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Life events, difficulties and depression among women in an urban setting in Zimbabwe

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ABSTRACT

Background. A previous paper (Abas & Broadhead, 1997) reported that among 172 women randomly selected from a Zimbabwean township 30·8% had a depressive or anxiety disorder during the previous year. Compared with London, the higher annual prevalence of disorders in Harare could mostly be accounted for by an excess of onset cases in the study year (annual incidence of depression 18%). This paper reports on the role of life events and difficulties in the aetiology of depression among these women.

Method. Randomly selected women ($N = 172$) from a township in Harare were interviewed with a Zimbabwean modification of the Bedford College Life Events and Difficulties Schedule (LEDS).

Results. Events and difficulties proved critical in provoking the onset of depression in Harare. Far more events occurring in Harare were severe or disruptive. Furthermore, a proportion of the Harare severe events were more threatening than have been described in London. As in London, certain types of severe event were particularly depressogenic, i.e. those involving the woman's humiliation, her entrapment in an ongoing difficult situation, or bereavement. However, more severe events in Harare involved these specific dimensions.

Conclusions. Results indicate a common mechanism for the development of depression, as defined by international criteria, between Zimbabwe and London. The high frequency of severe events, and their especially adverse qualities, offer an explanation for the high incidence of depression in Harare.

INTRODUCTION

We have previously reported an 18% annual incidence of depression, double that found in inner London, among a randomly selected community sample of women from a township suburb of Harare (Abas & Broadhead, 1997). Although diagnostic criteria were based on symptoms derived from a Shona translation of the Present State Examination (PSE) (Wing *et al*. 1974), recent exemplary ethnographic and qualitative research has confirmed the relevance of such 'international' symptoms in establishing the presence of locally relevant common mental disorders in Harare (Patel *et al*. 1995*a*, *b*). For the present study, open interview techniques prior to PSE assessment allowed women to describe symptoms in their own terms and to ascribe causal explanations for these (Abas & Broadhead, 1997).

In Western settings a substantial proportion of onsets of depression are preceded by a life event (Paykel & Cooper, 1992). Brown *et al*. (1995) have shown that it is severe events involving the woman's humiliation, or her entrapment in an ongoing difficult situation, which are especially associated with onset. It was hypothesized that the emotional response of women to life events and difficulties would be much the same in Harare as in London but that the high annual incidence of depression in Harare would be explained by greater social adversity in the society as a whole.

There are obvious problems in eliciting, rating and comparing life events occurring in another culture (Kleinman, 1988). However, compared to some other measurement methods, the Life

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Events and Difficulties Schedule interview (LEDS) (Brown & Harris, 1978) offers advantages. Its semi-structured conversational approach facilitates the collection of a full account of each event and relevant current circumstances. This, together with details of the woman's biography and beliefs allows the 'likely meaning' of an event to be established (Brown & Harris, 1978). Because ratings for each woman (e.g. 'threat' of a particular event) are based on this likely meaning, they can be compared cross-culturally. This paper describes use of the LEDS in Zimbabwe and compares the threat of events and difficulties in Harare with those from the original London (Camberwell) series (Brown & Harris, 1978) and with a rural series from the Basque Country (Gaminde *et al*. 1993). When dealing with the new method of rating humiliation and entrapment for events rated severely threatening, a random series of inner-city women from London (Islington) (Brown *et al*. 1995) is used for comparative purposes.

METHOD

A previous paper (Abas & Broadhead, 1997) describes the random selection of 172 women from a suburb of Harare, the collection of sociodemographic information and the use of the Shona Screen for Mental Disorders, a locally developed and validated 20-item screen for depression and anxiety, followed by a LEDS interview. Using a cut-off of four, the sensitivity and specificity of the screen in detecting psychiatric caseness was 96% and 83% respectively. All those scoring above the cut-off and a random 30% of those scoring below were interviewed with a Shona translation of the PSE (Wing *et al*. 1974) by a psychiatrist (J. B. or M. A.), trained in its use and with a year of prior experience of working through interpreters in Harare.

Caseness was established using Bedford College criteria (Finlay-Jones *et al*. 1980), these being somewhat stricter than threshold level 5 of the CATEGO-ID system and comparable with Research Diagnostic Criteria (Dean *et al*. 1983). For 'case' depression, depressed mood and a minimum of 4 of 10 core PSE symptoms of depression are required. The 1-year prevalence of depressive and anxiety disorders in Harare was 30·8% (95% CI 23·9–37·7) (taking into account the two false negatives found in the second phase interviewing the likely prevalence based on simple use of conditional probabilities is 34% (Pickles *et al*. 1995)). This high annual prevalence was mostly accounted for by the finding that 18% of women (this was twice as high as the prevalence found in London, using the same criteria (Brown & Harris, 1978)) had had an onset of depression (with or without anxiety) in the study year.

Although there may be problems in the transposition of diagnostic criteria from one setting to another (Weiss *et al*. 1992), remarkable similarities have been found in the manifestation of mood disorders across cultures (Beiser *et al*. 1994) with recent work confirming this for the Zimbabwean situation (Patel *et al*. 1995*a*, *b*). As part of the present study, the depressive syndrome was further shown to have local validity in that women with emotional distress volunteered collections of symptoms that were a mixture of core 'Western' features and of symptoms specific to Shona ways of expressing distress, the latter including such idioms as 'thinking too much' and a variety of terms describing heart discomfort (Abas & Broadhead, 1997).

Use of the Life Events and Difficulties Schedule (LEDS) in Zimbabwe

The LEDS includes a semi-structured interview that elicits information necessary for contextual ratings of threat to be made for all events and difficulties occurring in a predetermined time period of a woman's life. For this study, women were questioned to ascertain the life events and difficulties they had experienced during the year before interview or, for those with an onset of caseness of depression in the study year, for up to 6 months before the onset. Contextual threat ratings are based on the notion of the likely meaning of a particular experience to an individual, given her biographical circumstances including her plans and purposes prior to the event. Manuals supply many examples of ratings made in various parts of the world, but largely from studies in Europe. Before use in Zimbabwe, LEDS questions were reframed to ensure they would be understood and not cause offence. Modifications and additions were made following in-depth interviews and focus group discussions (Khan & Manderson, 1992) with village health workers, traditional healers,

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Zimbabwean sociologists and primary care attenders to ensure: (1) that all relevant events and difficulties in a Zimbabwean woman's life would be likely to be explored; and (2) that once an event had been identified, the information would be gathered to allow its likely meaning, for the particular woman under study, to be ascertained. Thus, questions were added in all nine broad domains of the LEDS e.g. work, housing, partner relationship, etc.

In the health domain, for example, questions were added about the outcomes of visits to traditional healers (*ngangas*) or faith healers (e.g. apostolic prophets). In the case of events involving infertility, such as a miscarriage in a childless woman, questioning had to establish: (1) the woman's own desire to have a child; (2) the effect not having a child would be likely to have on the marital situation (e.g. whether the husband might divorce her, as traditionally he is entitled to do); (3) the attitude of the woman's in-laws (e.g. active criticism); and (4) the everyday embarrassment of having no child. Women, for instance, are referred to socially as the 'mother of' their eldest child. In the marital section of the LEDS women were questioned as to whether the bride price (*lobola*) had been paid for them and, if not, how they and their family felt about this; about their sexual relationship, their knowledge and fears about sexually transmitted disease, including AIDS; if the woman was in a polygamous marriage about the advantages and disadvantages of having a husband with other wives. Elsewhere, questions were added about relationships within the extended family and to explore issues arising from having duties in both rural and urban homes. Questions were added to cover 'traditional' events such as spiritual ceremonies and accusations of witchcraft. A series of probes was used to gain insight into potential supernatural explanations and implications of each event or difficulty. (A full version of the Zimbabwean LEDS is available from the authors.)

Interview and 'consensus meetings'

Each interview was carried out by one of a team of four Zimbabwean Shona-speaking women, all with a background in psychiatry or the social sciences and trained in the LEDS (two trained at Royal Holloway College, Bedford Square, University of London). Regular workshops were held to maintain reliability and review the cultural relevance of schedule questions.

Interviews, arranged for when relatives were not present, were mostly tape-recorded and took 1–3 hours, often needing two or more visits. Dates of events were established in relation to one another, to national events and seasons and, crucially, to the onset of caseness, with probes asked in the direction contrary to the hypothesis at issue (i.e. 'Could it be that you began to feel sad/think too much *before* your husband lost his job?').

The interviewer presented a brief 'sketch' of the subject, followed by a detailed vignette of each of her events and difficulties, at a consensus meeting at which team members, who were blind to the woman's mental state and to the woman's reported reaction to the event, made independent ratings of threat of each event or difficulty. Any rating difference was discussed and a consensus rating agreed. Women were revisited if information needed clarification before a rating could be agreed.

Community preparation

The joint research/health team met with suburb representatives e.g. councillors, priests, police, healers, and with women's organizations, to gain their support for the research and obtain advice about interviewing. All approached were supportive. Addresses from the random sample were located with the help of local housing officers whose involvement reassured householders that the study had community approval.

METHOD

Definitions

A 'severe event', as in other research using the LEDS, refers to an event scoring 1 or 2, on a 4-point scale of long-term threat (i.e. at 10–14 days) which is focused on the subject or on the subject jointly with another person. A 'major difficulty' is a difficulty scoring 1, 2 or 3, on a 7-point scale of severity, which has lasted at least 2 years.

Classification

Each event or difficulty was classified into one of the nine main domains such as 'work' or

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'partner relationship'. Also each event was identified as 'regular' (e.g. birth, marriage), 'irregular' (e.g. job loss, premature death) or 'disruptive' (e.g. marital crisis, shocking revelation about someone close) (Prudo *et al*. 1984).

Threat

(*i*) '*Zimbabwe*' versus '*London*' *ratings*

In view of the possibility that there might be systematic differences in threat ratings in the Zimbabwean situation, two separate contextual threat ratings were made for each event and difficulty. The 'London' rating was based on the likely meaning of the same event occurring to a 'London' woman, following the examples in the LEDS manual. The 'Zimbabwe' rating for the event was made using the principles outlined in the LEDS manual, but: (*i*) requiring full consideration of local factors in understanding the explanation and implications of the event; and (*ii*) demanding a consensus with LEDS-trained Zimbabwean raters, as a means of accounting for the Zimbabwean woman's likely interpretation of the event or difficulty.

(*ii*) *Severity of threat*

The usual 4-point rating scale for threat of events ('4' (little or none) to '1' (marked)) was extended to include a '1 plus' rating for events in which the threat was clearly greater than that previously encountered in studies using the LEDS in the UK. Examples of events rated '1 plus' for threat are shown below.

Case 1 Subject is aged 43, married with nine children. She works informally roasting maize cobs to sell at beerhalls. The family just afford basic food and government schooling costs. The event is her husband's death. His company refuse her access to his pension unless she can persuade a male elder from his family to claim it. His family live 200 miles away and she has no money for the bus-fare. The children are subsequently dismissed from school for non-payment of fees. They are living on one small meal a day.

Case 2 The subject is aged 40, is the second wife in a polygamous marriage. Her 9-month-old baby has just died after a long illness and her husband has early AIDS. The event is the husband blaming her for the baby's death. Over the next 10 days, she is beaten by him and given a black eye, obvious at the funeral. She is excluded from traditional healer consultations at which she is blamed for causing the child's death through negligence.

Loss and danger

Severe events were rated for the amount of loss or disappointment already entailed (loss rating) and for the likelihood of specific future crises occurring as a result of them (danger rating) (Finlay-Jones & Brown, 1981).

Humiliation and entrapment

Severe events (or a sequence of related severe events, e.g. row with landlord followed by eviction) were also rated to reflect their quality on a 'humiliation/entrapment/loss/danger' scale (Brown *et al*. 1995). This 9-point scale is hierarchical, putting severe events associated with three types of subject's humiliation at points 1, 2 and 3, above events confirming her entrapment in an ongoing difficult situation, at point 4 (see examples below). Both 'humiliation' and 'entrapment' events take priority over severe events involving loss or danger without humiliation or entrapment. Death and stillbirth events are at point 5, and all others involving loss alone or danger alone at points 7–9. Examples of 'humiliation' and 'entrapment' are shown below.

(*a*) *Severe event rated as* '*humiliation*'

Case 3 The subject is aged 43, happily married for 26 years. She lives between Zambia, with her four children and Harare, where her husband's business is. The event is returning to Harare to find her husband living with a young woman. She is forbidden entry to her own home and has to return to Zambia.

(*b*) *Severe event rated as* '*entrapment*'

Case 4 The woman is aged 19, married for 18 months. She lives with her husband in three rooms. Since two brothers-in-law moved in 7 months ago there has been tension as one of them bullies her when her husband is out. The event is his threatening to hit her for the first time. Despite her pleading, the husband gives no promise that he will ask his brother to leave.

RESULTS

Response rates

An earlier paper describes the random selection of 181 women, a take-up rate of 95% (five were never found, two completely refused and two interviews were discarded because women were subsequently uncooperative) and the socio-demographic associations with depression

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(Abas & Broadhead, 1997). Sixty-seven per cent of women were interviewed at least twice and of these 75% were seen on three or more occasions.

1 Life events and difficulties in a 1-year period for the total sample ($N = 172$)

(i) Severe events and major difficulties in the Zimbabwean context

In terms of the critical distinction between events rated severe or non-severe for long-term contextual threat, a total of 202 events were rated severe and 607 non-severe in the Zimbabwean context. Sixty-five major and 379 non-major difficulties were recorded.

It will be recalled that both 'London' ratings of threat and parallel ratings from a 'Zimbabwe' perspective were made. Only 9/202 (5%) of events rated severe in the Zimbabwean context would have been rated non-severe for a 'London' woman. Most of these differences were due to the presence of beliefs in Zimbabwe concerning supernatural implications of, for example, accidents or illness. Of events rated non-severe for the Zimbabwean context, 31/607 (5%) would have been rated severe for a 'London' woman (see Discussion).

For major *versus* non-major difficulties, three of the 65 (5%) rated major for Zimbabwe were given a non-major 'London rating' and 16 of the 379 (4%) of those rated non-major for the Zimbabwean context were given a major 'London rating'.

Although differences between the two approaches are small, henceforth, analyses utilize Zimbabwean ratings.

(ii) Self-reported threat of life events

Ten per cent (20/202) of events rated severe contextually were reported as not markedly threatening by the subject. Less than 1% (3/607) were reported as markedly threatening when the contextual rating was non-severe.

(iii) Classification of severe events and major difficulties

Forty-four per cent of severe events involved marital or other relationship crises. A further 18% were deaths of close ties, 10% an accident or illness, 8% reproduction or infertility and 8% housing problems including seasonal moves between the rural and the urban home with their attendant separations and changes in obligations. Most major difficulties involved either a marital relationship (26%), low income (24%), a non-partner relationship (19%), or, poor housing (15%).

Table 1. *Percentage of women who in a 1-year period experience at least one: severe event; major difficulty; or, severe event or major difficulty (i.e. a provoking agent), in Harare, Camberwell (London) and Ayala (Basque Country)*

	At least one severe event (A) % (CI)	At least one major difficulty (B) % (CI)	Any provoking agent, i.e. either A or B % (CI)
Harare ($N = 172$)	54 (47–62)	29 (22–36)	63 (56–70)
Camberwell (London) ($N = 458$)*	31 (27–35)	22 (18–26)	48 (43–53)
Ayala (rural Basque Country) ($N = 169$)†	16 (11–22)	17 (12–23)	30 (23–37)

* Brown & Harris, 1978.
† Gaminde *et al.* 1993.

(iv) Severe events rated '1 plus' on threat

Six per cent (13/202) of severe events in Harare were considered particularly extreme (i.e. scored '1 plus'). No events recorded in the London (Camberwell) series were as threatening in contextual terms (T. O. Harris, personal communication). It is noteworthy that 10 of the 13 '1 plus events' in Harare involved humiliation or entrapment (see below).

(v) Rates of severe events and major difficulties in three populations

Fifty-four per cent of women in Harare experienced a severe event in a 1-year period. Table 1 shows that this compares with 31% in Camberwell (OR 2·6; $P < 0·001$) and 16% in Ayala, a rural Spanish-speaking area in the Basque Country (OR 6·2; $P < 0·001$). Women in Ayala (OR 2·0; $P < 0·01$), but not in Camberwell, had fewer with at least one difficulty than those in Harare.

(vi) Rates of regular, irregular and disruptive severe events in three populations

The annual rates per 100 women of regular severe events in the three populations was similar

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(Harare, 29; London, 21; Ayala 20). However, irregular and disruptive severe events were very much higher in Harare (47 and 40 respectively) compared to London (21 and 10 respectively) and Ayala (6 and 2 respectively) (Prudo *et al*. 1984; Gaminde *et al*. 1993).

2 Severe events, major difficulties and the onset of depression (excluding cases with an onset before the beginning of the study year and those depressed at a caseness level for over 12 months)

(*i*) *Population attributable risk*

Table 2 shows that, in Harare, 26% (13/50) of women who had a severe event without a major difficulty became depressed within 6 months and 13% (1/8) who had a major difficulty alone became depressed. The proportions in London (Camberwell) are remarkably similar. However, given the joint presence of a severe event and a major difficulty, more women in Harare (55%) than in Camberwell (28%) became depressed. Logistic regression indicates that, in Harare, severe events and major difficulties are both independently associated with onset (effect of severe events adjusted for major difficulties: OR 31·5, $P < 0·001$; effect of major difficulties adjusted for severe events: OR 7·8, $P < 0·001$).

Ninety-four per cent of onsets in Harare were preceded by a severe life event.[1] The population attributable risk for severe events (i.e. the link allowing for the chance association of severe events and onset) (Brown & Harris, 1989) was 0·89, i.e. 89% of cases had a severe event of aetiological importance. If major difficulties are taken into account this estimate increases to 94%.

(*ii*) *Onset following events rated '1 plus' on long-term contextual threat*

Seventy-one per cent of women (5/7) having an event rated '1 plus' on threat compared with 31% (25/80) of the rest with a severe event or major difficulty became depressed ($P = 0·045$, Fisher's Exact Test, 1-tailed).

(*iii*) *Classification of pre-onset events*

Forty-two per cent (12/29) of pre-onset severe events in Harare were marital or other relationship crises. Twenty-four per cent (7/29) were deaths and 17% (5/29) were events directly related to infertility or to an unwanted pregnancy. Of the 31 women with an onset of depression three became depressed within 3 months of having a baby, and two of these births had, in fact, been characterized as the severe event preceding onset.

(*iv*) *Pre-onset events and clinical features of depression*

There was no association between the degree of threat conveyed by the pre-onset event and the severity of illness, as measured by the Index of Definition (Wing *et al*. 1974). More (85%: 24/28) pre-onset severe events in Harare than in Islington, London (26%) were associated with severe danger (OR 17·3, CI 3·9–83·8) but a similar proportion in Harare (85%) and Islington (74%) involved severe loss. Levels of danger and loss were not associated with severity of depression or with the co-morbidity of anxiety or the severity of any anxiety.

3 Rating of severe events using categories of humiliation, entrapment, bereavement, or other loss/danger (excluding cases with an onset before the beginning of the study year and those depressed at a caseness level for over 12 months)

It will be recalled that severe events were classified in addition in terms of their quality on the hierarchical humiliation/entrapment scale. As in the London series, for non-depressed women all severe events in the study year are included and for onset cases, only severe events occurring in the 6 months preceding onset (Brown *et al*. 1995). The number of severe events under consideration for the Zimbabwean sample of women is hence 116.

Table 3 shows that women in both Harare and Islington were far more likely to become depressed following severe events involving humiliation, entrapment or bereavement than following events with loss or danger but without these added qualities (Harare, OR 4·1, $P = 0·004$; Islington, OR 9·6, $P < 0·001$). (Where there was more than one severe event in the defined pre-onset period both in Harare and Islington only the severe event (or related sequence of severe events) nearest to onset was taken for this analysis.) In both settings, most events provoking depression involved humili-

[1] Vignettes of all pre-onset events are available from the authors.

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Table 2. *Proportion of women becoming depressed in the 6 months following at least one severe event or major difficulty, in Harare and Camberwell (London)*

	Severe event alone % (CI) *N*	Major difficulty alone % (CI) *N*	Severe event and major difficulty % (CI) *N*	Neither % (CI) *N*
Harare	26% (15:40) 13/50	13% (0:53) 1/8	55% (36:74) 16/29	2% (0:8) 1/64
Camberwell (London)*	23% (14:35) 15/65	18% (8:31) 9/51	28% (14:47) 9/32	2% (0:4) 4/271

* Brown & Harris, 1978.

Table 3. *Proportion of women becoming depressed following severe events in the different categories of the humiliation/entrapment/bereavement/other loss/danger scale in Harare and Islington (London)*

Event category	Harare % (CI) *N*	Islington (London)* % (CI) *N*
1 Humiliation or entrapment	38% (25:53) 20/52	32% (24:40) 41/128
2 Death (not 1)	23% (8:45) 5/22	29% (13:51) 7/24
3 Other loss (not 1 or 2)	13% (3:34) 3/23	5% (2:11) 7/129
4 Danger (not 1, 2 or 3)	5% (0:26) 1/19	3% (1:10) 3/89

* Brown *et al.* 1995.
Chi-square statistic: no differences significant at 0·05 level.

ation or entrapment. However, Table 4 shows that, compared with Islington, a greater proportion of severe events in Harare following the hierarchical scale involved either the woman's humiliation, her entrapment in an ongoing difficult situation, or the death of a close tie (Harare, 74/116, 64%: Islington, 152/370, 42%; OR 2·5; $P < 0·001$).

DISCUSSION

Having previously reported an 18% annual incidence of depression among women in a Harare township (Abas & Broadhead, 1997), approaching double that found using comparable methods in inner London (Brown & Harris, 1978), we have now established that both severe events and major difficulties were critically related to the onset of depression in Harare (Table 2).

The population attributable risk for severe events was 89% (increasing to 94% when major difficulties were taken into account), this being remarkably similar to that in Western populations (Brown & Harris, 1989). Further-

Table 4. *Proportion of all severe events occurring in the different categories of the humiliation/entrapment/bereavement/other loss/danger scale in Harare and in Islington (London)*

Event category	Harare *N* % (CI)	Islington (London)* *N* % (CI)	Differences in proportions % (CI)	*P*†
1 Humiliation or entrapment	52/116 45% (36:54)	128/370 35% (30:40)	10% (0:21)	0·05
2 Death (not 1)	22/116 19% (12:26)	24/370 7% (4:10)	13% (5:20)	0·001
3 Other loss (not 1 or 2)	23/116 20% (13:27)	129/370 35% (30:40)	−15% (−24:−6)	0·01
4 Danger (not 1, 2 or 3)	19/116 16% (10:23)	89/370 24% (20:28)	−8% (−16:0)	NS

* Brown *et al.* 1995.
Events treated as independent for this analysis, χ^2 test was used.

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more, three types of severe event particularly associated with a high risk of onset, i.e. those concerning a woman's humiliation, her entrapment in severe ongoing difficulty, or with the death of someone important to her, were as equally likely to provoke depression in Harare as they have been shown to in London (Table 3) (Brown *et al*. 1995). Significantly more severe events in Harare involved these adverse dimensions (Table 4).

It may be surprising that 95% of selected women complied with the intrusive questioning involved in this study. It should be noted, however, that interviewers were chosen for their skills in encouraging co-operation and eliciting sensitive information and that this approach was enhanced through training. Women knew the study had approval from local community leaders and had faith in the confidentiality and goodwill of university and health care staff. They were often revisited even between interviews enabling trust to be gained and a small gift was given whenever a second or subsequent interview took place. Perhaps at least partly as a result of these measures, most welcomed the opportunity to talk about their lives. Less than 1% of events rated contextually as non-severe were self-reported as markedly threatening, suggesting that women did not tend to over-report the unpleasantness of the stressors they had faced. While 10% of events rated severe contextually were reported as not severely threatening by the woman, this is very similar to the difference between contextual and self-reported ratings made in other studies using the LEDS (Brown & Harris, 1978).

One possible explanation for the high rate of severe events is that they were over-rated in contextual terms, based on Eurocentric attitudes. While there are problems in importing a European approach to measurement, we made no prior assumptions about equivalence of meanings or explanatory models. The LEDS was extensively modified and piloted prior to use in Harare with questions added in all nine domains of the interview that were designed to gain insight into possibly locally relevant implications of each event and difficulty. Consensus threat ratings were made at meetings with LEDS-trained Zimbabwean raters who were blind to the woman's mental state and to the woman's own view of the threat that the event posed. Indeed, the exercise of making separate 'Zimbabwean' and 'London' threat ratings facilitated discussion of potential cultural differences for each event under consideration. Even so, only 5% of non-severe Zimbabwean events were ascribed a severe 'London' rating i.e. given the hypothetical situation that they had occurred to a 'London woman'. While this raises the possibility that contextual threat in Zimbabwe was over-rated for a small number of events, essentially the same set of results as those reported occurred when 'London' rather than 'Zimbabwe' threat ratings are used.

Although only a small proportion of events rated severe or non-severe in Zimbabwe were given a critically different 'London' threat rating, the cross-cultural differences illustrate where and how divergences occur. Most of the events that were severe in Zimbabwe but non-severe in London could be accounted for by the contextual consensus ratings taking account of the widespread beliefs in witchcraft and in the power of the spirit world, leading certain illnesses without medical explanations and events such as lightening strikes on one's house to be rated as severe with high levels of danger. Reasons for some events being rated more severe in London included more acceptance in Zimbabwe of difficult living conditions such as overcrowding or having to travel long distances for work; the greater value of having many children, despite housing or other difficulties, given that they are viewed as enhancing a woman's status, providing insurance for the future, and aiding spiritual development; the ability for certain customs to ameliorate difficult situations, e.g. the use of a ritual form of elopement to reduce the stigma of a young daughter's illegitimate pregnancy; and the greater acceptance of a woman's subjugation and of her obligations to her husband and family e.g. accepting a husband's infidelity in situations where his behaviour is otherwise 'fair' and he maintains family financial support.

It is likely though, that our estimate of the rate of major difficulties was too conservative. It proved harder to make cross-cultural appraisals of ongoing deprivations than of life events. For example, for financial circumstances, definitions were made of what were believed to be culturally appropriate 'translations' of the LEDS manual (e.g. 'luxury' in Zimbabwe would be having sugar and meat every day rather than, as in

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London, a car or a holiday abroad) but less tangible attributes, such as the insecurity associated with having no savings, or little access to welfare assistance in times of hardship were almost certainly underestimated.

However, even given this probably conservative bias compared with women in London, women in Harare encountered many more severe events, many more events involving humiliation and entrapment and many more irregular and disruptive severe events (and the differences were even greater with a Spanish-speaking Basque rural sample of women). Many severe events in Harare reflected the high levels of physical illness and premature death in family members, the predicaments associated with seasonal migration between rural and urban homes, problems associated with infertility and the large number of marital and other relationship crises. Six per cent (13/202) of severe events were rated contextually as more threatening ('1 plus') than severe events encountered in the original Camberwell series. Such '1 plus' events typically included extreme loss and powerlessness to resolve the situation, with all but three involving humiliation or entrapment. Some had a quality, from a European perspective, of the woman falling through a trapdoor totally out of a range of expectations arising from her everyday life. This was obviously in part a consequence of lack of an adequate welfare safety net or the difficulty, for often poorly educated women, to gain access to the legal system (Stewart *et al*. 1990). Such '1 plus' events were almost twice as likely to provoke onset as severe events not rated '1 plus'.

As in London severe events involving humiliation, entrapment and bereavement were particularly likely to provoke a depression onset. The proportion of severe events involving humiliation, entrapment or bereavement was much higher in Harare than in London, and it is striking that women in Harare were as likely as women in London to become depressed following these events. Although the Zimbabwean context could influence what made, for instance, an event humiliating, or an ongoing situation particularly entrapping, we have found no evidence that cultural differences between Harare and London modify the core emotional response to the central meaning of such events. It would seem that despite some differences in how depression, as defined by international criteria, is expressed between Zimbabwe and London (Abas & Broadhead, 1997), there lies a common mechanism for its development. A theoretical explanation for the particularly potent effect of humiliation and entrapment, for which there are correlates in ethological research (Gilbert, 1992), is that these meanings specifically trigger what at some time in our evolutionary history has been an adaptive depressive response to powerlessness and defeat (Brown *et al*. 1995).

A future paper reports on factors that confer vulnerability to the development of depression in Harare following severe life events.

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