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Letter

Mental health among British South Asians: reflecting on granularity

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South Asians are the largest ethnic minority in the UK,[1] reflecting a migratory flow which began in earnest following the Partition of India in 1947 to fill a labour shortage in post-war Britain. Indian, Pakistani and Bangladeshi communities today represent 3.1, 2.7, and 1.1% of the British population, respectively.[1] A further 1.6% of the population belong to other Asian heritages, capturing Sri Lankan and Nepali ethnicities, among others.[1]

The grouping of 'South Asians' privileges geographical commonality and conceals a myriad of individual identities incorporating language, gender, religion, caste and culture. As such, the term South Asian reflects an essentialist stance, which homogenises ethnicity and in so doing risks overlooking important social differences. This is particularly true when considering British South Asians, in which differences by migration, generation, location, financial deprivation, and perceived discrimination interweave to influence national identity and acculturation.

Taking a granular lens to ethnicity can help inform our understanding of mental health outcomes. While an increased risk of serious mental illness has been shown for South Asians in the UK relative to White individuals,[2] this broad-brush approach to defining ethnicity lacks nuance; for example, research has reported lower rates of psychosis among British Bangladeshi communities. Furthermore, among British South Asian populations differences in common mental disorders are documented, with older Indian and Pakistani women being particularly vulnerable relative to their White counterparts.[3] Experiences of discrimination, behavioural and lifestyle factors, and broader beliefs about health and illness, are all likely to partly account for the differences observed between South Asian ethnic groups and their White counterparts. Variability in access and uptake of healthcare must also be recognised and may even impact the accuracy of existing prevalence estimates which often rely on first diagnosis data.[2]

Healthcare access does not merely relate to the availability of services but also how such services are used. Service utilisation is dependent on the acceptability and affordability of services as well as the process and quality of care. Despite the implementation of national policies in the UK to promote equality in service uptake, (e.g. National Service Framework for Mental Health (1999); Race Relations (Amendment) Act (2000); Delivery Race Equality in Mental Healthcare Action Plan (2005)), differences in utilisation by broad ethnic group persist, even at the primary care level. Among British South Asian populations, Pakistani and Bangladeshi women are less likely than White women to have used any mental health services.[4]

Ethnic differences in the uptake of mental healthcare have, in part, been explained by culture, defined as *"a set of language, identity and race governed by social norms that contribute to an individual's view of mental health"*.[5] Cultural factors that may affect the propensity to seek help include stigma and shame (including *izzat,* family honour, for Pakistanis); religious belief systems and the use of religious coping (particularly for Bangladeshi Muslims); language barriers and the need for interpreters; and the availability of language surrounding mental distress including 'tension', and for Punjabis, 'sinking heart' (*dil ghirda hai*).

However, research on cultural diversity has come under criticism for overlooking how failures in healthcare systems contribute to institutional racism. The concept of cultural difference as fixed, with pervasive stereotypes of eastern cultures seen as repressive and patriarchal, has been described to account for healthcare professionals' misdiagnosis of mental illness; an example of which being the (harmful) notion of 'Bibi-itis'.[6] General Practitioners have been shown to be less able to correctly identify common mental disorders in British Punjabis than White English patients.

Moreover, culture is not the only factor shaping individual experiences across ethnic groups and care must be taken to not overlook important similarities. For example, while collectivist aspects of South Asian cultures have been posited to explain lower engagement with mental healthcare, research examining the relational aspects of wellbeing (such as social support networks), has failed to reveal differences between ethnic groups.[7] In addition, the widely discussed 'somatisation' of depression symptoms has not been found to be patterned by ethnicity, at least for British Pakistani and Punjabi individuals. Data from the Millenium Cohort Study suggest that household income confounds the lower prevalence of mental health problems in Pakistani and Bangladeshi youth, suggesting deprivation rather than ethnic differences are key.[8] Age has been recognised to be an important factor in explaining British Bangladeshis' attitudes towards depression, with younger groups sharing similar conceptualisations of mental health as White British participants. Indeed, a recent review found that the intersection of ethnicity with experiences of racism, migration history, religion, and complex trauma may have more explanatory power than "*crude ethnic group classification*" in understanding inequalities in mental healthcare.[9]

In conclusion, while we recognise that the broad grouping of South Asians, at least in physical health contexts, facilitates public health messaging (e.g. campaigns around Vitamin D and body weight), and can sometimes be necessary due to under-representation of ethnic minorities in population-level cohort studies, we suggest that disaggregation of ethnicity in relation to mental healthcare holds the promise of recognising differences that effect uptake, use and outcomes of healthcare services. However, culture should not be used as a scapegoat, allowing researchers to fail to (a) examine other aspects of individual and social experience that transcend ethnic boundaries to effect mental health, and (b) recognise the holding of bicultural and/or *desi* identities for second and third generation British South Asians.

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Author contribution

LP and MR formulated the idea for the letter. LP conducted literature searches and reviewed the literature, synthesised the literature, wrote and revised the manuscript. MR synthesised the literature and reviewed and revised the manuscript. RR, AM, PG, HF, AR, MS and AS reviewed and revised the manuscript.

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Declaration of interest

None to declare.

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