The purpose of the study was to develop and validate a self-report scale to measure depression in both clinical and non-clinical Pakistani populations. The 72 items obtained from university students were judged for their relevance to depression by psychiatrists and clinical psychologists. An approximate 50% consensus among judges was taken as the selection criterion. The 36 items so obtained were split into two equivalent halves and tested on clinical as well as non-clinical populations. The split half reliabilities of the scale with Spearman-Brown correction were $r = 0.79$ and $r = 0.84$ for the clinical and $r = 0.80$ and $r = 0.89$ for the non-clinical samples respectively. The Alpha coefficients for the clinical and non-clinical samples were 0.91 and 0.89 respectively. The scale correlated significantly with Zung's Depression Scale, $r = 0.55$ ($p < .001$) and psychiatrists' ratings of depression $r = 0.40$ ($p < .05$). The scale showed a significant correlation with subjective mood ratings for the clinical group $r = 0.54$ ($p < .001$) as compared to the non-clinical group $r = 0.14$ ($p < .ns$). The scale also demonstrated high sensitivity and specificity. The percentiles and cut-off scores for the clinical as well as non-clinical groups have been determined.

**Siddiqui–Shah Depression Scale (SSDS): Development and Validation**

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The psychological concept of depression has been variously described as having the blues, feeling sad, guilty, hopeless, help-

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less and melancholy and as reacting to the grief of losing some loved object. It is also described as a feeling state or symptom, a syndrome or reaction, a characteristic or lifestyle, and/or an illness (Schuyler, 1974). Some researchers have adopted an operational approach to the definition and subsequent classification of depression (Depue & Monroe, 1978; Spitzer, Sheehy, & Endicott, 1977). The most prevalent definition is that of a dysphoric (chronic) feeling of illness and discontented mood and/or a pervasive loss of interest which is characterised by certain symptoms (Spitzer, Sheehy, & Endicott, 1977). These and other similar definitions of depression are the result of work on the conceptualisation of depression and the development of instruments for its assessment primarily carried out in the West. Assuming the universality of psychological disorders, such as depression, these instruments can be used in other cultures, which have a different outlook than the Western one. However, one cannot ignore errors in assessment stemming from the total disregard for local values and norms. One way of overcoming such errors is to adapt and standardise the instrument before using it in cultures other than where it was developed. Such attempts, too, have their limitation as cultures differ not only with respect to their norms and values but also in terms of their lexical categories for emotions (Russell, 1991). Emotional experiences and their expressions are determined to a great extent by the words available in a particular language. The basic categories of emotion may be pan-cultural but the expression varies with the degree of permissiveness in a culture along with the available distinct lexical categories. For instance, Muslim societies impose religious restrictions on the expression of sexual desires. The lack of sexual experiences, therefore, in the case of unmarried persons, especially women, renders the items attempting to measure a decrease in libido or sexual feelings as an indicator of depression, irrelevant.

Cross-cultural research has yet to emphasise the peculiarity and complexity of cultural meanings associated with psychological disorders by lay persons. There appears overwhelming concern to adapt Western models of psychological disorders while disregarding the more local nuances of emotional and other experiences. Such an approach poses both methodological problems as well as problems of validity due to difficulties in linguistic and conceptual translation in representing illness episodes as meaningful
social events. Therefore, to make the analysis and conceptualisation of a disorder more universal, credence must be given to the conceptual organisation of cultural knowledge of that disorder. That is, to discover how a lay person talks about his illness in a social as well as a personal context. This emphasis becomes critical with reference to the assessment of depression. Despite its universality, the manifestation of depression may vary across different cultures as the expression of emotion is determined both by the language and conceptual organisation of the disorder. For instance, psychological and mental symptoms are reported to be less prominent (and/or less differentiated) in certain non-Western societies than somatic symptoms (Marsella & White, 1984). In non-Western cultures, there is a tendency among depressives to somatise their illness (Nijdam, 1986; Sethi, 1986) either due to illiteracy or lack of awareness as well as lower acceptability of psychological disorders in these cultures (Shah, 1993). In addition to this, a difference in value orientation may determine specific predictors of depression as well (Aldwin & Greenberger, 1987). For instance, due to differences in intrinsic cultural values Japanese university students obtained higher scores on self-report of depression as compared to their American counterparts (Baron & Matsuyama, 1987). With regard to traditional Muslim societies one significant difference is in terms of suicide ideation, which is generally regarded as a taboo (Shah, 1993) and, therefore, may not be an appropriate measure of depression.

Moreover, the suicidal ideation of depressives may have no correspondence with the actual proportion of suicides committed (Venkoba Rao, 1978) which may be a mere desire to be dead. Such differences in value structure across cultures and the documentation of culture specific contents of emotion have highlighted the need to develop indigenous norms and culture relevant operational definitions of psychopathology.

The present study was carried out to realise this need in the context of Pakistani culture, which is rather unique in its composition. The complex intermingling of religious dictates and social values influences the individual's attitude and thought pattern toward distressing situations. Often religious considerations come into conflict with the more pressing social values. In a culture where long-standing values are giving way to more materialistic pursuits, the class structure has been undergoing rapid change.
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English Translation of Siddiqui-Shah Depression Scale (SSDS)

This questionnaire describes the thoughts and feelings of an individual. The four columns against each statement reflect the various degrees of these thoughts and feelings. You are requested to read each statement carefully and indicate how much they apply to you with the help of given columns. For instance, if a statement 'never' applies to you indicate it by putting a (/) correct sign in the first column. If the statement stands true for you 'all the times', put a mark in the last column. Likewise use other columns as well.

Never  Sometimes  Often  All the times

1. I have become very hopeless.
2. I feel myself confused.
3. I am very unfortunate.
4. I have almost lost my appetite.
5. My prayers do not get answered.
6. I have differences with my parents.
7. People always criticise me.
8. I feel like crying aloud.
10. I am being punished for my deeds.
11. My heart starts pounding suddenly.
12. Success and failure depends upon kismat (luck).
13. My life is reaching its end.
14. I am haunted by the feeling of having lost something.
15. I lack something.
16. I feel myself as worthless.
17. Others always dominate me.
18. I get anxious easily.
19. I hate my life.
20. I feel lonely.
22. I am a useless person.
23. I have many flaws.
24. Friends do not understand my feelings.
25. I lose heart very quickly.
26. I am incapable.
27. I am inferior to others.
28. I have lost zeal of life.
29. I am a detestable person.
30. My friends seem selfish to me.
31. The memories from the past make me sad.
32. My sleep is disturbed.
33. I am very hopeless about my future.
34. I do not come up to my parents’ image of an ideal child.
35. Most of the people are not trustworthy.
36. I intensely wish for death.

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