This article reviews the research on the mental health status of South Asian women living in UK. It reports on the findings from epidemiological studies of the prevalence of depression, suicide, parasuicide, deliberate self-harm and eating disorders in this community. Focus is on research studies that describe cultural influences on conceptualisations and expressions of distress, help seeking behaviours and alternative coping strategies. The influence of acculturation and "culture conflict" as they impact upon women's mental health is also highlighted. The review concludes by considering, first, salient cultural and religious concepts identified in studies that may facilitate understanding South Asian women's mental ill health, and second, the urgent need to develop gender, linguistic and culturally sensitive mental health services for women of South Asian origins now citizens of UK.

The Mental Health Status of South Asian Women in Britain: A Review of the UK Literature

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The mental health of South Asian women in Britain has been extensively researched over the past few decades. Much of this interest has been generated from early epidemiological studies which have found certain groups of South Asian women to be vulnerable to elevated risk of psychological morbidity. The interest in the area has been further stimulated by recent UK government initiatives, such as the Department of Health (2003) report “Delivering Race Equality: A Framework for Action”, in which the importance of addressing the mental health needs of Black and minority ethnic groups in Britain was highlighted and targeted as a priority in the provision of appropriate mental healthcare within the National Health Service.

The review first considers the findings from epidemiological studies and critically examines the hypotheses and explanations offered to explain the
seemingly high incidence of mental health problems within this group. Studies reporting cultural influences on conceptualisations of distress, beliefs about causes and cures, help seeking and coping strategies are also presented. Acculturation variables in relation to trends in psychopathology are also considered as these have been reported to affect the mental health status of British South Asian women.

Following Marshall and Yazdani’s (2000) definition, the broad ethnic category of “South Asian” is used to refer to women whose cultural or familial backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka, including people from East Africa.

According to the 2001 Census data, 7.9% (4.6 million) of people living in Britain are from non-white minority ethnic backgrounds. Over 2.3 million of these (4% of the total population) self-identified as having cultural origins in the Indian subcontinent. Within the South Asian group, 1 million people are of Indian origin, 750,000 from Pakistan and nearly 300,000 from Bangladesh. British South Asians are a culturally diverse and heterogeneous population. They include many distinct subgroups (such as Indian-Punjabi, Indian-Gujarati, Pakistani-Mirpuri) and have their own languages, religions, dietary practices and migration histories. Within each group, there are wide variations in terms of educational level, familial income, geographical area and level of acculturation.

**Mental Health Problems**

**Prevalence Rate**

Early epidemiological studies of South Asian women living in Britain suggested lower rates of psychopathology in this community than in the indigenous population (Cochrane & Stopes-Roe, 1977; 1981). However, there is now considerable evidence suggesting a higher prevalence of mental health problems among these women in certain domains, such as, depression, suicide, deliberate self-harm, and eating disorders (Bhugra & Bhiu, 2003; D’Alessio & Ghazi, 1993; Fazil & Cochrane, 2003).

**Depression and Anxiety**

Cochrane’s (1977) early study of depression, using psychiatric hospital admission rates showed that both Indian and Pakistani women had lower rates of
admission for affective disorders than their native white counterparts. However, this study was criticised on methodological grounds, for errors in recording ethnicity and place of birth and excluding Bengalis, who are considered to be a high risk group (Cochrane & Stopes-Roe, 1980a). These factors might have distorted the accuracy of the reported findings. A slew of subsequent studies from the 1970s to the present time have attempted to understand the incidence and nature of anxiety and depression among various subgroups of South Asian women. The studies have all used indigenous white women as the comparative standard. Results have been conflicting, although they have yielded some useful insights. Nazroo (1997) undertook a large-scale community survey of minority ethnic groups living in England and Wales between 1996 and 1997. Interviewers were matched by ethnicity and language and structured interviews were conducted with 1,273 Indian, 1,185 Pakistani and 591 Bangladeshi and 2,867 white participants. Version 9 of the Present State Examination (PSE) was used to assess morbidity in cases indicative of potential mental illness. The findings indicated that all subgroups of South Asian women had comparatively lower rates of anxiety and depression than their white counterparts. When the South Asian women were aggregated together as one homogenous group, white women had an estimated prevalence of 4.8% and South Asian women had a prevalence of 2.5%. Analyses on South Asian subgroups indicated that Pakistani women had similar rates of depressive neuroses as white women while Indian and Bengali women showed the lowest rates. These results highlight the importance of distinguishing between subgroups of the South Asian population. Nazroo’s study also showed that second generation immigrants (UK born or those who migrated at age < 11) had higher rates than migrants who had come to Britain aged > 11 years.

While Nazroo’s (1997) findings support Cochrane’s earlier research suggesting that South Asian women are psychologically healthier than indigenous white women, he cautioned against this interpretation because of methodological difficulties with his study. For example, he found the prevalence instrument (the PSE) to be insensitive in conceptualising terms into South Asian languages. Words commonly used to describe or diagnose depression in English had no direct translation, a limitation known as “category fallacy” (Kleinman, 1987).

In contrast to the findings of the Cochrane-Nazroo’s studies, other studies have yielded contradicting results. Hitch (1981) in a long-term study of South Asian women in Bradford between 1968 and 1970 found high rates of depression among Pakistani women and low rates in Indian women. Further, a recent cross-sectional survey assessing the prevalence of depression
in primary care attenders (Bhui et al., 2004) found a higher incidence of depressive disorders among Punjabi women (39.1%) as compared to white women (19.5%).

Interestingly, several large scale community studies (Creed et al., 1999; Sonuga-Barke & Mistry, 2000; Fazil & Cochrane, 2003) seemingly point to Pakistani Muslim women as being particularly vulnerable to depression and anxiety. For example, Creed and his associates compared the prevalence of anxiety and depression in a sample of British South Asian women (Hindu, Sikh and Muslim) based in West London with a sibling sample living in India and found that Muslim women obtained the highest scores on the Self-Rating Questionnaire used. Sonuga-Barke and Mistry (2000) examined the mental health of three generations of Indian/Hindu and Pakistani/Muslim women using three versions (English, Gujarati and Urdu) of the Hospital Anxiety & Depression scale and found that levels of depression and anxiety were more pronounced among Pakistani/Muslim women. However, the researchers identified demographic differences between the two samples, such as age, socio-economic background, acculturation level and familial roles to explain their findings. Fazil and Cochrane (2003) used the GHQ-28 to measure the prevalence of depression in a community sample of 100 British Pakistani women and 100 white native women. Pakistani women had higher scores on the GHQ-28 sub scales of severe depression, anxiety and insomnia and somatic symptoms. Both Pakistani and white women in paid employment obtained significantly lower scores than women who were home bound. An unexpected finding was that high levels of depression in Pakistani women were not associated with high levels of personal and social dysfunction as was the case for white women.

The findings from studies on anxiety/depression among South Asian women over a 30+ year are contingent on multiple factors: the South Asian subgroup under study, sample size, generational and demographic factors, participants’ level of acculturation, sensitivity of measures used, and methodological “goodness” of the study. Results should be interpreted with caution, as no conclusive findings exist regarding the prevalence of anxiety and depression among British South Asian women.

Suicide/Attempted Suicide/Deliberate Self-Harm (DSH)

The lower rates of depression in general for Indian women cited by epidemiological studies are puzzling as there is parallel evidence suggesting that the
rate of suicide amongst Indian women in England and Wales is two to three times higher than the national average (Soni Raleigh, 1996). Soni Raleigh et al. (1990) found that in the indigenous population, suicide rates were highest for elderly, widowed, and divorced men, whereas in the South Asian population, the highest rates were found among younger, married women. D’Alessio and Ghazi (1993) found the rate to be three times higher for the 15–24 years South Asian age group than the national average for all women, and 60% higher for South Asian women in the 25–34 age cohort.

Over the past decade, both service and population based studies have reported high rates of attempted suicide and self-harm among South Asian females in Britain compared to females from white Caucasian and African-Caribbean cultural backgrounds (Bhugra et al., 1999a; D’Alessio & Ghazi, 1993). In a London-based treatment study, Bhugra and his colleagues (Bhugra et al., 1999b; Bhugra et al., 1999c; Bhugra et al., 1999d) aimed to establish inception rates of attempted suicide for men and women and associated social and cultural factors across four ethnic groups: South Asian, African/African-Caribbean, White and “Other” (mixed). The sample was drawn from general medicine, accident emergency and psychiatric wards of local hospitals and matched by age with a community group attending a GP surgery. Bhugra and his colleagues found that the rates of attempted suicide for South Asian women were 1.5 times higher than those for white women. These differences peaked for the 16–24 year age cohort of young South Asian females, 44% of whom were married. These women were considerably more at risk of attempting suicide than their peers in other ethnic groups or older South Asian women. Women aged over 45 were the lowest risk. Creed et al., (1999) found suicidal ideas to be more common among Muslim women (18.4%) than Hindu (12.0%) and Sikh (4.9%) women.

Soni Raleigh and Balarajan (1992) have identified socio-cultural factors that play a salient role in producing intense distress and eventual suicide among young South Asian women. These include arranged marriages, family disputes over marriage and lifestyle, marital conflict, in-law difficulties, stigma, expectations of submission and deference by women to men and elders and culture conflict. Factors suggested in literature that increase suicidal behaviour in married South Asian women include social isolation, alienation, cultural incompatibility, religious beliefs, lack of supportive community and pressure from the family to conform to traditional values (Ineichen, 1998; Thompson & Bhugra, 2000).
Eating Disorders

The prevalence of eating psychopathology among South Asian females in the UK has been found to be much greater compared to their white contemporaries. South Asian females have a higher prevalence of clinical bulimia and unhealthy eating attitudes in adulthood (Dolan et al., 1990; McCourt & Waller, 1996) and in childhood and adolescence (for example, Ahmad et al., 1994). McCourt and Waller (1996) reported that Asian females from the most traditional homes (that is, those who are least integrated into British society) have greater levels of eating disturbances and explained their findings in terms of culture conflict.

A further study of 226 teenagers in a mixed-sex school in East London explored the variations in prevalence of bulimic symptomology in relation to acculturation indices (Bhugra & Bhui, 2003). As the distribution of gender across ethnic groups was similar, no differentiation was made between males and females. All South Asian subgroups were aggregated as one group. Results indicated that the mean scores on the Bulimia Investigation Test, Edinburgh (BITE) were highest for South Asians (5.71), compared to 4.52 for whites, 5.04 for African-Caribbeans and 4.86 for the “Other” group, indicating very unhealthy eating habits among South Asian youngsters.

Critique of Studies of Prevalence Rates

The status of the mental health of South Asian women is far from clear. Studies have yielded multiple contradicting findings. This may be due to the inherent limitations of epidemiological studies, which range in scope and severity of methodological problems: semantic, sampling, control measures, test instruments and interpretation. Small samples may obscure participants’ regional origins or religion. Further, classifying South Asian groups as a homogeneous sample risks giving rise to cultural stereotypes (Burr, 2002) and distorts the overall clinical picture.

Demographic variability due to religion, education, family income and levels of acculturation may also produce differing prevalence rates among different samples of the South Asian population in Britain. The intra-group diversity of this population questions the validity of generalising findings across subgroups of South Asian women. Further, the use of instruments based on Western diagnostic conceptualisations of mental health may prove insensitive to probing distress in non-Western populations. Results may be over- or underestimated or confounded in other ways.
To conclude, the “true” prevalence of mental health problems among British South Asian women has been difficult to establish. Hussain and Cochrane (2004), among others, have made the valid point that most prevalence data have been derived from treated cases and it cannot be assumed that all individuals have equal access to treatment or, indeed, have even sought treatment. South Asian under-utilisation of formal mental health facilities is well documented (for example, Fazil & Cochrane, 2003; Furnham & Malik, 1994; Kleinman, 1987). Institutional, cultural and linguistic barriers (Cochrane & Sashidharan, 1996) deter the women from using the available health services. “Treated” prevalence, therefore, does not reflect the “true” prevalence, hence, the epidemiological findings reported must be regarded with some caution.

Cultural Conceptualisations of Mental Health

The cultural expression of symptoms and beliefs about causes and cures of mental distress have been explored utilising qualitative methods to investigate the complex meanings that “symptoms” have across cultures. Cultural influences offer one explanation for differences between British South Asian and white native conceptualisations of self, the relationship between self and social groups and the relationship between the body and the mind (Beliappa, 1991; Malik, 2000; Wilson & MacCarthy, 1994). Such cultural differences are likely to have a pervasive influence on recognition and reporting of psychiatric symptoms, the meaning attributed to them, help seeking and use of mental health services and response to contemporary mental health treatment procedures.

A growing number of studies have focused on personal constructions of distress among South Asian women in Britain and have attempted to understand the “cultural idioms” surrounding distress symptoms (Krause, 1989; Malik, 2000). Research has identified social and cultural variation in the content and interpretation of distress-related emotions. Translating these cultural expressions and meanings becomes problematic when clinicians do not share a common language with their patients. The language barrier certainly complicates a culturally-informed diagnosis (Hussain & Cochrane, 2002). This lack of understanding may lead to misinterpretation of symptoms creating diagnostic and treatment errors.

Further, South Asian patients are likely to somatise their distress through physical discomfort and similarly, GPs may misinterpret communications of distress as indicative of a physical health rather than a mental health problem.
This tendency is especially characteristic of depression (for example, Bal, 1987). Among Punjabis, for instance, depression is associated with culture specific bodily complaints such as a “sinking heart” (Krause, 1989). “Sinking heart” (dil ghirda hai) describes an illness in which physical symptoms in the heart (or chest) are experienced and perceived to be caused by excessive heat, exhaustion, worry and/or social failure. These ideas link physical sensations, emotions and their causes into one illness complex, with specific meanings and associations. “Ayurveda”, a traditional Indian medicinal system, has been identified as a potential conceptual framework for insight into Indian ideas about ill health and treatment (Krause, 1989).

Fenton and Sadiq (1993) conducted in-depth semi-structured interviews with 16 South Asian women living in Bristol about their experience of depression, and the nature of their difficulties, principally to inform them about service provision. These women were clearly able to identify their difficulties in psychological terms, and to talk freely about their feelings in their mother tongue with the mental health worker. This finding contrasts with the view that people from the Indian subcontinent somatise their emotional symptoms (Wilson & McCarthy, 1994).

Malik (2000) argues that understanding experiences of depression and distress in British Pakistanis requires a broader understanding of cultural ideologies. In a comparative interview study of 120 indigenous and British Pakistanis (aged 30–65 years), Malik, using a social constructionist approach, found that the causes of distress were linked to external factors, such as, situations and relationships, rather than personally internalised. Affective, somatic and socio-behavioural symptoms of distress were described and expressed in relation to “others” and social roles. Participants’ conceptions of mental health were embedded in a religious, holistic and relational context and originated in religious (Hindu and Muslim) belief systems. Cultural meanings of distress deriving from these belief systems affected the experience of depressed mood and expression of symptoms (Kleinman, 1987).

Hicks and Bhugra (2003) conducted a thematic analysis on data drawn from focus group discussions to identify possible perceived causal factors for suicidal behaviour among a community sample of 180 British South Asian women. Three factors were identified: marital violence, being trapped in an unhappy family situation and depression. The authors claimed that these findings highlight the significance of socio-cultural conflicts in the genesis of vulnerability to parasuicidal depression. The danger of attributing socio-cultural factors to the etiology of depression risks pathologising South Asian culture and promoting cultural stereotypes. Caution must be exercised.
Stereotyping South Asian culture as “repressive” in comparison to the “liberated” West can be readily incorporated into “pseudo scientific explanations” of mental illness and come to be regarded as “fact” for legitimate use in explaining and treating mental health illness among women in this minority group (Burr, 2002).

**Help Seeking Behaviours and Alternative Coping Strategies**

Just as cultural factors influence expressions and conceptions of illness for British South Asian women, so too, culture influences the types of intervention considered appropriate for the prevention and treatment of emotional disturbances and illnesses. Furnham and Malik (1994) reported that both perceptions about mental illness and perceptions of how to respond to it were related to culture. For example, they found that middle-aged (first generation) South Asian women indicated they found it more helpful to talk to a family member about their depression than to a friend. By contrast, white women preferred a friend as a confidante. Clearly South Asian culture places priority on family in dealing with deep-seated individual needs.

A recent study by Gilbert et al. (2004) highlights the saliency of collectivist cultural values for British South Asian women in the mental health arena. Their study was based on focus group discussions with South Asian women living in Derby and explored meanings, beliefs and views about izzat (family honour), shame, subordination and entrapment and how these factors influenced mental health and help seeking. Experiences of physical entrapment within the constraints of traditional cultural values (such as maintaining family honour, role fulfilment and obligation to duty) contributed to the development of mental health difficulties and the uptake of services. Help seeking was related to izzat, confidentiality and the fear of exposure. Anxieties about professionals maintaining confidentiality emerged as a barrier to seeking help from a GP, especially where the GP was of the same ethnic background as the client or was known to the family in a shared sociocultural context (friend or member of the same community). Similar findings are reported by the Newham Innercity Multifund and Newham Asian Women’s project (1998).

Three recent studies (Cinnirella & Loewenthal, 1999; Sheikh & Furnham, 2000; Hussain & Cochrane, 2003) have examined the role of religion and prayer in coping with mental health problems. In an in-depth qualitative
interview study, Cinnirella and Loewenthal (1999) examined beliefs about mental health, causes and cures, coping and help seeking and stereotypes of health professionals in five different cultural-religious groups in Britain. Specifically, the researchers looked at the degree to which beliefs about religion interfaced with beliefs about depression and schizophrenia. They found that Pakistani-Muslim participants, in particular, felt that religion had an impact on their choice of coping strategy, and prayer was perceived to be effective in the management of depressive and schizophrenic symptoms. Theories of causation were guided by a more holistic view of illness and often attributed to supernatural causes. A fear of community stigma associated with mental illness was indicated in the study, which pointed to a preference for private coping and help seeking strategies over seeking help from formal agencies. The attribution of stigma to mental illness in South Asian communities has been widely reported.

Sheikh and Furnham (2000) argued that in South Asian cultures the range of treatment options for any disorder have traditionally been pluralistic. Thus, British South Asians with mental health problems might consider talking to a family member and/or to someone from their social network (for example, a community elder or a priest) rather than approach a mental health professional, which is the most favoured option for a white British person. Sheikh and Furnham (2000) found religion to be a significant predictor of attitudes towards help seeking. Causal beliefs about mental distress predicted positive attitudes to help seeking among the British South Asian and Pakistani groups. Muslims were the least likely, and those with no religious affiliation the most likely, to have a positive attitude to seeking help from a mental health professional. Their research confirmed the value of Islamic prayer in attitudes towards seeking help for mental illness (Beliappa, 1991). These results did not support the commonly held belief that British South Asians had inhibitions about seeking professional help for psychological distress.

In an interview study of 10 South Asian women, Hussain and Cochrane (2003) explored the coping strategies adopted by women who experienced depression, factors which influenced their choices and how these related to treatment options. The coping strategies used by women in their sample included religion and prayer, crying, self-harm (through self-inflicted wounds and altering medication) and talking. Choice of coping strategy was influenced by how the problem was perceived and also motivational factors (such as the need to maintain gender roles and fulfil cultural obligations). For Hindu women, a belief in *kismet* (destiny), where control is externally located, impacted upon attitudes toward mental illness. A belief that an individual’s mental illness is “God’s will” may help explain why South Asian women, in
Mental Health of South Asian Women in Britain

In general, do not engage formally in mental health services and why services are under-utilised by this group. Hussain and Cochrane (2003) proposed that culturally specific strategies such as visiting religious healers who work within the woman’s religious frame of reference might be a more favourable help seeking option for these women.

Bhugra and Hicks (2004) conducted an exploratory study to pilot an educational pamphlet about depression and suicidal behaviour, targeted at South Asian women. They found that having read the pamphlet, a significant proportion of their sample was more inclined to confide in health professionals, friends and spouses if they felt depressed and/or suicidal rather than keeping their feelings private. These results highlight the usefulness of providing educational information to clients to raise awareness of mental health issues. Providing information might well help to overcome some of the barriers to accessing professional help (Alexander, 2001).

Mental Health and Acculturation

Literature on acculturation and mental health reveals a wealth of theoretical writing, which far outweighs the limited empirical investigations in this area. Findings, therefore, are not definitive and remain inconclusive, but some interesting insights have been offered.

In an early study conducted by Cochrane & Stopes-Roe (1980), an association was identified between socio-economic status and mental health where lower social status was related to higher levels of psychological disturbance. In a follow-up study, Cochrane & Stopes-Roe (1981) compared Indian immigrants and white indigenous participants while controlling social class, defined in terms of occupation. The findings showed that the white group had higher symptom scores in the lowest social class and the Indian group showed higher scores in the highest social class. Further analysis revealed that the pattern for the Indian group was entirely accounted for by the sample of Indian females in the non-manual subset who scored highly on the symptom measure. These findings suggest that upward social mobility was a predictor of psychological symptom levels for female Indian immigrants (the opposite was found for males). When marital status was related to symptom levels, single women had significantly higher mean scores compared to married women. Cochrane and Stopes-Roe (1981) concluded that unmarried, employed Indian women who were socially upwardly mobile and becoming more integrated into British society and culture reported the highest levels of psychological disturbance.
Bhugra and Bhui (2003) also found tentative support for the hypothesis that acculturation and cultural identity influenced the development of eating disorders (bulimia) among teenagers. The authors highlighted the role of family expectations and conformity to family values in the aetiology of eating psychopathology among adolescent South Asians. Their mean scores on a test for bulimia were significantly higher than those for their white and African-Caribbean peers.

Bhugra et al. (1999c; 1999d) investigated the association between deliberate self-harm (DSH) and the various components of cultural identity. The participants were 54 South Asian women (27 clinical cases and 27 controls) and 22 South Asian adolescents (11 clinical cases and 11 controls). Comparisons were made between two generations of South Asian women and between subgroups. In the domains of social contact and aspirations, women who had attempted DSH showed less traditional attitudes than the controls. The most significant generational differences were found in the areas of language and marriage preference, inter-racial relationships, decision-making, work and leisure and food shopping, where adolescents were found to show less traditional attitudes than their parents. Bhugra et al. (1999c) postulated that these adolescent/parent differences are potentially risk factors for DSH among adolescents and demonstrated generational differences in the “protective” value of tradition (versus modernity) in the possible development of psychopathology.

Generational differences in cultural attitudes among first, second and third generation South Asians in Britain have suggested that variations in the structure of family life might help account for their higher levels of psychological morbidity. In a community survey, Guglani et al. (2000) investigated the influence of cultural identity on the psychological adjustment of Indian Hindu women. The sample consisted of grandmothers and mothers (born in India) and their British born adolescent granddaughters. The data were examined for relationships between grandmothers’ mental health and the adolescents’ cultural identity, cultural integrity, traditionalism, religious practice and demographic data. The authors found that the more the family was assimilated into British society (least traditional), the greater the mental health problems experienced by the grandmothers. Grandmothers of adolescents who considered their cultural identity to be exclusively “Asian” or “Indian” or “Hindu” had better psychological outcomes as compared to grandmothers whose granddaughters considered themselves to be “British” or “English”. These findings were explained in terms of the “interdependency of the generations in the context of psychological adjustment” (Guglani et al., 2000, p. 1051). The authors posited that adjustment is at least partially
mediated by the level of traditional belief within the family. This finding provides tentative support for Bhugra et al.’s (1999c) contention of a (potentially) protective effect of traditionalism.

However, although the (potential) protective characteristics of traditional families have been reported in literature, there is also evidence to show that the traditional extended family may constitute a risk factor (for example, Sonuga-Barke et al., 1998). Research has demonstrated that traditionalism in family structures may have a detrimental effect for some South Asian women and for particular generations (Sonuga-Barke et al., 1998). These studies have shown positive effects of extended family living for Muslim children and their grandmothers but negative effects for Muslim mothers. Mothers were found to have significantly higher levels of depression and anxiety compared to Muslims living in nuclear families and as compared to Hindu mothers. Similarly, Fazil and Cochrane (2003) found high levels of depression among Pakistani women and showed factors such as low intimacy with spouse, social isolation, living with the extended family, unhappy marriage and generational conflicts with offspring, to be associated with depression.

In a recent preliminary study using a sample of British South Asian women drawn from the general population of five large cities in UK, Anand and Cochrane (2003) found significant associations between acculturation and overall psychological distress, specifically depression. The aim of their study was to position shame within this relationship. The results showed that low involvement in British society and developing negative attitudes towards the majority white culture were significant factors in the development of psychological symptoms for both first and second generation South Asian women. Women who utilised the “rejection” and “integration” strategies perceived higher levels of prejudice from mainstream society, identified with more aspects of their culture of origin and conversed more frequently in their mother tongue. The authors posited that the relationship between acculturation and mental health is mediated by the capacity to experience shame (shame prone-ness), where women who were more affiliated with the South Asian culture were found to be more vulnerable to experiencing shame about some aspect of themselves (in relation to personal characteristics, behaviour or their body). These results emphasise the value of shame within South Asian cultures. It was hypothesised that shame functioned as an intervening variable to regulate behaviours that were considered important in maintaining group cultural identity (such as community and family ties). This study adds credence to the evolutionary view of shame within collectivist cultures (Greenwald & Harder, 1998) and also supports Gilbert et al.’s (2004) contention that South Asian cultures operate within strong dynamics of shame.
In summary, the relationship between acculturation and mental health is unclear, complex and inconclusive as research has shown that acculturation can have either positive or negative mental health outcomes. The incongruities observed in literature may be due to differences in the operational measures used to assess constructs, sample characteristics and demographic variables, such as age, generation, gender, class and religion.

The Culture Conflict Hypothesis

A dominant explanation for distress, which may lead to suicide (D’Alessio & Ghazi, 1993), self-harm (DSH) (Bhugra et al., 1999d) and eating psychopathology (Bhugra & Bhui, 2003) among British South Asian women has been in terms of “culture conflict”. Literature suggests that the acculturation process may become conflictual when there is a “disparity between traditional and modern attitudes in oneself as well as social and gender role expectations from individuals’ significant others” (Bhugra & Jones, 2001, p. 219).

Bhugra et al. (1999c; 1999d) attempted to measure aspects of cultural identity in relation to DSH and attempted suicide, respectively. They found that South Asian females vulnerable to DSH experienced culture conflicts due to managing discrepancies between family expectations and actual social behaviour. Attempted suicide was found to be related to liberal views on marriage, cohabitation, sharing domestic duties, favouring intercultural sexual relationships and openness to change in religion. A further study (Thompson & Bhugra, 2000) identified conflicts in relation to marriage and lifestyle, pressures of economic competition, loss of self-esteem associated with failure and anxiety from nonconformist behaviour as vulnerability factors in the development of DSH. These pressures are exacerbated particularly for South Asian females by the rigidity of cultural gender role expectations.

Some authors have questioned the popular application of the culture conflict hypothesis (for example, Burman et al., 2002) as this concept tends to privilege cultural factors in the causation of distress and excludes or “masks” the relevance of other crucial factors such as “race”, gender and class. The apparently increasing levels of symptomology among South Asian women have been explained in literature in terms of their contemporary class and gendered positions within a globalising economy (Littlewood, 1995). The position of South Asian women in British society has shifted over the years, as reflected in their growing numbers in higher education and the labour market. The underlying assumption of studies which invoke the notion of culture conflict for British South Asian females is that “being successful and
hence ambivalently autonomous in something approximating to a male Western norm may [lead] to considerable identity conflict for these women” (Littlewood, 1995, p. 56). For example, Cochrane and Stopes-Roe (1981) found a positive relationship between upward social mobility and psychological symptom levels among first generation Indian women. These findings were explained in terms of the strain placed upon women from traditional backgrounds who were participating in the labour market and becoming materially successful.

Burman et al., (1998) postulate that South Asian women from particular educational and class/caste backgrounds “may access and inhabit forms of femininity that are sufficiently congruent to manifest distress in ways equivalent to white women in Europe or the US” (p. 235). According to this hypothesis, modernisation and industrialisation may steer individuals away from an identity rooted in kinship (such as family obligations or gender roles) towards an identity that is more egocentric, self-deterministic and competitive (Bhugra & Bhui, 2003). The form and expression of distress supposedly then become more “westernised” manifesting as self-harm or eating disorders. Marshall and Yazdani (2000) used discursive analysis to explore constructs of self-harm behaviours in a clinical sample of South Asian women, examining the location of culture within their discourses. Findings indicated that self-harm behaviours were not construed as a “problem”, but as a coping strategy for managing emotionally distressing circumstances. Their study also identified the important role of shame within participants’ discourses on culture, which was viewed as shaping constructs of acceptable behaviour. Articulations of self-harm were described in relation to traditional family expectations for South Asian young women as “causative” of pressure and distress, For example, failure to marry by a certain age was expressed as failure to fulfil gendered familial role expectations, not just for the individual or her family, but for maintaining family honour (izzat) within the community. Thus, intersections of culture, race, gender and class are important considerations when hypothesising causes of distress among women from South Asian backgrounds (Burman et al., 2002).

Conclusions

South Asian women in Britain have in the past been regarded as psychologically “more resilient” than the indigenous population of women and epidemiological studies have, until recently, reflected lower rates of psychological
morbidity. However, this review has highlighted substantial evidence to indicate that British South Asian women do struggle with mental health difficulties and that Western diagnostic classifications may fail to adequately capture the essence of the South Asian women’s experience of distress. Findings from acculturation studies have shown that culture exerts a powerful influence upon the experience and development of psychological symptoms for South Asian women. It is also well recognised that there are marked cultural differences in the ways in which health and illness are conceptualised across different subgroups of South Asian cultures. Religious and philosophic differences influence the way in which, for example, Islamic Pakistanis and Hindu Indians understand, conceptualise and cope with disturbances in mental health. Factors such as class, gender and race are equally important considerations when formulating a more informed understanding of distress among South Asian women. New developments in research have focused on the articulation of personal narratives and discourses that give meaning and expression to mental ill-health and help-seeking behaviours which are embedded within cultural and religious belief systems that do not necessarily reflect Western notions of mental health. The role of prayer as a coping strategy, the so-called “protective” effect of tradition, the curative potential of non-traditional medicine and the place of cultural healers warrant further attention. In the absence of a more comprehensive assessment of distress, the studies reviewed have provided new insights and contributed to a richer understanding of the issues that relate to the mental health of South Asian women in UK. For example, culturally specific concepts such as “sinking heart”, izzat, kismet, and “shame” might enable mental health professionals to understand the belief systems within which South Asian women function and develop a shared understanding of emotional distress. This may help to establish therapeutic rapport, facilitate trust and lessen the discrepancy between patients and professionals’ views of mental health while promoting a recognition and valuing of “difference” and of non-Western perspectives.

Further, several studies make a valuable contribution and pose important challenges for service commissioners and those responsible for developing appropriate services by increasing awareness of the intersections of race, culture, class and gender when planning relevant services that work on a practical level rather than policy documents theoretically addressing service inequalities on paper. Research has shown the importance of understanding these factors within a broader national context and construes distress as a product of how services operate, for example, excluding and disadvantaging...
particular populations by failing to provide gender, linguistic and culturally sensitive services (Burman et al., 2002). It is hoped that the findings reported within this review will help configure services that are more responsive to the psychological needs of South Asian women.

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