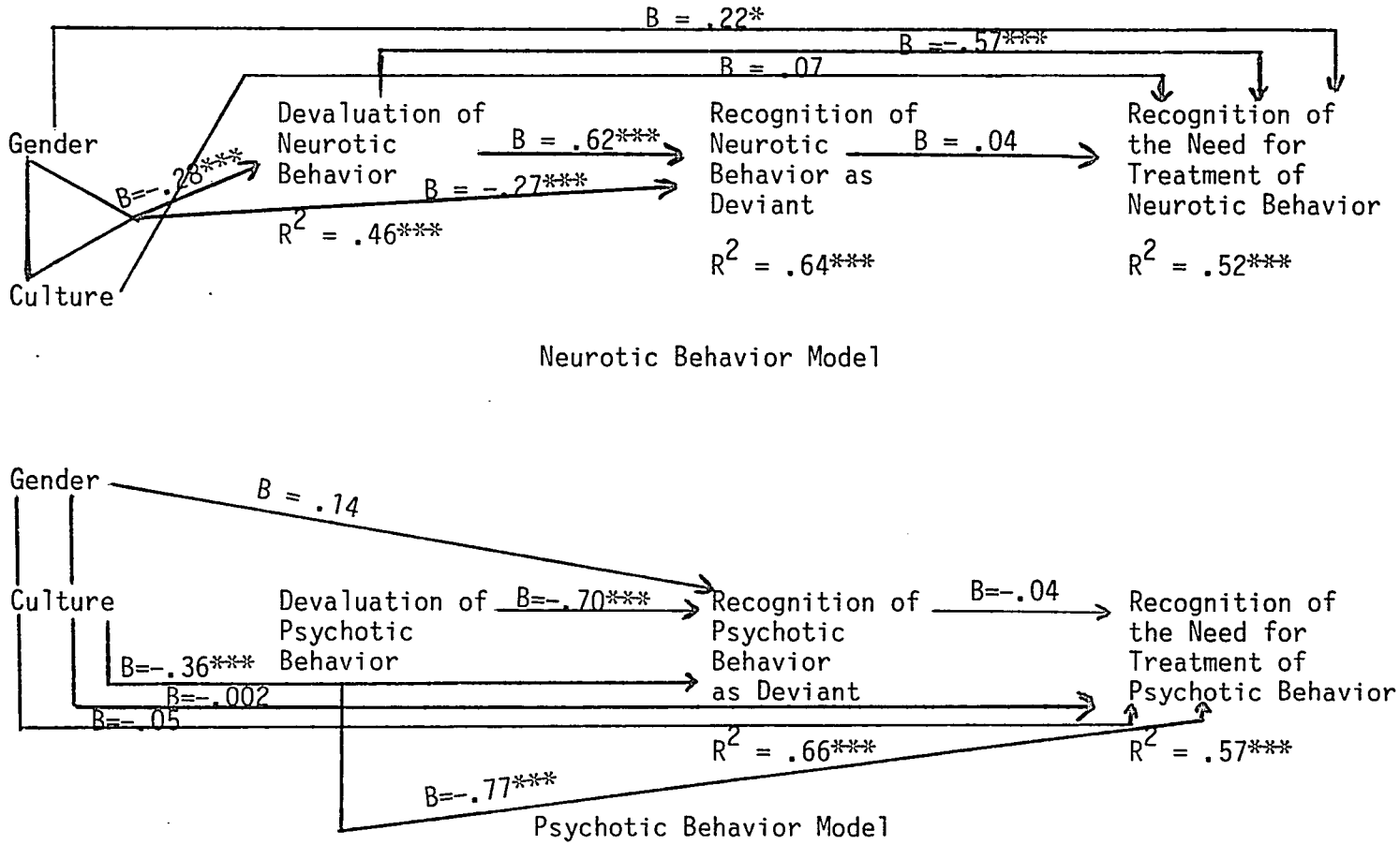
Table 12. Analysis of Variance: Recognition of the Need for Treatment of Neurotic Behavior by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	234.73	2	117.36	19.75	.001
Culture	.112	1	.112	.02	.891
Gender	234.61	1	234.61	39.48	.001***
Culture X Gender	3.61	1	3.61	.608	.438
Error	451.65	76	5.94		
Total	689.99	79	8.73		

*** $p \leq .001$

Table 13. Analysis of Variance: Recognition of the Need for Treatment of Psychotic Behavior by Culture and Gender (N = 80)

Source of Variation	SS	Df	MS	F	P
Main Effects	.925	2	.462	.080	.923
Culture	.612	1	.612	.106	.745
Gender	.312	1	.312	.054	.816
Culture X Gender	.612	1	.612	.106	.745
Error	437.2	76	5.75		
Total	438.69	79	5.55		



B = Standardized Regression Coefficient

R^2 = Adjusted R^2

* = $p \leq .05$

*** = $p \leq .001$

Figure 3. Empirical Model: Cross-Cultural Gender Differences on Evaluation of Women's Psychological Needs for Treatment (N = 80) = Neurotic Behavior and Psychotic Behavior

significance criterion level for the regression coefficients and explained variance measure was set at $p \leq .05$.

Culture and gender as categorical variables as well as the interaction among them were effect coded before being entered into the regression equations. Effect coding is a method of coding categorical variables, where the code is a set of symbols to which meanings can be assigned such as one of the groups is assigned 1's in all the coded vectors and the other group is assigned -1's in all the vectors. As a result, the regression equation reflects the linear model in which the intercept a is equal to the grand mean of the dependent variable $\bar{y}$, and each b is equal to the treatment effect for the group with which it is associated, or the deviation of each group's mean from the grand mean, $\bar{y}$ (Pedhazur, 1982). In effect coding, the b's represent the difference between the mean of the group associated with that b-weight and the grand mean (Volicer, 1984).

In this study, effect coding was used to determine the nature of the effect and to decompose the main effect and the interaction effect to determine which category of gender or culture was explanatory in causing the main effect. The effect coding were 1, -1 for gender (i.e., female = 1 and male = -1) and 1, -1 for culture (i.e., Arabs = 1 and American = -1) creating four groups. The regression equation applied to decompose the main effect was:

$$y' = a + b_1X_1 \text{ (gender)} + b_2X_2 \text{ (culture)}$$

where:

y' is the predicted value (score) of the dependent variable

a, the intercept constant in the prediction equation, equals the mean of the dependent variable. It is not the mean of one group on the dependent variable, but the overall mean for all the subjects in the analysis (i.e., this is referred to as the grand mean of the dependent variable) (Volicer, 1984).

b's, represent the difference between the mean of the group associated with that "b" weight and the grand mean (i.e., b is equal to the treatment effect for the group with which it is associated). The regression equation which was applied to decompose the interaction effect was the same as the previous equation except for the interaction term of gender crossed with culture.

$\hat{y} = a + b_1X_1$ (gender) + b_2X_2 (culture) + b_3X_3 (interaction term)

Four research questions were constructed for testing the theoretical model for the total sample. The first research question was:

> Do gender, culture, or an interaction of gender and culture influence devaluation of women's neurotic or psychotic behavior?

The variables of culture and gender were grouped in one block and entered into the regression equation on the basis of theoretical considerations plus the results of the analysis of variance. The analysis did not indicate any separate main effect for either variable on devaluation of neurotic behavior. Gender, culture, and the interaction term were regressed on devaluation of neurotic behavior (Stage I) and evidenced a significant effect from gender (B = -.64) and a significant interaction effect of gender crossed with culture

(B = -.28), together they explained 46% of the variance in devaluation of neurotic behavior (R^2 = .46). Table 14 depicts the contribution of each independent variable on devaluation of neurotic behavior.

Application of the equation mentioned previously to decompose the interaction effect of gender crossed with culture on devaluation of neurotic behavior results in: a) males had higher scores than females in both cultures (i.e., the main effect of gender); b) the differences were greater for Arabic males (i.e., had the highest score among the groups); and c) American females had higher score than Arabic females. Males were more devaluing of neurotic behavior than females and this effect was stronger with Arabic males than other groups. American females were more devaluing the neurotic behavior than were Arabic females.

Results of the ANOVA on devaluation of psychotic behavior indicated no significant effect of either culture or gender on devaluation of psychotic behavior, thus no further analysis was conducted on this variable.

The second research question was:

> Do gender, culture, or an interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence the degree of recognition of neurotic or psychotic behavior as deviant?

The variables of gender, culture, the interaction of gender and culture, and devaluation of neurotic behavior were regressed on the recognition of neurotic behavior as deviant (Stage II). Results evidenced the significant explanatory value of culture (B = -.44),

Table 14. Relative Contribution of Each Independent Variable Entered on Devaluation of Neurotic Behavior (N = 80)

Independent Variable in Order of Entry	Beta	Dependent Variable: Devaluation of Neurotic Behavior (DNB) R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender } Block Culture }	-.64*** .05	.41	.39***	.41	.64	26.5***
Gender X Culture	-.28***	.48	.46***	.08	.70	23.7***

*** $p \leq .001$

gender crossed with culture (B = -.27), and devaluation of neurotic behavior (B = -.62) upon recognition of neurotic behavior as deviant. Together the variables of gender, culture, gender X culture, and devaluation of neurotic behavior explained 64% of the variance in recognition of neurotic behavior as deviant (R^2 = .64). Table 15 depicts the contribution of each independent variable on recognition of neurotic behavior as deviant.

Application of the regression equation to decompose the interaction effect of gender crossed with culture on recognition of neurotic behavior as deviant results in: a) American subjects had higher score than Arabic subjects (i.e., the main effect of culture); b) American females had the highest scores among the groups; and c) Arabic males had higher scores than Arabic females. This means that American women were more able to consider neurotic behavior as deviant than were Arab subjects, either male or female.

The variables of gender, culture, the interaction of gender and culture, and devaluation of psychotic behavior (Stage I) were regressed on recognition of psychotic behavior as deviant (Stage II). Results indicated that devaluation of psychotic behavior evidenced a direct negative relationship (B = -.70) with the dependent variable, culture was also a significant predictor variable (B = -.36). Together the variables devaluation of psychotic behavior and culture explained 64% of the variance in recognition of psychotic behavior as deviant (R^2 = .64). Table 16 depicts the contribution of each independent variable on recognition of psychotic behavior as deviant.

Table 15. Relative Contribution of Each Independent Variable Entered on Recognition of Neurotic Behavior as Deviant (N = 80)

Independent Variable in Order of Entry	Beta	Dependent Variable: Recognition of Neurotic Behavior as Deviant R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender	.09	.24	.23***	.24	.49	24.13***
Culture	-.44***	.46	.44***	.22	.68	32.2***
Devaluation of Neurotic Behavior	-.62***	.60	.59***	.15	.78	38.21***
Gender X Culture	-.27***	.66	.64***	.06	.81	36.8***

*** $p \leq .001$

Table 16. Relative Contribution of Each Independent Variable Entered on Recognition of Psychotic Behavior as Deviant (N = 80)

Independent Variable in Order of Entry	Dependent Variable: Recognition of Psychotic Behavior as Deviant					
	Beta	R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Devaluation of Psychotic Behavior	-.70***	.53	.52***	.53	.73	86.5***
Culture	-.36***	.65	.64***	.13	.81	72.5***

*** $p \leq .001$

In applying the regression equation to decompose the main effect of culture on recognition of psychotic behavior as deviant, results indicated that American subjects had higher scores than Arabic subjects which means that Americans were more able to consider the psychotic behavior as deviant than were Arabic subjects.

The third research question was:

> Do gender, culture or an interaction of gender and culture, and devaluation of women's neurotic or psychotic behavior influence the recognition of the need for treatment of neurotic or psychotic behavior?

The variables of gender, culture, the interaction of gender and culture, and devaluation of neurotic behavior (Stage II) were regressed on the Stage III variable recognition of the need for treatment of neurotic behavior. The findings indicated that gender ($B = .22$) and devaluation of neurotic behavior ($B = -.57$) were strong predictors of recognition of the need for treatment of neurotic behavior. Together the variables of gender and devaluation of neurotic behavior explained 52% of the variance in this variable. Table 17 depicts the contribution of each independent variable on recognition of the need for treatment of neurotic behavior.

Application of the regression equation to decompose the main effect of gender on recognition of the need for treatment of neurotic behavior indicated that females had higher scores than males. This means that females were more able to recognize the importance of the need for treatment of neurotic behavior than were male subjects from either culture.

Table 17. Relative Contribution of Gender, Culture, and Stage I Variables Upon Recognition of the Need for Treatment of Neurotic Behavior (N = 80)

	Dependent Variable: Recognition of the Need for Treatment of Neurotic Behavior					
Independent Variable in Order of Entry	Beta	R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender	.22*	.34	.33***	.34	.58	40.2***
Culture	.04	.34	.32	.0001	.58	19.8***
Devaluation of Neurotic Behavior	-.57***	.54	.52***	.20	.73	29.2***

* $p \leq .05$

*** $p \leq .001$

The variables of culture, gender, the interaction of gender and culture, and devaluation of psychotic behavior were regressed on the Stage III variable recognition of the need for treatment of psychotic behavior Results indicated that gender and culture have no significant impact upon recognition of the need for treatment of psychotic behavior. However, devaluation of psychotic behavior evidenced a negative significant influence (B = -.77) and explained 57% of the variance in the recognition of the need for treatment of psychotic behavior (R^2 = .57). Table 18 depicts the effect of each independent variable on recognition of the need for treatment of psychotic behavior.

The fourth research question was:

> Do gender, culture, or an interaction of gender and culture, devaluation of women's neurotic or psychotic behavior and recognition of behavior (neurotic or psychotic) as deviant influnce the degree of the need for treatment of neurotic or psychotic behavior?

The variables of gender, culture, the interaction of gender and culture, devaluation of neurotic behavior (Stage I), and recognition of neurotic behavior as deviant (Stage II) were regressed on the Stage III variable recognition of the need for treatment of neurotic behavior. Of the four variables, only gender (B = .21) and devaluation of neurotic behavior (B = -.54) were significant predictors of the recognition of the need for treatment of neurotic behavior. Together the variables of gender, culture, interaction of gender and culture, devaluation of neurotic behavior, and recognition of neurotic

Table 18. Relative Contribution of Gender, Culture, and Stage I Variable Upon Recognition of the Need for Treatment of Psychotic Behavior (N = 80)

Independent Variable in Order of Entry	Dependent Variable: Recognition of the Need for Treatment of Psychotic Behavior					
	Beta	R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender	-.05	.0007	-.01	.0007	.03	.06
Culture	-.002	.002	-.02	.001	.05	.08
Devaluation of Psychotic Behavior	-.77***	.59	.57***	.58	.77	35.9***

*** $p \leq .001$

behavior as deviant explained 52% of variance in the recognition of the need for treatment of neurotic behavior (R^2 = .52). Table 19 depicts the effect of each independent variable on recognition of the need for treatment of neurotic behavior.

Application of regression equation to decompose the main effect of gender indicated that females were more able to consider the importance of the need for treatment of neurotic behavior than males.

The variables of gender, culture, interaction of gender and culture, devaluation of psychotic behavior (Stage I), and recognition of psychotic behavior as deviant (Stage II) were regressed on the Stage III variable recognition of the need for treatment of psychotic behavior. Of the four variables, only devaluation of psychotic behavior was found to be a significant predictor of the recognition of the need for treatment of psychotic behavior (B = -.80) with that one variable accounting for 57% of the variance. Table 20 depicts the effect of each independent variable on recognition of the need for treatment of psychotic behavior.

Summary of the Results of Testing the Theoretical Model

In testing the theoretical model underlying this study, eight relationships held as predicted on the theoretical model. Regression analysis revealed the following for the total sample:

1. Gender had a significant effect and an interaction effect crossed with culture on devaluation of neurotic behavior (i.e., males were more devaluing of neurotic behavior than females and this effect was stronger with Arabic

Table 19. Relative Contribution of Gender, Culture, Stage I and Stage II Variables Upon Recognition of the Need for Treatment of Neurotic Behavior (N = 80)

	Dependent Variable: Recognition of the Need for Treatment of Neurotic Behavior					
Independent Variable in Order of Entry	Beta	R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender	.21*	.34	.33***	.34	.58	40.2***
Culture	.07	.34	.32	.000	.58	19.8***
Devaluation of Neurotic Behavior	-.54***	.54	.52***	.20	.73	29.2***
Recognition of Neurotic Behavior as Deviant	.06	.54	.51	.001	.73	21.8***

* $p \leq .05$

*** $p \leq .001$

Table 20. Relative Contribution of Gender, Culture, Stage I, and Stage II Variables Upon Recognition of the Need for Treatment of Psychotic Behavior (N = 80)

	Dependent Variable: Recognition of the Need for Treatment of Psychotic Behavior					
Independent Variable in Order of Entry	Beta	R^2	Adjusted R^2	R^2 Change	Multiple R	F to Enter
Gender	.05	.0007	-.01	.0007	.03	.06
Culture	.01	.002	-.02	.001	.05	.08
Devaluation of Psychotic Behavior	-.80***	.59	.57***	.58	.77	35.9***
Recognition of Psychotic Behavior as Deviant	-.04	.59	.56	.0006	.77	26.6***

*** $p \leq .001$

males than other groups). Gender and culture did not have significant impact on devaluation of psychotic behavior as predicted.

2. Culture had a significant effect as well as interaction effect crossed with gender on recognition of neurotic behavior as deviant as predicted (i.e., American females were more able to consider neurotic behavior as deviant than were Arabic males or females).
3. Culture had a negative impact on recognition of psychotic behavior as deviant which was inconsistent with predictions (i.e., American subjects were more able to consider the psychotic behavior as deviant than were Arabic subjects either males or females.
4. Culture did not have an impact on recognition of the need for treatment of neurotic behavior which was inconsistent with predictions. Gender had a positive impact on recognition of the need for treatment of neurotic behavior as predicted (i.e., females were more able to recognize the importance of the need for treatment of neurotic behaviors than were male subjects from either culture).
5. Culture and gender did not have significant impact on recognition of the need for treatment of psychotic behavior as predicted.
6. Devaluation of neurotic behavior had a significant negative impact on recognition of neurotic behavior as deviant

as predicted. Also devaluation of psychotic behavior had a strong negative impact on recognition of psychotic behavior as deviant as predicted.

7. Recognition of either neurotic or psychotic behavior as deviant did not have a significant impact on recognition of the need for treatment of either neurotic or psychotic behavior which was inconsistent with predictions.
8. Devaluation of either neurotic or psychotic behavior had a direct negative impact on recognition of the need of treatment of either neurotic or psychotic behaviors as predicted.

In terms of the purpose of the study, the regression analysis indicated that evaluation of women's psychological need for treatment of neurotic behaviors was influenced by gender, culture, and degree of devaluation of women's neurotic behaviors but not by the degree of recognition of women's neurotic behavior as deviant. Contrary to what was predicted, degree of recognition of women's neurotic or psychotic behavior as deviant did not have any influence on the degree of recognition of the need for treatment of either neurotic or psychotic behaviors. As predicted, gender and culture did not have an impact on the recognition of the need for treatment of psychotic behaviors. However, culture had a negative impact on the recognition of psychotic behavior as deviant which was not predicted. Devaluation of psychotic behavior had a direct impact on recognition of the need for treatment of psychotic behaviors as predicted. Thus, recognition of either neurotic or psychotic behavior as deviant was not found to be one

of the variables influencing the degree of recognition of the need for treatment of either neurotic or psychotic behavior.

Summary

The initial purpose of this study was to investigate the influence of devaluation of women's psychological problems upon the recognition of women's behavior as deviant and the subsequent impact of both variables upon the recognition of women's need for treatment. A secondary purpose was to determine whether culture and gender influenced each concept in this study. Results of the data analysis to test the theoretical model supported most of the theoretically predicted relationships except for the relationship between recognition of behavior as deviant and recognition of the need for treatment. The instrument used in this study demonstrated adequate reliability and validity for only five subscales. This chapter also contained a description of the sample as total group and among the groups (i.e., Arabic males and females, American males and females).

This chapter ended with results of decomposing the main effects and the interaction effect of gender and culture on each concept level (i.e., neurotic level and psychotic level).

CHAPTER V

INTERPRETATIONS, IMPLICATIONS AND RECOMMENDATIONS

This chapter includes an interpretation of the findings, measurement issues, and implications for nursing practice. Recommendations for further study are presented. The findings are interpreted for the description of the sample and the theoretical model. Limitations of the study are woven throughout the interpretation.

Description of the Sample

The sample consisted of 80 subjects (20 Arabic males, 20 Arabic females, 20 Anglo American males, and 20 Anglo American females), who were living in a southwestern city. The sample selected by convenience, included all subjects who met the subject criteria during the three-month data collection period. All subjects who met the criteria agreed to participate in the study. Differences among the subjects by gender and culture on the demographic variables of age, years of education, income, work, and school were calculated resulting in the findings that American male subjects were older, had more full time work and a higher frequency of full time or part time school than American females. Arabic male subjects were older, had more higher years of education, and had more full time school than Arabic females.

Generally American subjects were older, more frequently rated themselves as having a high income and having more full or part time

work, while the Arabic subjects rated themselves as having higher frequency of full time study. As a result, most of American and Arabic subjects were upper-middle class and highly educated, especially the male subjects. Thus, although it is inappropriate to generalize the findings to all Arabs and Americans, these findings are limited to the Arabic and American sample under this study, or others fitting the sample characteristics. Differences in the demographic variables of income and years of education might have an influence on the model testing and findings of this study.

Findings of the Theoretical Model Test

The central purpose of this study was to investigate the influence of devaluation of women's psychological problems upon the recognition of women's behavior as deviant and the subsequent impact of both variables upon the recognition of women's need for psychological treatment. A secondary purpose was to determine whether culture and gender influenced each concept in this study. Findings are interpreted based upon discussion of the central and secondary purpose of the study relative to variables at each stage whether neurotic or psychotic level.

Neurotic Level of Concepts

Stage I. Concerning the neurotic level of the first concept in the model (Figure 3), there was a significant interaction effect of gender crossed by culture on devaluation of neurotic behavior as predicted. Results of decomposing the interaction effect indicated

that males had higher scores than females and the difference was greater for Arabic males, i.e., males are more devaluating of women's neurotic behaviors than females and this was accounted for by the Arabic males. An explanation for this result is that males in general are the more dominant figure in the family. The man considers his problems as more important than a woman's concerns because his problems are related to a wider sphere of activity outside of the home. It is his primary concern to avoid negative judgment by others that compels or repels his activities in the society. On the other hand, women are less socially important, and seen as having an impact on a smaller sphere of activity; thus their problems are considered secondary to men's problems. This is stronger in the Arabic culture where in male-dominated societies men have, as a group, greater power than women (Saadawi, 1980; Lakoff, 1975). Strong support was provided for the effect of culture and gender on evaluation of women's neurotic behaviors. The social condition arising from traditional cultural conceptions of male and female roles is implicated as having a detrimental effect on evaluation of women's psychological problems and, in many instances, women's psychological disorders may be attributable to social conditions rather than to psychic factors (Epstein, 1970; Poloma & Garland, 1971; Roby, 1972; Theodore, 1971). Saadawi (1980) states femininity is characterized by these characteristics; laudable in obedience and well adapted and resigned to their inferior position. Masculinity, on the other hand, is distinguished by qualities of a master, of strength, dominance, determination, and initiative. Saadawi (1980) concluded that woman's low status and the inequities between

men and women have led to a lack of recognition of women's psychological problems as important. This is why devaluation of women's psychological problems was more evident among the Arabic sample than in the American sample.

Stage I variable, devaluation of neurotic behavior, had a significant negative impact on recognition of neurotic behavior as deviant (Stage II). This relationship was predicted and indicates that the devaluation of women's problems by both men and women causes them to be less likely to consider neurotic behavior as deviant. For example, vignette four, which illustrates a woman's difficulty fulfilling her role as a new mother, was not evaluated as a problem nor considered a serious situation. Support for the direct negative relationship between devaluation of women's psychological problems and recognition of behavior as deviant was provided by Saadawi (1980). She reported that many women suffer from psychological disorders due to their devalued status and their desperate desire to fulfill the norms for femininity imposed on them by their society. As a result of their social status, their psychological problems are less visible and recognized. Additional support for the direct negative relationship between devaluation of neurotic behavior and recognition of neurotic behavior as deviant is provided by Howell & Bayes (1981). Howell & Bayes (1981) reported that women's psychological problems may be neglected or seen as individual and intra-psychic without awareness of the massive societal forces that women face due to their lower status.

Moreover, there was a significant interaction effect of gender and culture on recognition of neurotic behavior as deviant with culture providing both a main effect and an interaction effect.

Decomposing the interaction effect of gender and culture on recognition of neurotic behavior as deviant, it was found that American subjects were more likely to recognize neurotic behavior as deviant than were Arabic subjects. American females were more likely to recognize neurotic behavior as problematic than any other group, while Arabic females were less likely to recognize this. The difference between cultures may be due to Arabic women's stereotyping images of femininity and their identification with women's problems in the vignettes made them less able to recognize the situations as stressful. This is supported by Guttentag, Salasin & Belle (1980) who state that socially conditioned and stereotypical images produce in women a cognitive set against assertion which is reinforced by societal expectations. Guttentag, et al. (1980) continued, young girls learn to be helpless during their socialization and thus develop a limited response when under stress. These self images and expectations are internalized in childhood so that the young girl comes to believe in the stereotype of femininity, especially its emphasis on youthfulness, beauty and passivity, and is expected to be valued and normative. This passivity observed in women based upon the previous explanation is more intensified in Arabic culture more than American. This explains why Arabic females were less likely to consider neurotic behaviors as deviant. On the contrary, American females more frequently recognized the neurotic behaviors as deviant based on this cultural

background. Banner (1974) stated that there are large numbers of American educated women. These along with the working women as well as feminist movement has achieved wide spread strength in government, in education, and in politics. The sample of American females had a higher mean educational level of 17.1 than Arabic females ($\bar{x}$ = 14.8). This may make American women more oriented toward recognizing psychological problems than the Arabic women.

Devaluation of neurotic behavior also had a direct and indirect negative impact mediated by Stage II variable, recognition of neurotic behavior as deviant, on recognition of the need for treatment of neurotic behavior (Stage III). The negative relationship was predicted and interpreted as, the more subjects devaluated women's problems, the less they recognized their need for treatment. Tudor, et al. (1977) provided a support for this relationship. They reported that poor performance by a woman does not threaten the family in the way a man's loss of job would, and is thus more likely to be tolerated and less recognized as problematic, as well as less likely to be treated the same behavior by a male. Consequently, sex stereotypes of traditional roles provide the basis for the recognition of behavior as deviant and recognition of the need for treatment of women's psychological problems. Thus the general tendency is to stereotype and devalue women, frequently misjudging their problems as unimportant and "unreal". This results in a lack of recognition of the need for treatment. As a result, the emotional responses that women demonstrate are seen as expected gender appropriate behavior. For example, the woman in the vignette three describes a difficult relationship between

her and her mother-in-law. She responds to her mother-in-law by getting frustrated, upset, crying, and isolating herself in her room. This behavior was seen as passive and weak in this situation. Both are feminine characteristics.

Gender also had a significant impact upon recognition of the need for treatment of neurotic behavior (Stage III). Females were more sensitive to the importance of the need for treatment. This is supported by the previous relationship in the model that found females to be more sensitive to women's emotional problems and more aware of the importance of the need for treatment than males. Even though Arabic females were less likely to label women (in the vignettes) as having deviant behaviors, they were still accepting of treatment for these behaviors.

A perusal of the types of treatments chosen by Arabic females indicated that most were related to social networks as sources of help (such as talking with a spouse, family member, a friend, a clergy person, praying and appealing to God, talking to a social worker or seeking recreational activities) rather than seeking professional help such as psychological or psychiatric treatment. This was most evident with neurotic type of behaviors. However the American sample did not often consider social network help seeking, but they were more channeled toward professional help even with the neurotic type of behavior. Professional help included talking to a nurse, social worker, psychologist, or psychiatrist.

An explanation was provided by Meleis (1983) to support why Arabic subjects had chosen social networks in seeking help for

emotional problems. She reported that Arabs have very high affiliation needs even when not in crisis or under stress. She adds, an Arab's predominant copying style is "turning to others" for help and advice. In doing so, the need for others' help is not directly communicated; rather, it is understood and acted upon without being verbally articulated. The expected help must be offered with persistence and, whether the seeker acknowledges the need or not, the offer must be repeated. She added that the Middle Easterners resist seeking help from psychiatrists because of the stigma associated with mental illness and by the time psychiatric help is finally sought, a person may be very sick.

Stage II. Recognition of neurotic behavior as deviant did not have a significant impact upon recognition of the need for treatment of neurotic behaviors. This finding was not predicted. A plausible explanation for this nonsignificant relationship is that Arabic females were less likely to recognize neurotic behavior as deviant than American females, thus they did not ascribe to the need for treatment of neurotic behavior, resulting in a weak relationship between these two variables. Another explanation was provided by Good & Good (1986) who argued that anthropological and cross-cultural psychiatric research has found variation in the content of symptoms across cultures. Good (1977) presents the example of the Iranian culture (which is Middle Eastern) in which persons often complain that their hearts are upset. "Heart discomfort" for the Iranian is not equivalent of "heart palpitations" for Americans; the two terms do not have the same meaning. Heart discomfort refers to emotional

distress in Iranian culture. The same label of emotional expression occurs with Arabs who are also Middle Eastern. Differences in cultural expression of distress provides an explanation for why Arabic females did not consider neurotic behavior as deviant and did not recommend much treatment.

Psychotic Level of Concepts

Stage I. Neither culture nor gender had significant effects on devaluation of psychotic behaviors. Psychotic behavior was less devalued than neurotic behavior. This finding indicated that both Arab and American subjects were similar in their evaluation of women's psychotic behaviors. Support provided by Saadawi (1980) is that visibility of women's psychological problems depends upon the family's inability to control the disruptive behavior. Thus, once the disruptive behavior is uncontrollable and highly visible, it is recognized as important. Additional support provided by Perrucci & Targ (1982) is that certain combinations of unusual behaviors within any group may make a problematic member most visible or most problematic to network members. For example, both physical problems and role failure could be seen as physical problems in origin (tension, nervousness) but may be expressed as a network problem in the form of inability to carry out role responsibilities (work, household duties). In addition to being visible, these unusual behaviors could be perceived by network members as having created problems for persons associated with the problematic member.

Devaluation of psychotic behavior (Stage I) had a significant negative impact on recognition of psychotic behavior as deviant. This

relationship was predicted and can be explained as; when subjects continued to devalue women's psychotic behavior, there was less recognition of psychotic behavior as deviant, but for those for whom devaluation was less, recognition of the pathology of the behavior as deviant was highly evident. Comparison of the mean scores on devaluation of neurotic behavior and psychotic behavior showed a decrement in mean scores from 40.34 for devaluation of neurotic behavior to a mean of 28.1 for devaluation of psychotic behavior, indicating that there was a lower level of devaluation of psychotic behavior than there was of neurotic behavior. This means that females are most likely to be seen as credibly sick, when the illness is acute, then a problem can be recognized equally by females and males across both cultures.

Gender did not have an effect on recognition of psychotic behavior as deviant as predicted. Strong support was provided by Rushing (1979) who emphasized that when behavior of people is extremely bizarre, disorganized, and unpredictable as among individuals who are severely impaired mentally, this evokes societal reactions to the behavior and the effects of their sex are weak or nonexistent.

Although not predicted, culture had a main effect on recognition of psychotic behavior as deviant. A direct support provided by Good & Good (1986) for this finding is that anthropological and cross-cultural psychiatric research has found great variation in the content of symptoms across cultures. They added that culture-specific idioms of distress and symptom vocabularies are not merely consistent between Western and non-Western cultures; they are the language in which

members of any culture express distress. For example, somatic idioms are more prevalent among Arabs than Americans and may have quite different diagnostic implications among different groups.

Decomposing the main effect of culture indicated that American subjects were more able to recognize and consider psychotic behavior as deviant than were Arabic subjects. Direct support for this finding was provided by Saadawi (1980) who presents the idea that the frequency of severe psychological problems in Arabic females may be due to the culture reluctance to recognize these problems in their earlier form and even in their acute presentation. As a result of exploitation, oppression, devaluation and lower status, their psychological problems are less recognized and visible. Additional support is provided by Kleinman & Good (1985) who argue that cultural meanings and norms for expressing distress significantly alter the relationship between symptoms and diagnosis. For example, it is possible that Arabic subjects evaluated some of the psychotic behaviors presented in vignettes as highly religious not as psychological behaviors. For example, vignette three (second set of vignettes) describes a woman with hallucinatory behaviors who sees figures of spirits around her and also hears voices mumbling to her. Such a vignette seemed to represent religious behavior rather than psychotic behavior. It is possible that Arabic subjects supported the spiritual and religious cultural view in their evaluation of some psychotic behaviors. The difference between Arabic subjects and American subjects in the recognition of psychotic behavior as deviant may be due to cultural differences in belief symptoms, norms, and idioms of expression.

Devaluation of psychotic behavior also had a direct negative impact on recognition of the need for treatment of psychotic behaviors as predicted. The more subjects devalued the psychotic behavior, the less they recognized the importance of the need for treatment of psychotic behaviors. Support was provided by Williams (1977) who stated that immature and unadaptive behavior is viewed as normal for women. She added that women fit so naturally into the role of patient that often their complaints are seen as not "real" and stereotyped attitudes and assumptions about "woman's place" pervasively colored the method chosen for treatment of women's problems. Additional support was provided by Chesler (1972) and Broverman et al. (1970). They documented that the psychiatric treatment of women is characterized by oppression, exploitation and infantilization. A double standard of mental health and treatment exists for men and women which parallels sex-role stereotypes in the society and within which women are essentially devalued.

Comparison of the mean scores on devaluation of neurotic behavior and devaluation of psychotic behavior showed a decrement in mean scores from 40.34 for devaluation of neurotic behavior to a mean of 28.1 for devaluation of psychotic behavior, indicating that there was a lower level of devaluation of psychotic behavior than there was of neurotic behavior. This leads to an increment in mean scores from 28.5 for recognition of the need for treatment of neurotic behavior to a mean of 31.9 for recognition of the need for treatment of psychotic behaviors, indicating that there was a high level of recognition of the need for treatment of psychotic behaviors. This means

that females are less likely to be devalued when their behaviors are psychotics, then the need for their treatment can be recognized equally by both females and males in both cultures.

Neither culture nor gender had significant impact on recognition of the need for treatment of psychotic behavior as predicted. This means that the need for treatment of psychotic behaviors can be recognized equally by females and males across both cultures. Strong support was provided by Perrucci & Targ (1982). They argued that the path to the psychiatric treatment (mental hospital) is characterized by great visibility and considering of unusual behaviors and great negative effects of such behaviors on other persons.

Stage II. Recognition of psychotic behavior as deviant did not have a significant impact on recognition of the need for treatment of psychotic behaviors. This finding was not predicted. The interpretation of this finding will be discussed with measurement issues.

In summary, across all three concepts in the neurotic level, the Arabic sample differed from the American sample. The traditional orientation of the Arabic culture, as described by Saadawi (1980), appears to account for the differences found in the data. Along with cultural influences, gender also appeared to impact upon two of the concepts, devaluation of neurotic behavior and recognition of the need for treatment of neurotic behaviors, with males evidencing a lower level of sensitivity to women's psychological problems. Gender interacted with culture for two concepts (devaluation of neurotic behavior and recognition of neurotic behavior as deviant) and Arabic males were the least sensitive group. It was interesting that in

non-recognition of neurotic behavior as deviant, Arabic females joined with Arabic males in supporting the cultural view.

In the concepts measuring psychotic behavior, there were no gender and cultural differences in the devaluation of psychotic behavior and recognition of the need for treatment of psychotic behaviors variables. However, there were cultural differences in the recognition of psychotic behavior as deviant probably due to cultural variations in the meanings and norms for expressing psychological problems. It was proposed that in recognition of psychotic behavior as deviant, Arabic subjects evaluated some of psychotic behaviors as highly religious rather than considering them as psychopathological behaviors.

Only the variable, devaluation of women's psychological problems, was found to be a predictor of recognition of women's need for treatment. Also the variable, devaluation of women's psychological problems, had an impact upon recognition of women's behaviors as deviant.

Measurement Issues

Three scales were used in this study. Each scale has two subscales. Adequate estimates of reliability and validity were not established for recognition of the need for psychotic treatment subscale because of the lack of variance on one of the two items among groups. The present items need to be revised and more items to be added before the instrument is reused.

Construct validity for the variables was assessed through predictive modeling in which correlation coefficients and regression

coefficients were used to determine the existence and direction of relationships between variables (Hinshaw, 1978). If relationships between variables were found to exist as predicted and the direction of the relationships were as predicted, initial construct validity was established. The predicted relationships are shown in Figure 3. No significant relationship was found between recognition of neurotic behavior as deviant and recognition of the need for treatment of neurotic behaviors variables. There was also no significant relationship between recognition of psychotic behavior as deviant and recognition of the need for treatment of psychotic behavior variables.

Three possible interpretations for the absence of evidence establishing construct validity of a measure are described by Cronbach & Meehl (1955). The first interpretation is that the instrument does not index the intended construct. A second interpretation is that the theoretical model is incorrectly specified. A third interpretation involves measurement error resulting from the methods used to test the theoretically derived relationships. Based on the lack of reliability of the subscale recognition of the need for treatment of psychotic behavior, the third interpretation provides the most plausible reason for the lack of construct validity of the recognition of the need for treatment of psychotic behaviors subscale. Measurement error was evidenced in the data due to inadequate reliability and internal consistency estimates of this subscale. Therefore, the amount of measurement error was great enough to alter the relationship with other variables in the theoretical model.

Implications for Clinical Nursing Practice

This current study could extend the present knowledge base of psychiatric mental health nursing by identifying factors that impact on women's psychological conditions cross-culturally as well as women's psychological needs for treatment. By knowing which factors increase and which decrease women's pathways into professional psychological treatments, the psychiatric mental health nurse is able to educate the public, especially women, in terms of early recognition of psychological problems.

Nursing prevention and intervention have also been an increasingly important part of nursing activities due to concern with cost-effectiveness of treatment and early recognition and prevention of chronic psychological problems. Early recognition of psychological problems may lead to decreased costs of treatment due to hospitalization.

Before findings from this study can be useful for nursing practice, the study needs to be replicated. Since it is not known how representative the sample is, the findings cannot be generalized without further investigations.

Recommendations

This study is viewed as an initial step in investigating the relationship among evaluation of women's psychological problems, recognition of women's behavior as deviant, recognition of their need for psychological treatment, and the effect of culture and gender on each concept under study. Conducting the study has resulted in

the identification of future steps necessary for continuing documentation of these relationships. Recommendations for future steps include: One recommendation is for further development and testing of the recognition of the need for treatment subscale. A methodological study is recommended to develop and test this subscale. Another recommended step is for the replication of the study with a more representative sample before results can be generalized to the general population. Thirdly, since these findings have implications for theories of etiology of psychological disorders and for treatment and prevention, they could be used to form the basis of a program for women. Such a program could be designed to fit their needs for treatment so that other groups in the society follow this model and implement new programs, especially for Arabic women. Lastly, it is important to orient other practitioners to the study findings in order that they be sensitized to the issues in treatment of women's psychological problems.

Summary

The central purpose of this study was to investigate the influence of devaluation of women's psychological problems upon the recognition of women's behavior as deviant and the impact of both variables upon the recognition of women's need for psychological treatment. A secondary purpose was to determine whether culture and gender influenced each concept under study. Only the variable, devaluation of women's psychological problems was found to be a predictor of recognition of women's need for treatment (either on neurotic or psychotic level). Gender and culture were found to be a predictor

of each variable under study on neurotic level, however, only culture was a predictor of recognition of psychotic behavior as deviant. The findings were interpreted and discussed. Measurement issues emerging from the study were addressed. Implications were presented in relation to nursing practice. This chapter concluded with a list of recommendations for future research efforts.

APPENDIX A

DEMOGRAPHIC FORM

Instructions: The following series of short stories are about an individual's daily life situations. Each short story is followed by five questions representing your judgment about the specific situation. I am interested in the extent to which you agree or disagree with each item. Please read each of these stories. After you have read the story, take your time and respond to each statement. You will have a choice of four responses for answering each statement: Strongly Agree, Agree, Disagree, and Strongly Disagree. For each statement please place an "x" under the response that most closely measures your opinion. Your response will be kept confidential.

It is important that you refrain from discussing these stories with anybody else in order to answer the questions because the research is measuring your own opinion and any assistance from others will affect the result of the study.

DEMOGRAPHIC DATA FORM

STUDY: Cross Cultural Gender Differences on Evaluation of Women's Psychological Needs

Subject Information

Subject No._____ Date_____

Sex: Male___ Female___ Age_____

Years of Education_____

Family Income

1 High ___
2 Moderate ___
3 Low ___

Working

1 Full time ___
2 Part time ___
3 Not working ___

School

1 Full time ___
2 Part time ___
3 No school ___

Home Country_____

Language

1 Arabic ___
2 English ___
3 Others ___

Religion

1 Moslem ___
2 Christian ___
3 Others ___

APPENDIX B

VIGNETTES

This 42 year old woman has been married for more than 20 years, and has no children. Recently her husband has changed his relationship with her. He told her that he has decided to marry another woman so he can have children. This has been a shock to her after all the years they have lived together. She has responded by being angry with him. She creates reasons for quarreling with him during the day and night. She starts an argument any time she knows that he is going outside the home. Every morning she starts to argue with him so he can not get to his job on time. She refuses to sleep in the same room with him. She neglects to take care of herself and refuses to spend time putting on make-up or taking care of her appearance. She cries and weeps daily. She refuses to have any contact with her husband, does not eat or talk with him, and does not stay in the same room with him. She refuses to wash his clothes and instead has ripped them into pieces. She has begun to have physical complaints; headache, loss of appetite and indigestion. In addition, she has started talking badly about him with her family and neighbors.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This 26 year old woman has been childless after 3 years of marriage. During these three years she has experienced a feeling of inadequacy and has felt she is not a perfect woman to herself and others. As a result, this woman has had some difficulties with her husband's family. The family constantly reminds her about her inability to get pregnant. They keep pressuring her to be checked and examined, but do not pressure their son to have an examination. She is sensitive to anything having to do with children and she constantly avoids any discussions about children. Her husband is also sensitive about not having children and from time to time they have a hard time discussing the situation. As a result, she is nervous, irritable, and she can not stay in one place for a long time or tolerate much discussion about children. Moreover, she has physical symptoms such as headache, occasional chest tightness and stomach pain.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
____ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This woman is 25 years old, married and has three children. She has a hard time dealing with her mother-in-law, who keeps criticizing her in front of others any time there is any guest or a friend visiting her. The mother-in- law does not let her talk to or stay alone with visitors. In front of the son and others, the mother-in-law orders the woman to do tasks, such as cleaning her room, cooking food or taking care of her children because they are making noise in front of visitors. Her mother-in-law continuously puts her down in front of others. This makes her life so miserable that she has complained to her husband. He does not support her because she is complaining about his mother and she should tolerate his mother and not make trouble. She also feels she must try to avoid making his mother angry at her. Because of this experience, this woman gets frustrated and emotional, and becomes upset, sometimes crying. She has isolated herself in her room and has refused to talk to any people in the house. She refuses to share or to eat with anybody at the house, especially her husband.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This 26 year old woman is married and has one child. She has difficulty fulfilling her role as a new mother. She cannot manage to control her house work. She does not have time to take care of herself; for example, fixing her makeup or changing her dress. Her house is unorganized and sometimes unclean. The baby is her main concern. No one cares about her problems as a new mother. Her husband thinks that this is a normal situation for any new mother and it is her responsibility because this is a woman's role. Her family and friends blame her for inadequacy in handling her baby and home responsibilities. One exception is her neighbor who helps her in a simple way. As a result of this experience, she complains of low self-confidence and low self-esteem. She expresses her feelings by crying, getting tired easily, and feeling nervous and uncomfortable. She hates to listen to others when they try to advise her and feels they are blaming her for the situation. She feels that she is the only one in the world unable to handle her own problems.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree	Agree	Disagree	Strongly Disagree
(4)	(3)	(2)	(1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree	Agree	Disagree	Strongly Disagree
(1)	(2)	(3)	(4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree	Agree	Disagree	Strongly Disagree
(4)	(3)	(2)	(1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This woman is 27 years old, married and has one 3 year-old daughter. The woman complains that her child is a trouble maker. She claims her child demands to have every toy she sees and throws valuable things including money from the windows. Her child cries and refuses to eat. The mother punishes and beats her daughter and once burned the daughter's hand to stop her from throwing things. The mother becomes nervous and irritable when relating to her husband and her child. At times she cries, especially after punishing her child, because of guilt feelings. Her husband does not participate in helping to handle the situation with her. He says "This is a woman's business to handle the children, a man has enough to do that is more important than that." She says that his lack of support makes her situation worse because no one cares. Other mothers blame her and say it is her fault that she is unable to handle her child's problem.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This woman is 30 years old, married and has no children. She gets angry every time she meets a specific acquaintance. This acquaintance always criticizes her and makes fun of her in front of the group about her way of talking and her appearance; the acquaintance continuously tries to degrade her in front of others. This woman feels she cannot stop the acquaintance from being abusive. This situation makes her nervous and angry to the point where she cannot express her anger. She feels angry enough to kill the other person. She keeps avoiding this acquaintance and refuses to stay in the same place with her. For approximately one month, she has had a repeated nightmare of quarreling and killing the acquaintance. Sometimes she has interrupted sleep and insomnia.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

A young woman in her twenties has never had a job, and she does not seem to want to go out and look for one. She is a very quiet person and does not talk much to anyone, even her own family. She acts like she is afraid of people, especially young men her own age. Whenever someone comes to visit her family, she stays in her room until they leave. She just stays by herself and day dreams all the time.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This woman is 30 years old, married, and has one child. Her husband is always busy and has no time or interest in her problems. She feels that he isn't interested in her problems and that he won't help her with her problems. He expects his wife to handle her own problems by herself. He says, "Wives only cause troubles for husbands because wives have nothing to do except talk." Sometimes he criticizes her in front of her friends. As a result, she has become upset, crying and weeping and sitting in her room alone for hours. She does not argue with him because she has never gotten along well with him after any argument. She tries to get his attention to listen to her problems; for example, writing a short message to tell him about the problem. Recently she has started to complain of headaches and stomach pain. When she complains to him about her symptoms, she feels that he ignores her.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This young woman is 27 years old, very calm, but lacks self confidence. She believes that her face is ugly, and that she is skinny and short. She has never had a relationship with a man. When she talks with anybody she cannot look the person in the eye. Whenever she attempts to talk to a man she feels like she has a fever, is excessively sweaty and shakes. She avoids social contact because she feels that others make fun of her.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This person is a 40 year-old woman who is married. She is a very suspicious person. Sometimes she thinks that the people she sees on the street are talking about her or following her around. A couple of times she has yelled at women who did not even know her because she thought that they were plotting against her. The other night she began to curse her husband terribly, then threatened to kill him because, she said, he was working against her too, just like everyone else.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This 42 year-old woman thinks she has special mental powers and that she receives messages through electrical waves that other people cannot hear. Most of these messages are about danger to her country from other countries. She has tried very hard to get in touch with the president of her country and the governor to warn them of nuclear attacks. The messages she hears tell her that her country is going to be bombed and she tries to warn the government of these attacks. People in government ignore her and do not answer her letters or phone calls.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This 35 year-old woman, who is married, has for the last several years experienced episodes in which she can see figures of spirits standing around her and she can also sometimes hear voices mumbling to her. No one else can see or hear these things. During these experiences, she talks in a strange, low-pitched tone of voice and reveals messages from the spirits. These episodes may occur anywhere and last from a few hours up to a week. Between them, she carries on her regular activities but is not very outgoing.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This is a 30 year old woman, married and has three children. Every day she cries and weeps for hours on end and does not take care of her children. She claims that all kinds of people are accusing her of trying to hurt them. She feels that her thoughts and deeds may have harmed thousands of people. She thinks and talks about killing herself. She sits for hours without moving. She does not take a bath or wash and comb her hair or change her clothes.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This is an 18 year-old girl, who is in high school. She has always been a moody girl and has never gotten along well with people. A few months ago she began to cry all the time and act afraid of everything. She has stopped going to school and stays at home. She screams at her parents, and often what she says does not make any sense to them. She has talked about hearing voices talking to her and thinks she is really somebody other than herself.

1. I think this girl's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this girl's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this girl has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this girl should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This is a woman, aged 27, who is not married. Every now and then she sees the figure of her mother, who died a few years ago, standing before her. She then talks to her and her mother replies. People who are with her when she talks to her mother do not see or hear her. She is described by her friends as a rather excitable but friendly person.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This is a 25 year-old woman, married and has a baby. Every time she hugs her baby, she has a desire to squeeze him to death. As a result, she has stopped caring for him. She shakes constantly when she touches her baby. As a result she is afraid to care for him and she lets him cry for hours. Moreover, she is afraid to walk alone in the street because she thinks there is danger everywhere.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
_____	_____	_____	_____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
_____	_____	_____	_____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (4)
_____	_____	_____	_____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

She is a 30 year-old married woman with one child. She thinks that her sister is having an affair with her husband. She has started to accuse her husband about his relationship with her sister. She has noticed that people in the street are talking about this relationship, even songs in the radio are about that relationship. She thinks that anytime her sister visits her, she is having a date with her husband. She also believes that her sister puts microphones everywhere to spy on her.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

This is a 35 year old woman who is married and has three children. A few months ago, she began to complain that people were avoiding her in the street or at work due to her bad odor. For this reason she stopped going to work and stayed at home, bathing herself five to six times a day. Despite her frequent baths, she felt people continued to avoid her, and that she could not talk with anybody. Sometimes she has attacked people in the street because she thought they were covering their noses when they saw her.

1. I think this woman's situation is a problem to be concerned about.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

2. I think this woman's situation is serious.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

3. I think this woman has a psychological problem.

Strongly Agree (1)	Agree (2)	Disagree (3)	Strongly Disagree (4)
____	____	____	____

4. I think this woman should seek some help for her problem.

Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
____	____	____	____

5. Which of the following activities would you suggest that this woman do to assist her in her situation? Check as many activities as you think are appropriate for the problem.

___ Talking with a social worker.
___ Resorting to sleep.
___ Talking with a spouse.
___ Visiting a mental health clinic.
___ Seeking recreational activities (such as joining a club, going shopping, going to the movies, etc)
___ Traveling
___ Consulting a psychiatrist.
___ Consulting a general practitioner
___ Praying/appealing to God
___ Talking to a clergy person
___ Talking to a friend
___ Seeking inpatient therapy at a psychiatric hospital.
___ Talking to a nurse
___ Talking to a family member
___ Talking to a psychologist

APPENDIX C

DISCLAIMER

SUBJECT DISCLAIMER FORM

STUDY: Cross Culture Gender Differences on Evaluation of Women's Psychological Needs

You are being asked to participate in a study exploring the effect of cultural differences as well as gender differences on the evaluation of Arabic and American women's psychological needs. The purpose of this study is to increase understanding of the influence of culture and/or gender on the appraisal of women's psychological problems as well as the recognition of their treatment.

You are being asked to answer a questionnaire about women's daily life situations. You will be asked to judge whether or not these life situations are problematic. This will take approximately 45 minutes.

There are no hazards or costs to you as a result of participation in this study. Your name is not on the questionnaire, and you may choose not to answer some or all of the questions, if you desire. Please feel free to ask questions regarding the study, and know that you are able to withdraw from the study at any time. Whatever your decision, there is no risk involved.

By responding to this questionnaire you will be consenting to participate in the study. All information will be treated with anonymity and confidentiality. Thank you for your willingness to participate. Again, please feel free to ask questions, comments, or concerns regarding the study.

Signed: _____

Nefissa M. Abdel Kader
Doctoral Candidate
College of Nursing
University of Arizona

APPENDIX D

HUMAN SUBJECTS APPROVAL

THE UNIVERSITY OF ARIZONA
TUCSON, ARIZONA 85721

COLLEGE OF NURSING

MEMORANDUM

TO: Nefissa M. Abdel Kader
Graduate Student
College of Nursing

FROM: Ada Sue Hinshaw, PhD, RN ASH
Director of Research

Linda R. Phillips, PhD, RN
Chairman, Research Committee

DATE: May 20, 1986

RE: Human Subjects Review: Cross Cultural Gender Differences on Evaluation of Women's Psychological Needs

Your project has been reviewed and approved as exempt from University review by the College of Nursing Ethical Review Subcommittee of the Research Committee and the Director of Research. A consent form with subject signature is not required for projects exempt from full University review. Please use only a disclaimer format for subjects to read before giving their oral consent to the research. The Human Subjects Project Approval Form is filed in the office of the Director of Research if you need access to it.

We wish you a valuable and stimulating experience with your research.

ASH/fp

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