THE PSYCHOLOGICAL HEALTH & WELLBEING OF SOUTH ASIANS WHO MIGRATE TO THE UK

Romana Farooq, Imran Abbas

INTRODUCTION

International migration has now become a norm and in the UK alone there were over 105.2 million admissions by the year end September 2011, an increase of 2% from the following year[1]. Asian and Asian British people represent more than 50% of the ethnic minority population in the United Kingdom[2]. South Asians therefore constitute UK's largest ethnic minority group[3]. The term 'South Asian' is mainly used to refer to people whose cultural or familial backgrounds originate from India, Pakistan, Bangladesh, Sri Lanka and East Africa[4]. Pakistani migrants are ranked the second largest migrant group to the UK, where as Indian migrants are ranked fourth[5]. Overall there are more than 2.3 million South Asians in the UK[4] and their health and wellbeing is of an increasing concern.

There is growing evidence to suggest that Ethnic Minorities in the UK are suffering from increasing mental health problems and that they are over-represented in secondary services[6] Moreover rates of recovery are low and drop-out rates exceedingly high[7]. The present article looks at the current literature on the mental health of South Asians who have migrated to the UK and highlights implications for services and policy.

Mental Health Status of South Asians in the UK

The mental health status of South Asians is of much academic and clinical interest, stimulated most recently by UK Government Initiatives, such as the Department of Health 'Delivering Race Equality: A Framework for Action'[8] for mental health services which emphasised the importance of addressing the mental health needs of Black and Minority Ethnic (BME) groups in the UK. Moreover people from BME groups are known to be at risk of inequitable access to healthcare[9]

Early epidemiological research on South Asians in the UK suggested lower levels of psychopathology in comparison to the general population[10,11]. This evidence was based primarily on community surveys such as Cochrane's[11] study which looked at admission rates across England and Wales and found lowers rates of admission for Pakistani and Indian women. However this study was methodologically flawed in that almost 30% of the patients whose place of birth was not recorded on admission were treated as UK born.

Romana Farooq: Clinical Psychologist in Training (B.Sc, MBPsS), University of Leeds, UK
Imran Abbas: General Practitioner in Training (MPharm, MBChB), Mid Yorkshire Hospitals NHS Trust, Dewsbury & Hospital, UK.
Correspondence:
Romana Farooq
E-mail: romana.farooq@swy

However more recently in light of some of the limitations evident in early epidemiological studies the opposite is now considered to be true especially with methodologically sound research suggesting higher rates of depression and suicidality[3]. Many large scale studies have found Pakistani Muslims to be particularly vulnerable to depression and anxiety[12,13], which may be associated with the recent rise in Islamophobia[14]. In Fazil and Cochrane's[12] study they used the General Health Questionnaire (GHQ-28) to measure the prevalence of depression amongst Pakistani and native white women. They found that Pakistani women had scored higher on the GHQ-28 Sub Scales of severe depression, anxiety, insomnia and somatic symptoms. This is supported by other research which reports higher rates of depression in Pakistani women and lower rates in Indian women[4].

Furthermore it is now generally a well-documented statistic that South Asian women are two to three times more likely to commit/attempt suicide and self-harm in comparison to their white counterparts[15,16]. Reasons for this increase in suicidal behaviour have been attributed to socio-cultural and negative social factors[17]. Likewise the prevalence of eating disorders have been reported to be much higher in South Asian Women[4]. In one study conducted in a mixed-sex school in East London exploring the prevalence of bulimic symptomatology, it found higher rates of clinical bulimia in South Asians (regardless of gender) compared to any other group[18].

Though there has been recent increase in research dedicated to exploring and investigating the mental health of South Asians in the UK, the results are not being replicated in Primary and Secondary Care Services. This is apparent with the current lack of referrals of South Asians to specialist mental health services regardless of the fact that they are frequent attendees in Primary Care[7]. This lack of recognition in Primary care settings may be because the language in which people of different cultures communicate distress varies considerably, and can include both somatic and psychological symptoms[19]. However clinical measures of distress in Primary Care often fail to capture somatic symptoms. "Mera Dil Ghirda Hai" or "My Heart is Sinking" is one commonly used physical idiom by Punjabi's to refer to emotional distress[20]. Research has established that South Asian culture, significant somatic symptoms and physical illness carries a large risk of depression among South Asians[5].

Therefore many South Asians will present in Primary care reporting only Somatic Symptoms some of the most common being pain, gastrointestinal problems, arthritis, fatigue etc[5]. Without a thorough understanding of culture

specific manifestations of distress a practitioner is at risk of misdiagnosing or even overlooking signs of a possible psychiatric problem. However if a client is reporting persistent somatic symptoms and is frequently attending their GP surgery with medically unexplained symptoms then there is most definitely a cause for concern of an underlying psychiatric problem.

This recent recognition in the literature of the prevalence of somatic symptoms in South Asian populations has meant that 'Sinking heart' has been included as an item of neurosis and psychological morbidity in some questionnaires and inventories, which can successfully be used with South Asians[21,22].

Exploring the Barriers and Challenges

Clearly there is growing inconsistency in the reported prevalence of mental health problems in South Asian communities. This discrepancy could be attributable to some of the barriers and challenges that surface when working with South Asians.

Firstly culture specific communication of distress such as complaints of physical health problems among South Asians may be one reason for the diminished recognition of mental health problems, as they can mask the real problems[5,23]. To date there is only one published paper looking at the 'Sinking Heart Syndrome'[20], an illness which manifests itself as physical sensations in the heart or in the chest as experienced by Punjabi's in the UK. These culture specific idioms of distress are not picked up in Primary care and neither in secondary care services resulting in lack of referrals to specialist mental health services.

Furthermore linguistic barriers also pose a challenge, many Psychiatric and Psychological Tools are based on westernised frameworks and therefore they fail to capture any meaningful data when applied to South Asians. Nazroo[10] himself acknowledged that in his Survey the use of the Clinical Interview Schedule-Revised (CIS-R) and the Present State Examination (PSE) was not culturally and linguistically appropriate in assessing neurotic disorders in South Asians. Moreover using specific tools such as the Wechsler Adult Intelligence Scale with South Asians in a clinical or research capacity can be an arduous task, mainly because translating the verbal comprehension subtests to adapt them for use with South Asians is virtually impossible[24]. This highlights the importance of selecting appropriate tools when assessing psychological distress in South Asians. In addition the provision of interpreters for South Asians has also been shown to not improve the client-therapist relationship[25], in addition many South Asians feel 'not heard' when having to speak through an interpreter[17].

South Asians whether Pakistani, Indian or Punjabi in general tend to retain their cultural identity irrespective of their current country of residence[26]; this brings forth many complications in Psychiatric Treatment especially if it is based on a Eurocentric Model. Clearly every encounter between a client and a mental health practitioner is a form of cross-cultural knowledge transfer, the mental health practitioner is likely to bring culturally embedded knowledge, attitudes and beliefs to the meeting as is the client. Currently the rigidity of treatment and diagnosis and the stereotypical belief that Western values and knowledge are superior to any other is most likely to be conflicting and therefore will hamper the therapeutic relationship..

So What Now? Opportunities & Directions

Clearly there is a need for Mental Health Practitioners from the West to collaborate with those from developed countries in order to fully understand the contributing factors. In addition it also allows Mental Health Practitioners from developed countries to come across to the West and deliver teaching on cultural sensitivity.

Furthermore Mental Health Service Providers need to move away from the current categorising of South Asians as a Homogenous Group, rather they need to consider each individual separately as a culturally distinct sub-group i.e. you may get Indian-Punjabi and Pakistani-Mirpuri who may differ quite considerably in their practices, values and level of acculturation.

In addition Psychiatry and related disciplines could benefit from a move away from the traditional medical model of treatment and towards a more holistic and culture specific approach. It has been noted that culture specific interventions for treating mental health problems in South Asians have been successful, such as Culturally Sensitive Cognitive Behavioural Therapy[27] and the incorporation of Hakims (Traditional Healers) in to Services[28]. Furthermore adapting current psychiatric tools for use with specific cultures could be beneficial for example when somatic items were introduced to the GHQ-28 it performed much better than when they were omitted[19].

In summary this paper paints a somewhat bleak picture of the Mental Health of South Asians who have migrated to the UK, however this is only so because the mental health of South Asians has only recently been brought on to the agenda. No doubt with the commissioning of more research to investigate factors contributing to the decline of mental health in this community and the implementation of more culturally sensitive practices and interventions a positive change could be made.

REFERENCES

1. National Statistics. Immigration statistics July - September 2012: summary of key facts [Online]. 2012 [cite on 2012 Dec 10]. Available from URL: https://www.gov.uk/government/publications/immigration-statistics-july-to-september-2012
2. Nadirshaw Z. Race, culture and ethnicity in mental health care. In: Newell R, Gournay K, editors. Mental health nursing: an evidence-based approach. 2nd ed. Edinburgh: Chuchill Livinstone Elsevier; 2009. p. 39.
3. Bhugra D, Hicks MHR. Effect of an educational

pamphlet on help-seeking attitudes for depression among British South Asian women. Psychiatr Serv 2004;55:827-9.

4. Anand AS, Cochrane R. The Mental health status of South Asian Women in Britain. Psychol Dev Soc J 2005;17:195.

5. Bhui K, Bhugra D, Goldberg D, Sauer J, Tylee A. Assessing the prevalence of depression in Punjabi and English primary care attenders: the role of culture, physical illness and somatic symptoms. Transcult Psychiatry 2004;41:307.

6. Sproston K, Nazroo J. Ethnic minority psychiatric illness rates in the community (EMPIRIC). London: The Stationery Office; 2002.

7. Bhui K, Bhugra D. Mental illness in Black and Asian ethnic minorities: pathways to care and outcomes. Adv Psychiatr Treat 2002;8:26-33.

8. Health DO. Delivering race equality: a framework for action. UK: Department of Health; 2003.

9. Kovandzic M, Chew-Graham C, Reeve J, Edwards S, Peters S, Edge D, et al. Access to primary mental health care for hard-to-reach groups: from 'silent suffering' to 'making it work'. Soc Sci Med 2011;72:763-72.

10. Nazroo JY. Ethnicity and mental health findings from a national community survey. London: Policy Studies Institute; 1997.

11. Cochrane R. Mental illness in immigrants to England and Wales: an analysis of mental hospital admissions, 1971. Soc Psychiatry Psychiatr Epidemiol 1977;12:25-35.

12. Fazil Q, Cochrane R. The prevalence of depression in Pakistani women living in the West Midlands. Pak J Womens Stud 2003;10:21-30.

13. Sonuga-Barke EJS, Mistry M. The effect of extended family living on the mental health of three generations within two Asian communities. Br J Clin Psychol 2000;39:129-41.

14. Hussain F. The mental health of muslims in Britain. Int J Ment Health 2009;38:21-36.

15. Burr J. Cultural stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression. Soc Sci Med 2002;55:835-45.

16. Raleigh VS. Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales. Ethn Health 1996;1:55-63.

17. Husain M, Waheed W, Husain N. Self-harm in British South Asian women: psychosocial correlates and strategies for prevention. Ann Gen Psychiatry 2006;5:7.

18. Bhugra D, Bhui K. Eating disorders in teenagers in East London: a survey. Eur Eat Disord Rev 2003;11:46-57.

19. Williams R, Eley S, Hunt K, Bhatt S. Has psychological distress among UK South Asians been under estimated? A comparison of three measures in the west of Scotland population. Ethn Health 1997;2:21-9.

20. Krause IB. Sinking heart: a Punjabi communication of distress. Soc Sci Med 1989;29:563-75.

21. Wig N, Verma S. PGI health questionnaire N-1: a simple neuroticism scale in India. Indian J Psychiatry 1973;15:80.

22. Mumford DB, Bavington JT, Bhatnagar KS, Hussain Y, Mirza S, Naraghi M. The Bradford Somatic Inventory. A multi-ethnic inventory of somatic symptoms reported by anxious and depressed patients in Britain and the Indo-Pakistan subcontinent. Br J Psychiatry 1991;158:379-86.

23. Bhui K, Bhugra D, Goldberg D. Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. Soc Psychiatry Psychiatr Epidemiol 2002;37:38-45.

24. Farooq R. Suppressed voices, neglected lives. Psychologist 2012;25:634-5.

25. Neal RD, Ali N, Atkin K, Allgar VL, Ali S, Coleman T. Communication between South Asian patients and GP's: comparative study using the Roter Interactional Analysis System. Br J Gen Pract 2006;56:869.

26. Singh P, Thandi SS. Punjabi identity in a global context. New Delhi: Oxford University Press; 1999.

27. Rathod S, Kingdon D, Phiri P, Gobbi M. Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. Behav Cogn Psychother 2010;38:511.

28. Webb-Johnson A. A cry for change. London: Confederation of Indian Organizations; 1995.