NEW VOICES

Suppressed voices, neglected lives

Romana Farooq with the latest in our series for budding writers (see www.bps.org.uk/newvoices for more information)

Zara is a 25-year-old Indian Muslim woman with a daughter aged four. She has suffered from intimate partner violence for the past five years and is currently going through a divorce. She has started isolating herself in her home, avoiding contact with family and friends. She has become overly protective of her daughter, going into a state of panic if she is not with her. She has reported paranoid thoughts about her ex-partner and has become distrustful of everyone. Her family say she locks herself in her bedroom and cries for hours on end.

The above vignette is a clear description of a South Asian woman suffering from early onset of depression, which may seem familiar to many British South Asians. There is growing evidence to suggest that ethnic minorities in the UK are suffering from increasing mental health problems and that they are overrepresented in secondary services (Sproston & Nazroo, 2002). Furthermore, rates of recovery are low and drop-out rates exceedingly high (Bhui & Bhugra, 2002).

Asian and Asian British people constitute more than 50 per cent of the ethnic minority population in the UK (Nadirshaw, 2009), and 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 (Anand & Cochrane, 2005).

With increasing evidence to suggest deteriorating mental health and a lack of possible solutions, South Asians are therefore a real concern for mental health service providers and professionals.

The problem

Early epidemiological studies suggested lower rates of psychopathology for British South Asians, but the opposite is now considered to be true, most specifically in the case of depression and suicidality (Husain et al., 2006). Many studies have reported higher rates of suicide in South Asian women, sometimes more than double the national rate (Burr, 2002). Furthermore, several large-scale community studies have found higher rates of depression and anxiety in Pakistani/Muslim women in comparison to Indian/Hindu and their white counterparts (Anand & Cochrane, 2005). This clearly suggests the importance of distinguishing between South Asian subgroups in order to fully understand the mental health of the population under study. In addition, high rates of self-harm and eating disorders have also been reported (Anand & Cochrane, 2005) and are a real cause for concern for mental health professionals, especially if left untreated.

From my own experiences of having worked extensively with South Asians in the community, culture-specific symptoms of distress are highly prevalent and are yet to be adequately researched and understood by clinicians. Without this valuable information mental health professionals are at a disadvantage, and are very likely to make a misdiagnosis without having the cultural knowledge to inform their decision.

Reducing rates of mental illness and suicide is a key national mental health target in the UK, and particular emphasis has been placed on South Asians (Husain et al., 2006). However, there is increasing evidence suggesting South Asians tend to under-utilise services and report negative service experiences. We need to identify the barriers and implement necessary changes.

The barriers

Most importantly the presentation and reporting of psychological symptoms are culturally grounded: evidence suggests that mental illness in one culture may not be viewed as such in another (Fernando, 1991). Therefore mental health practitioners need to impose a model of mental illness and treatment that does not conflict with cultural and religious norms, and move away from the current eurocentric model of treatment and diagnosis (Nadirshaw, 2009).

Consider culture-specific communications of distress. For example, to date there is only one published paper looking at the 'sinking heart syndrome' (Krause, 1989), an illness that manifests itself as physical sensations in the heart or in the chest as experienced by Punjabis in the UK. From my experience, reports of a sinking heart are most often related to distress and anxiety and are common amongst not only Punjabis but South Asians in general. Many South Asians, whether Pakistani, Indian or Punjabi, commonly report feeling that their heart is sinking, but this is rarely picked up as a symptom of distress.

Furthermore, psychological tests should be used with caution. Many lack cross-cultural validity and can lead to misdiagnoses (Leong & Lau, 2001). For example, many South Asians struggle

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with intelligence scales based on Western frameworks. It can be difficult to translate the verbal comprehension subtests for use with ethnic minorities (Okazaki & Sue, 1995).

Language and cultural barriers are a recurrent theme; many South Asians do not feel 'heard' by mental health professionals (Husain et al., 2006). Research suggests in the first instance that South Asian referrals from GPs to secondary care services are scarce, mainly because GPs fail to recognise culture-specific symptoms of distress (Bhui & Bhugra, 2002). Once referred to secondary mental health services, South Asians face linguistic barriers and are often offered interpreters. Unfortunately, having an interpreter does not necessarily improve communication between a client and a clinician (Neal et al., 2006). Research also suggests that sharing a language as well as a cultural background with a client is an important factor in the uptake of services (Hussain & Cochrane, 2004), so it is worth having mental health professionals from a similar background.

There is increasing evidence suggesting South Asians tend to under-utilise services

The consistent picture of poor mental health services for ethnic minorities, which are characterised by increasing rates of psychological distress, detention and poorer pathways to care (Commission for Healthcare Audit & Inspection, 2007) have been attributed by many to institutional racism (Bradby, 2010; McKenzie & Bhui, 2007). Attitudes and stereotypes such as 'Asians take care of their own' or 'South Asian women are depressed due to their repressive culture' do nothing to assist recovery in clients and result in distrust of service providers (Burr, 2002). Many South Asians report dropping out of services due to service providers having fixed views about Asian communities and offering simplistic yet unrealistic solutions with no regard to their culture and values (Husain et al., 2006). Services need to adopt anti-discriminatory approaches in order to eradicate both overt and covert institutional racism; this would usually involve teaching and training on culturally sensitive practice.

What next?

Some suggestions from specialists have been to provide separate mental health services for minority ethnic groups (Bhui & Sashidharan, 2003). This begs the question of whether we still live in a society that thrives on segregation i.e. 'us' and 'them'. If service providers feel strained and somewhat challenged when faced with a minority group that requires alternative interventions, is the answer to that separation? Could the rigidity of services and a general fear of change be behind a drive to segregation? Perhaps a preferable answer would be to offer clients alternative interventions or adapt current interventions to suit the needs of ethnic minorities, e.g. culturally sensitive cognitive behavioural therapy (Rathod et al., 2010). Also, service providers need to either train current practitioners in cultural sensitivity or increase recruitment of practitioners specialising in BME groups. Clinicians and healthcare professionals should even open themselves up to working holistically with South Asians; this would usually mean working from a spiritual model as well as a medical model.

We also need to make an effort to familiarise ourselves with the client's degree of acculturation and religiosity, in order to determine how to best manage the case. Gaining an understanding of the client's values and traditions is a good way to further develop a positive therapeutic relationship, as well as challenge Westernised stereotypes of what 'normal' values are. For example, South Asian families place a lot of emphasis on 'multiple parenting', i.e. grandparents, uncles and aunties all contribute to parenting a child. If we were to remove a South Asian woman suffering from postnatal depression from her home we would also be isolating her from the supportive buffer provided through 'multiple parenting'. This could therefore deteriorate her health further and may cause implications for therapy. Indeed, due to the value placed on extended families and 'multiple parenting', we should look to work in partnership with families in order to support recovery.

Clearly the current failings of mental health services to adequately treat British South Asians doesn't just lie with the service providers and individual clinicians: it is also due to the lack of evidence-based research providing potential ways of working. Surely there is an increasing need to conduct research with South Asians in order to understand their needs and requirements? Only then can the necessary changes be implemented. Until then British South Asians will no doubt feel that there problems are falling on deaf ears.

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