# Acculturation, acculturative stress and depression – a review and proposal for the development of an assessment tool for South Asians in the UK

*In this paper S.Asians refers to those peoples who originate from Bangladesh, Pakistan and India (sometimes referred to as the Indian subcontinent).*

## Summary

Mental health experiences of S.Asian communities are summarised. The nature of acculturation is examined, drawing on work in the USA, and limited work in the UK. There appear to be no standardised method of measuring acculturation in any of the minority ethnic groups in the UK. Groups and individuals may acculturate in different ways: by *assimilation, integration, separation* or *marginalisation*. Acculturation, particularly marginalisation and separation, may leads to acculturative stress and mental ill health, including depression and suicidal ideation. It is proposed that questionnaires are developed that can be used in clinical practice to assess modes of acculturation, to reach a better understanding of the nature of acculturation among these ethnic groups, and help detect individuals who may be at risk of developing depression and suicidal risk.

## Mental health experiences of S.Asian Communities in the UK

Several comprehensive reviews describe differences in mental health experiences of the various ethnic groups in the UK, including S.Asians [1-4]

Suicide rates amongst Indian and Pakistani women are higher compared to Whites, but admissions for depression are not higher [5]. In some community surveys S.Asians show lower levels of psychological symptoms [6 7]. However, Commander et al found that, using the GHQ, S.Asians had higher prevalence of mental disorder than Whites (3.7% vs. 2.74 white, and 2.14 for Blacks) and higher consultation rates (Asian 2.9%, Whites 1.54% and Blacks 1.34%). Whites were more likely to have their disorder detected than other groups. S.Asians were less likely to be referred for their psychiatric problems [8].

In his summary of studies in primary care, Bhui highlights the following points [1]:

1) Asian-born men more likely to rate their health ‘not good’, although fewer admit to long-standing illness.
2) Few Asian men are on psychiatric drugs, but more are on non-psychotropic drugs than Whites.
3) Asian GPs are more likely to under-detect mental disorder than White GPs, but if there were social problems, or previous psychiatric illness, more mental health morbidity is likely to be detected.
4) Detection of mental disorders is more likely if there were no concurrent physical problem.

5) Asian GPs as likely to detect depression in White patients as White GPs therefore their non-detection problem was confined to Asian patients.
6) GPs are more likely to label Asians as having ill-defined conditions.
7) In one study of Indian women GP diagnosis of mental disorder had sensitivity of 17% and specificity of 91% (GPs largely Indian).
8) Study of Punjabis showed that almost no Punjabi men zero on GHQ. The conclusion was that the GHQ does not appear to distinguish between high and low scores in Punjabis as it does in Whites.

There is contradictory evidence about the ability of standard assessments, such as the General Health Questionnaire (GHQ), to accurately diagnose depression in S.Asians, [9 10]. People from 'non-western' cultures have different perceptions and responses to mental illness, and are more likely to present with somatic symptoms with the absence of guilt feelings [11 12]. S.Asian women may be reluctant to seek help for their depression, because they do not medicalise their problems [11 13]. General practitioners, even those originating from the Indian subcontinent, under-diagnose depression [14] and general practitioners prescribe lower doses of amitriptyline to S.Asian patients as well as shorter duration of antidepressants [15]. It would appear that in S.Asians there are differences in the way mental disorders are presented, detected and treated.

*Table 1 Age-standardised rates of admission to mental hospitals by selected place of birth, age 16+, 1981 (Smaje 1995)*

| **Standardised admission Rate for all diagnosis Per 100,000 population** | | | | **Standardised admission rate for schizophrenia & paranoia per 100,000** | |
|---|---|---|---|---|---|
| **Place of birth** | **Male** | **Female** | **All** | **Male** | **Female** |
| **England** | 418 | 583 | 504 | 81 | 74 |
| **Northern Ireland** | 793 | 880 | 838 | - | - |
| **Eire** | 1,054 | 1,102 | 1,080 | - | - |
| **All Ireland** | - | - | - | 191 | 162 |
| **Caribbean** | 565 | 532 | 548 | 278 | 181 |
| **India** | 317 | 326 | 321 | 77 | 82 |
| **Pakistan/Bangladesh*** | 259 | 233 | 245 | 105 | 31 |

**** All diagnoses figures refer to Pakistanis only***

## Nature of acculturation

Acculturation and assimilation are sometimes used interchangeably, but their nature needs to be teased out. Both occur when groups or individuals from different cultures (such as migrants and the 'host' community) come into continuous contact; in acculturation there is change in the cultural patterns of either culture, but in assimilation there is more intense sharing of memories, attitudes and experiences by 'interpenetration' and 'fusion', such that there is development of a common cultural life [16]. Assimilation is now regarded as merely one form of acculturation (see below) [17-20].

The assimilation model of acculturation is unidirectional and one-dimensional, and suggests that migrants gradually adopt the culture of the host society, while giving up their own culture [16]. This linear model of assimilation led to the belief of the development of the 'melting pot' society in the USA, [21]. The existence of an almost mythical unique American identity, irrespective of the origins of a migrant to the

USA, was challenged even as the melting pot idea was being popularised [16 21]. A cross-cultural, bi-dimensional model of acculturation and assimilation was later proposed and widely adopted in the USA [18 19 22 23].

Berry and his colleagues have suggested that individuals and groups undergo acculturation in four possible ways: by *assimilation, integration, separation or marginalisation* [19]. The method of acculturation is dependent on two dimensions: the degree to which individuals or groups wish to maintain their own cultural identity on the one hand, and the degree to which they value their relationship with members of the other group (figure 1) [Berry, 1990 #348.

*Figure 1 Methods of acculturation (from Berry, 1990)*

| | ***Wish to maintain own cultural identity*** | ***No value in maintaining own cultural identity*** |
|---|---|---|
| ***Maintaining relationship with other group is valued*** | Integration | Assimilation |
| ***Maintaining relationship with other group is not valued*** | Separation | Marginalisation |

Outcomes from the acculturation process will vary depending on the mode adopted. Integration results in the individuals maintaining their cultural identity, whilst acquiring some cultural components of the majority culture. Assimilation, on the other hand, means relinquishing almost all of one's cultural identity and adopting the beliefs, values and cultural traits of the other group. Separation involves withdrawal from the majority group, involving oneself only with one's own ethnic group. Marginalised people cannot identify with either their own group, or the majority group [18]. For the individual acculturation can result in changes in self identity (ethnic or religious); changes in attitudes and values about one's own culture and that of the majority group; changes in language use; and changes in various forms of behaviour, from the mundane, such as type of clothing worn, to more significant, such as intermarriage [18 19]. For the group as a whole, changes can occur in the way the group is organised socially and politically, and can undergo changes to its economic base [19].

## Acculturative stress and depression

The process of acculturation itself can lead to stress, and has been termed acculturative stress [19 20 24 25]. Acculturative stress has been much studied in the USA [19 20 24 25], and has been linked to increased rates of depression and suicidal ideation among Mexican Americans in the USA [20]. It is not inevitable that acculturation is stressful for all individuals – to many it offers life-enhancing opportunities. Nevertheless, many migrants do experience acculturative stress, which in turn can lead to reduction in physical and mental health [19 20]. Many variables are involved in moderating the acculturation experience (figure 1), and whether acculturative stress is encountered will depend on whether an individual experiences high or low levels of acculturation, or high or low levels or stressors. The mode of acculturation appears to have a strong bearing on whether acculturative stress is experienced: those who

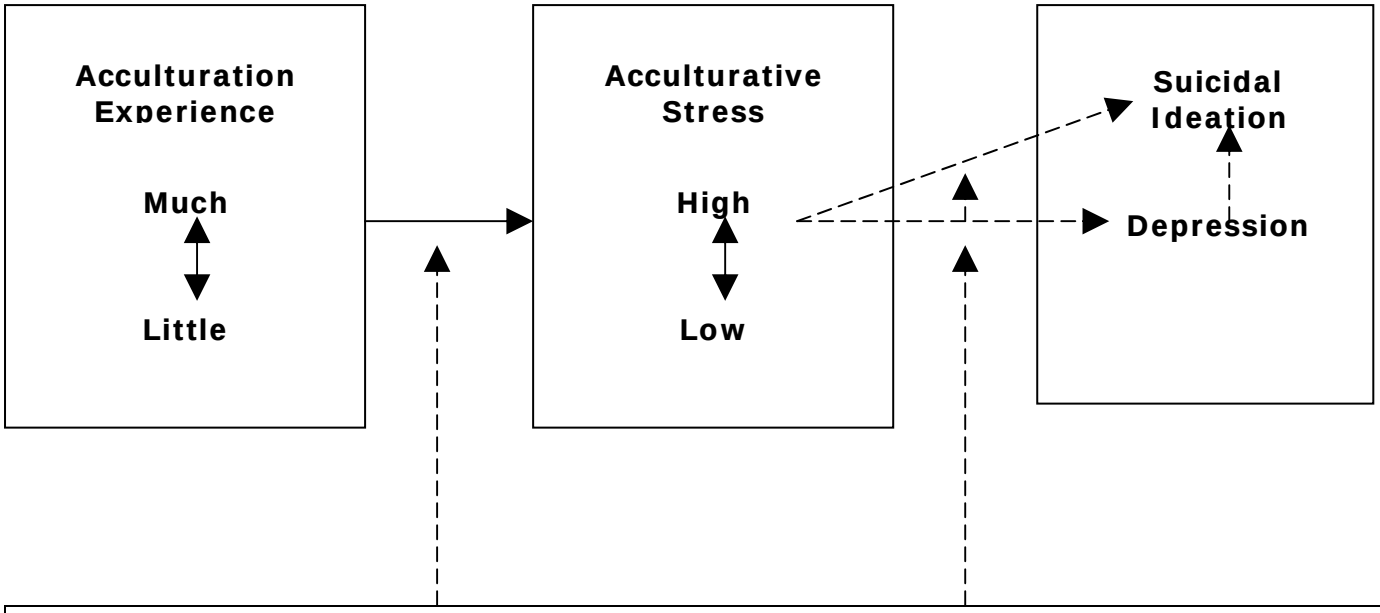
remain marginal, or choose separation as the mode of acculturation experience the most stress. Integrated individuals experience the least stress, and assimilation leads to intermediate levels of stress [19]. The presence of social support is probably the most important factor in preventing acculturative stress. Social support includes such things as nearby extended families, neighbour from own ethnic background, the presence of organisations and clubs of own group, regular visits the home country, and special agencies and clinics providing services [19 20 24].

There appears to be no reference to acculturative stress in large British surveys and reviews [3 4 26 27], although there is some discussion on modes of acculturation by Modood, and Smaje does discuss the possible role of acculturation in explaining differences in health experiences between ethnic groups. In one of the earliest studies in the UK, more acculturated Indians were found to have less depression [6]. The acculturation index in this study was based on the following factors: ties with India, visits to India, integration at work, social integration, and intention to return permanently to India. In contrast to many other indices of acculturation there is no mention of language and it does not appear that the questionnaire was independently validated.

In a study of acculturation in S.Asians (originating from India, Pakistan, Bangladesh, Sri Lanka and Nepal), adolescents and women attending the accident & emergency department with deliberate self-harm were compared to matched controls [28]. The adolescents were also compared to their mothers. Adolescent cases were more acculturated than their parents in five domains, including language preference and marriage preference, but they were not more acculturated than adolescent control. Women cases were only more acculturated than controls in two domains (social contact, and aspirations). Thus, in this study, there was some difference in acculturation between cases and controls, but the expected increased acculturation in adolescents compared to their mothers tends to validate the questionnaire used. However, this was a relatively small study (98 subjects in total), which did not appear to control for variables that affect acculturation (figure 1).

Furnham and Malik found that beliefs about depression amongst middle-aged S.Asian women were substantially different from those held by middle aged native Britons, and also different from young S.Asians. The latter group's beliefs were similar to their native peers [11]. Although the middle-aged S.Asians had

*Figure 1. Variables affecting acculturation, acculturative stress and link to depression and suicidal ideation.*




| Variables Moderating The Moderating Between Acculturation. Acculturative Stress, Depression, And Suicidal Ideation |
|---|
| **Majority/host community variables** |
| Degree of pluralism in host society (less in pluralistic societies, more in monistic ones) |
| Policies and attitudes in host society that 'exclude' minority groups (incl. racism) |
| Prevailing economic conditions |
| Prestige of the migrating group in host society |
| **Minority/migrating group variables** |
| Age and sex of individual (older migrants, and females are more likely to experience acculturative stress) |
| Years in host country |
| Age of arrival in host country |
| Prior knowledge of language and culture of host community |
| Education level attained |
| Motives for migration (voluntary vs. involuntary) |
| Attitudes towards acculturation |
| Settlement patterns |
| Socio-economic status and change in status (drop in status after migrating is more likely to result in acculturative stress) |
| Social support and social networks |
| Contact experience with host society (how much and how pleasant) |
| Control over the acculturation process |
| Degree of congruity of expectations and realisations of ambitions (the larger the discrepancy between expectation and achievement, greater the acculturative stress) |

more psychiatric morbidity, they were less likely to report themselves as being depressed, and none reported receiving treatment for depression (the reasons for this were not clear from their study) [11]. They concluded that reporting of depression was culturally dependent, but was influenced by acculturation.

## Measuring acculturation, acculturative stress and depression

Scales and questionnaires have been developed in many countries, including the USA, Canada, Singapore, and the UK [17 23 28-33]. Broadly speaking, the non-UK studies have used Berry's bi-dimensional model of acculturation to underpin development of their scales, and the UK studies have used a uni-dimensional model. This paper suggests that the former model is perhaps more appropriate, and relates more closely to clinical detection of people at risk of mental ill health. Some of the scales are aimed at specific groups [28 29 32 33], but others were validated in several ethnic groups [17 23 31]. It could be argued that the Stopes-Roe-Cochrane scale has been validated in more than one group, although the groups were identified by religion and not ethnicity or country of origin [33]. During the validation of the ACIS study, recruitment could potentially have occurred from any of the five countries in the Indian subcontinent, but the analysis was not carried out by ethnicity or country of origin [28]. ACIS cannot be classed as scale – it remains a large questionnaire with some qualitative components.

Some studies have produced final scales of 12-37 items, although the authors may initially have started with a large number of questions [23 29 31 32]. In all these scales factor analysis has shown that the majority of acculturation could be accounted for by three sets of items:

- Proficiency and preference for own ethnic language use, or use of English
- Use and preference for English/ethnic language media
- The preferred ethnicity of people with whom participant interacts

In some studies, food preference [23 31], and knowledge of current affaires was found to be of importance [23]. It must be emphasised that these scales do not measure all possible areas of acculturation, but rather provide an index of the degree of immersion in the dominant host society and an individual's ethnic society. It is perhaps remarkable that similar factors were largely able to provide an index of acculturation in many different ethnic groups, in peoples of different religions, in several different countries.

## Discussion and proposal for future research

IT may be impossible to resolve the contradictory evidence concerning the incidence of common mental disorders, such as depression, in S.Asians until one is confident that our current assessment methods can be used accurately to establish a diagnosis. However, clinical practice seems to agree with authors who suggest that S.Asians do not present with depression in the same way as whites [9 11].

Acculturation is an important factor in the lives of migrant groups, and Berry's model perhaps provides the best framework for its examination [19]. The link between mental

distress and some modes of acculturation has been established in some ethnic groups [19 20 24 25]. Acculturation and acculturative stress has been little studies amongst S.Asians in the UK (or any other ethnic group for that matter). For such studies to have validity, scales are required that can reliably measure mental distress or illness and acculturation. If the scales are to be used in clinical situations, they need to be short, easy to administer, and available in translated forms.

All available scales, developed in so many different ethnic groups, have similar acculturation factors [23 29 31 32]. It could be argued that acculturation in S.Asians in the UK should follow a similar pattern to acculturation in other ethnic groups, but of course this need confirming. In Stephenson's study, an initial list of 195 items was tested for reliability and validity in a series of 3 studies in five ethnic groups to give a final scale comprising 32 questions, which has many commonalities with scales validated in other groups [23]. This scale –Stephenson's Multigroup Acculturation Scale (SMAS)- can differentiate between the four different modes of acculturation. Using some items from ACIS [28], we intend to modify Stephenson's scale and attempt its validation the S.Asian population. This method has precedent: a scale for Filipino Americans was based on ASASH, a scale developed for Hispanic Americans [29 32 34], and Anderson's initial list of question were derived from previous studies [31].

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