

ORIGINAL PAPER

M. J. Commander · S. M. Odell · P. G. Surtees · S. P. Sashidharan

Care pathways for south Asian and white people with depressive and anxiety disorders in the community

Accepted: 29 September 2003

Abstract *Background* South Asian people with common mental disorders are less likely to have their problems recognised by their general practitioner and have lower rates of uptake of psychiatric services compared to native born white people. Less consideration has been given to their understanding of their mental health problems, their use of alternative supports and the treatment they receive in primary care. *Methods* A general population sample identified, using a semi-structured diagnostic interview, as having DSM-III-R depressive or anxiety disorders was obtained. South Asian and white participants' appraisal of their mental health problems and their use of informal and formal assistance during the period they were unwell in the previous 6 months were compared. *Results* There was no difference between south Asian and white people, either in what they understood to be the matter with them or in what they perceived to be the cause of their problems. No south Asian participants reported seeking help from lay or traditional healers, while white people more often discussed their problems with a relative or friend. Most south Asian people consulted their GP and this was significantly higher than for whites. However, only around half the people in both groups reported disclosing their problem to a GP and only one in ten received psychiatric medication or was referred to specialist psychiatric services. *Conclusions* Along with public education and GP training, the availability of appropriate and acceptable interventions for south Asian, and indeed white people, with common mental disorders consulting in primary care is key to ensuring that they gain access to necessary mental health care.

Key words common mental disorder – ethnicity – help seeking – explanatory models – primary care

Introduction

Despite their greater likelihood of consulting with a general practitioner (GP) (Commander et al. 1997b), south Asian people with mental health problems more commonly fail to have their condition recognised in primary care compared with native born white people (Odell et al. 1997; Bhui et al. 2003). South Asian people more often incorporate physical symptoms and idioms into the presentation of their psychological distress than whites (Nazroo et al. 2002). As GPs are hindered in case identification by the presence of somatic experiences and are more effective when people disclose social difficulties or a history of psychiatric help seeking, this has been proposed as a likely explanation for this under-recognition (Odell et al. 1997). However, even when south Asian people present in primary care with psychological difficulties, lower case identification by GPs has been reported compared to white people (Wilson and MacCarthy 1994), suggesting that other factors are involved. This is reinforced by the finding that south Asian people with conspicuous morbidity are less likely to be referred onto specialist psychiatric services than their white counterparts (Commander et al. 1997b).

A deficit in the receipt of mental health care for south Asian people compared to the white population may be linked more fundamentally to differing explanatory models of mental illness and especially attitudes to treatment. South Asian people may have a different understanding about what is primarily the matter with them and attribute their problems to different underlying causes. Their appreciation of mental health problems appears to be closely tied with expectations regarding social role functioning (Beliappa 1991). Consequently, although they may have a preference for non-pharmacological remedies (Fenton and Siddiqui 1993), individually focused models of distress and psy-

M. J. Commander (✉) · S. M. Odell · P. G. Surtees · S. P. Sashidharan
Birmingham & Solihull Mental Health NHS Trust
Northcroft Building
71 Fentham Road, Erdington
Birmingham, B23 6AL, UK
Tel.: +44-121/623-5614
E-Mail: martin.commander@bsmht.nhs.uk

chotherapy may lack relevance. Lay and traditional healers potentially offer a more acceptable alternative for south Asian people in contrast to their white counterparts who may be more receptive to Western models of psychiatric care (Bhui 1999).

The aim of this study was to compare the mental health care experiences of south Asian and white people with depressive and anxiety disorders identified in a general population survey. It was hypothesised that south Asian people would be more likely than white people to conceive the nature and cause of their mental health problems in terms of a physical condition, and, furthermore, that south Asian people would be more likely to use informal support networks as well as to consult within primary care. However, it was anticipated that they would subsequently be less likely to discuss their problems with a GP and to receive psychiatric treatment.

Subjects and methods

Participants

This study constitutes part of a wider project replicating Goldberg and Huxley's pathways to care model (Goldberg and Huxley 1992) in a deprived inner-city catchment area (the old West Birmingham Health District) (Commander et al. 1997a). This area has been consistently identified as one of the top ten most deprived in the country (Smith et al. 1996) and is well suited to the research as it has a high proportion of south Asian people (23%) (Census 1991). A domiciled sample of people aged 16–64 years was obtained from a random sample of West Birmingham residents registered with a GP drawn from the database held by the Family Health Service Authority. These people all had access to a uniform range of specialist psychiatric services provided by one local mental health unit. Permission was sought from GPs with potentially eligible patients to access their registration data and to invite people to become involved in the study. All the people identified were contacted by letter and subsequently approached for interview. There was no replacement for people who were ineligible, refused or could not be contacted. People were interviewed in their own homes by trained researchers. The interview was available in three languages (English, Punjabi and Urdu). Each person completed a written consent form prior to proceeding with the semi-structured interview. All completed interviews were reviewed by a member of the research team. In addition, each interviewer audio-taped their fifth and tenth completed interviews and every tenth completed interview after that. A payment of ≤£10 was made to each person who took part. The study was completed between December 1994 and May 1995.

Measures

Ethnic group codes were based on the OPCS 1991 Census classifications (OPCS 1992). The term 'south Asian' is used here to include people identified by self-report as Indian, Pakistani or Bangladeshi. A semi-structured mental state interview, the Structured Clinical Interview for DSM-III-R (American Psychiatric Association 1987) (Spitzer et al. 1992), was used to assess a range of diagnoses during the previous 6 months; major depression, dysthymia, panic disorder, agoraphobia and generalised anxiety disorder as well as substance abuse/dependence. Those with any disorder were then questioned about the time during the previous 6 months when they were experiencing the problem as defined by the person themselves. This included what if anything they thought was the matter with them and what they thought was the likely cause. Help seeking was ascertained. This encompassed discussion with relatives or friends, talking to a

GP/family doctor, involvement with psychiatric services as well as contact with anybody else about their problem. People were also asked whether they had been offered any help or support which they had turned down (and the reason for this) and about medication they had taken prescribed by a doctor. This section of the interview was based on the schedule utilised in the National Survey of Psychiatric Morbidity (Meltzer et al. 1995). Life events during the previous 6 months were determined using the List of Threatening Experiences (Brugha et al. 1985). In addition, people were asked: "Have you taken an overdose or attempted in any other way to deliberately self-harm in the past 6 months?". Physical health was assessed using items drawn from the Medical Outcomes Study (Tarlov et al. 1989). Each person's general level of functioning was determined using the Global Assessment of Functioning scale (GAF) (Endicott et al. 1976).

Analyses

Data were analysed using SPSS (1993). Levels of significance were tested using the Chi square statistic (χ^2) where appropriate.

Results

Of the 1500 people eligible for inclusion in the study, no contact was made with 95 and 608 were excluded, usually because they no longer lived at the given address or their GP refused consent to approach them. Of those remaining, successful interviews were undertaken with 149/227 south Asian (66%) and 310/424 white people (73%; $\chi^2 = 4.0$, $P = 0.05$). Twelve people refused to participate because of a lack of English language. A DSM-III-R depressive or anxiety disorder was identified in 33 south Asian and 44 white participants (22% vs. 14%; $\chi^2 = 4.6$, $P = 0.03$). All white people gave English as their preferred language whereas 8 south Asian people were interviewed in Punjabi and 1 in Urdu. Of the south Asian people, 9 identified themselves as Muslim, 12 Sikh and 12 Hindu. Only 6 were born in the UK; 17 were born in India, 7 in Pakistan and 3 elsewhere. Of those born abroad, 18 came to the UK on or before their sixteenth birthday.

There was no significant difference in the ages of south Asian and white people and the majority in both groups were women (Table 1). South Asian people were significantly more likely to be married, to have children and to be living with others. However, white participants were more able to identify 'someone they felt close to and could turn to to discuss their troubles'. There was no significant difference in their qualifications, but white people were more likely than south Asian people to be working outside the home. South Asian (28/33, 85%) and white participants (29/44, 66%) did not differ significantly in their likelihood of having experienced at least one of the life events enquired about. The only specific life event where there was a significant difference concerned south Asian participants' more frequent reports of a serious illness, injury or assault in the previous 6 months (20/33, 61% vs. 13/44, 30%; $\chi^2 = 7.4$, $P = 0.006$).

Apart from a higher proportion of south Asian people experiencing a depressive disorder (Table 2), there were no significant clinical differences between south

Table 1 Sociodemographic details

	South Asian (33)		White (44)		
	N	%	N	%	
Age					NS
16–29 years	11	33	12	27	
30–44 years	14	42	13	30	
45–64 years	8	24	19	43	
Women	26	79	30	68	NS
Married	24	73	22	50	$\chi^2 = 4.0, P = 0.04$
Live with others	32	97	36	82	$\chi^2 = 4.2, P = 0.04$
Have children	22	67	19	43	$\chi^2 = 4.1, P = 0.04$
Identify a person they are close to	28	85	43	98	$\chi^2 = 4.4, P = 0.04$
Any qualifications	20	61	18	41	NS
A-level or degree	8	24	6	14	NS
Employment status					P = 0.05
In work	9	27	20	46	
Unemployed	6	18	7	16	
Sick	4	12	19	23	
Other	14	42	8	18	

Table 2 Clinical details

	South Asian (33)		White (44)		
	N	%	N	%	
DSM-III-R diagnosis					
Panic	4	12	8	18	NS
Agoraphobia	3	9	11	25	NS
Generalised anxiety disorder	7	21	8	18	NS
Any anxiety disorder	10	30	21	48	NS
Major depressive disorder	23	70	26	59	NS
Dysthymia	8	24	9	21	NS
Any depressive disorder	31	94	33	75	$\chi^2 = 4.8, P = 0.03$
Drug abuse/dependence	1	3	1	2	NS
Alcohol abuse/dependence	1	3	3	7	NS
Any substance use disorder	1	3	4	9	NS
Total co-morbidity	10	30	15	34	NS
Duration of at least 6 months	23	70	29	66	NS

Asian and white participants. Around two-thirds in both groups reported the presence of symptoms for the full 6 months preceding the interview. There was no difference in the level of associated substance abuse/dependence nor in overall co-morbidity (found in a third of participants). Episodes of deliberate self-harm were reported by 2 south Asian but no white people. Levels of functioning, determined by the GAF, did not differ significantly [south Asian mean 60 (sd 11) and white mean 61 (sd 10)]. Nor were there any significant differences in the number of physical health problems reported [south Asian median 2 (range 0–9) and white median 2 (range 0–11)], with 83% of south Asian and 67% of white participants reporting at least one physical health problem.

There was no significant difference between south Asian and white people with respect to seeing someone previously for a mental health problem (36% vs. 48%) nor in past contact with a mental health professional (9% vs. 18%). South Asian and white people did not differ significantly in their explanations of what they con-

sidered to be the matter with them, nor did they identify different causes for their problems (Table 3). South Asian participants were significantly less likely than their white counterparts to discuss their problem with a relative or friend. None used lay or traditional healers or other forms of informal support as opposed to 1 white person who saw a homeopathist. However, south Asian people were significantly more likely than white people to come into contact with a GP and, having done so, were equally likely to discuss the problem with them (although this applied to only 58% of south Asian and 52% of white consulters). Two south Asian participants reported seeing a practice counsellor as did 1 white person. There was no significant difference between south Asian and white people in the proportion prescribed psychiatric medication (an antidepressant, anxiolytic, antipsychotic or mood stabiliser), yet only one in ten received such treatment. A similarly low proportion in both groups had contact with a mental health professional (a psychiatrist, community psychiatric nurse, so-

Table 3 Explanatory models and mental health care

	South Asian (33)		White (44)		
	N	%	N	%	
What if anything, did you think was the matter?					NS
Psychosocial problem	22	67	27	61	
Physical problem	8	24	5	11	
Other or no explanation	3	9	12	27	
What did you think was the likely cause?					NS
Psychosocial reason	14	42	22	50	
Physical illness	12	36	10	23	
Other or no explanation	7	21	12	27	
Discussed problem with a relative or friend	23	70	39	89	$\chi^2 = 4.3, P = 0.04$
Contact with general practitioner	31	94	31	71	$\chi^2 = 6.6, P = 0.01$
Discussed problem with general practitioner	18	55	16	36	NS
Psychiatric medication*	3	9	5	11	NS
Seen by mental health professional**	3	9	5	11	NS

* antidepressant, mood stabiliser, antipsychotic, anxiolytic

** social worker, CPN, psychiatrist, psychologist

cial worker or psychologist). A further 2 south Asian people turned down the offer of psychiatric assistance. In both instances, this was from a social worker and while one gave no reason for the decision, the other feared that her children might be taken away. One white person refused to see a community psychiatric nurse saying that she did not think that this was the right sort of person to help with her problems.

Discussion

Methodological issues

This study was undertaken in a deprived urban area in the UK and the findings may not readily generalise to other settings. In particular, the considerable social and material adversity faced by white people in inner cities may mask any diversity in mental health experiences when comparisons are made with people from ethnic minority groups. The use of general practice lists as a sampling frame is undermined by the large number of people who no longer live at the given address. Nevertheless, the high proportion of south Asian people registered with GPs in inner-city areas make this a reasonable approach for ensuring their adequate representation and participation in general population samples (Chaturvedi and McKeigue 1994). It should be acknowledged that the refusal to participate by almost a third of those eligible (including a higher rate for south Asians than whites), although probably acceptable for a study of this type, may have introduced bias. Despite our efforts, language difficulties contributed to the non-response rate. In a number of instances languages other than English, Punjabi and Urdu were required. In addition, because Punjabi- and Urdu-speaking interviewers could only be called upon when the first English-speaking interviewer confirmed a need, this allowed some people to refuse before they could be approached by someone who

spoke their first language. Our failure to use established translated versions of diagnostic instruments may have allowed unintended distortions to be introduced into the diagnostic process by the interviewers. However, the use of highly trained and experienced mental health staff to undertake the interviews in Punjabi and Urdu and careful scrutiny of documents and tapes partly dispels these concerns. More problematic is the on-going challenge to the validity of applying instruments derived from Western psychiatry in studies of ethnic minorities (Bhui 1999) although a recent study reported an acceptable level of overlap between etic and emic perspectives of mental illness in Indian women living in the UK (Jacob et al. 1998). Finally, it is worth sounding a note of caution when interpreting our findings, as these analyses were not the primary influence on the design of this study, which was part of a larger epidemiological project looking at morbidity rates and service use (Commander et al. 1997a), and the opportunities for comparison were limited both by the sample size and the range of variables available.

Interpretation of findings

The sample was clinically homogeneous with the exception that south Asian people were more likely to be diagnosed as having a depressive disorder. A similarly high proportion of south Asian and white people had chronic illnesses and experienced co-morbidity. GAF scores of around 60 in each group indicate that subjects had moderate symptom levels and were generally functioning with some difficulty. Although needs assessment in community samples is fraught with difficulty (Bebbington et al. 2000), these findings indicate a high likelihood that participants in both groups had morbidity of sufficient severity and duration to warrant intervention. There was no difference in past experiences of mental health care nor current physical health problems, both

factors which may otherwise account for ethnic differences in participants' explanations of their problems. Furthermore, south Asian and white people reported similar rates of life events for the previous 6 months.

Although south Asian participants were more often married and living with others, including children, they were less likely to be working outside the home and to be able to identify someone they could turn to and share their troubles with. This resonates with the finding that south Asian people were less likely than white people to discuss their problem with a relative or friend and concurs with evidence suggesting that many depressed south Asian women are isolated and struggling to cope with social difficulties, including marital discord (Beliappa 1991; Husain et al. 1997). Contrary to our expectations, but consistent with other recent work (Bhui et al. 2001a), south Asian people did not report seeking support from lay or traditional healers. This is congruent with a lack of spiritual or cultural explanations put forward to explain their predicament and suggests that it is unduly optimistic to suppose that south Asian people are obtaining assistance through this or indeed any other informal support pathway.

Most south Asian participants consulted their GP during the period they were experiencing their mental health problem and at a significantly higher rate than for white people. This is consistent with a wealth of previous research (Commander et al. 1997b; Bhui et al. 2003). What people disclosed cannot be ascertained from these data, but given their willingness to describe their mental health experiences as a psychosocial problem and in many cases to attribute them to life events and relationship difficulties, it seems likely, as has been noted elsewhere (Husain et al. 1997; Jacob et al. 1998), that, given the opportunity, south Asian as well as white people would have talked about the emotional nature of their problems. Bhui and colleagues (2001b) likewise found that psychological explanations were common in both Punjabi and English consultants in primary care and that the proportion of Punjabis giving somatic/medical explanations was small. There seem to be two likely explanations for the discordance of these data with a 'somatisation' theory of underdetection in primary care. Firstly, south Asian people may be selective in their symptom reporting and in particular less inclined to disclose depressive cognitions (Bhui et al. 2001b). Secondly, they may be more spontaneously disposed to present somatic experiences than white people (Jhadav et al. 2001). In either instance, there are clear implications for GP training around culture and mental health (NIMHE 2003), as well as for the allocation of sufficient time in primary care to allow people to reveal their distress.

Significantly only a half of those people who saw their GP, regardless of ethnicity, reported disclosing their problem. There is evidence that members of the public do not conceive the common mental health problems typically reported in community surveys as medical disorders especially where external causal factors are involved (Angermeyer et al. 1999). This may be true of the

white people in this study, including those who did not present in primary care, but sought support from a confidante. Likewise, south Asian people who consult their GP ostensibly for a physical complaint may perceive an emotional component to their problems, but simply may not envisage a GP being able to help (Bhui 1999). Interventions which are on offer in primary care, such as a diagnosis of mental illness, the prescription of psychotropic medication and referral to specialist psychiatric services may be perceived as stigmatising or irrelevant to their needs (Beliappa 1991). This is in keeping with results from the National Survey of Psychiatric Morbidity which confirm a reluctance on the part of people to seek treatment for neurotic disorders linked to both stigma and ignorance about the effectiveness of interventions (Meltzer et al. 2000). It is equally plausible that many GPs are uneasy about medicalising social difficulties which they doubt are amenable to medical treatment, especially where other disposal options are lacking (Goldberg and Huxley 1992). The mutual skepticism of GPs and the public may underpin our findings that only a minority of both south Asian and white people received further treatment in the form of medication, counselling or involvement with a mental health professional despite the severe and persistent nature of their problems. In addition to public education, it is difficult to escape the need for approaches to the management of common mental disorders that are not only effective but chime with expectations regarding what is required. The National Institute for Mental Health in England has advocated a role for community development workers to enhance the capacity within black and minority ethnic communities to deal with the burden of mental ill health and to promote change (NIMHE 2003). As the GP presently offers the main route for south Asian people seeking assistance, it seems important that any new initiatives are well integrated with and readily accessible via primary care.

References

1. American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn revised). APA, Washington DC
2. Angermeyer MC, Matschinger H, Riedel-Heller SG (1999) Whom to ask for help in case of a mental disorder? Preferences of the lay public. *Soc Psychiatry Psychiatr Epidemiol* 34:202-210
3. Bebbington PE, Brugha TS, Meltzer H, Jenkins R, Ceresa C, Farrell M, Lewsi G (2000) Neurotic disorders and the receipt of psychiatric treatment. *Psychol Med* 30:1369-1376
4. Beliappa J (1991) *Illness or distress? Alternative models of mental health*. Confederation of Indian Organisations, London
5. Bhui K (1999) Common mental disorders among people with origins in or immigrant from India and Pakistan. *Int Rev Psychiatr* 11:136-144
6. Bhui K, Bhugra D, Goldberg D, Dunn G, Desai M (2001a) Cultural influences on the prevalence of common mental disorder. General practitioners assessments and help seeking among Punjabi and English people visiting their general practitioner. *Psychol Med* 31:815-825

7. Bhui K, Bhugra D, Goldberg D (2001b) Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. *Soc Psychiatry Psychiatr Epidemiol* 37:38–45
8. Bhui K, Stansfeld S, Hull S, Priebe S, Mole F, Feder G (2003) Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. *Br J Psychiatry* 182: 105–116
9. Brugha T, Bebbington P, Tennant C, Hurry J (1985) The List of Threatening Experiences: a subset of 12 life event categories with considerable long-term contextual threat. *Psychol Med* 15: 189–194
10. Chaturvedi N, McKeigue PM (1994) Methods for epidemiological surveys of ethnic minority groups. *J Epidemiol Comm Health* 48:107–111
11. Commander MJ, Sashidharan SP, Odell S, Surtees PG (1997a) Access to mental health care in an inner city health district. 1. Pathways into and within specialist psychiatric services. *Br J Psychiatry* 170:312–216
12. Commander MJ, Sashidharan SP, Odell S, Surtees PG (1997b) Access to mental health care in an inner city health district. 2. Association with demographic factors. *Br J Psychiatry* 170:317–320
13. Endicott J, Spitzer RL, Fleiss JL, Cohen J (1976) The Global Assessment Scale. *Arch Gen Psychiatry* 33:766–771
14. Fenton S, Siddiqui B (1993) *The sorrow in my heart*. CRE, London
15. Goldberg D, Huxley P (1992) *Common mental disorders*. Routledge, London
16. Husain N, Creed F, Tomenson B (1997) Adverse social circumstances and depression in people of Pakistani origin in the UK. *Br J Psychiatry* 171:434–438
17. Jacob KS, Bhugra D, Lloyd KR, Mann AH (1998) Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *J Royal Soc Med* 91:66–71
18. Jhadav S, Weiss MG, Littlewood R (2001) Cultural experience of depression among white Britons in London. *Anthropol Med* 8:47–69
19. Meltzer H, Gill B, Petticrew M, Hinds K (1995) *OPCS Surveys of Psychiatric Morbidity in Great Britain Report No. 1. The prevalence of psychiatric morbidity among adults living in private households*. HMSO, London
20. Meltzer H, Bebbington P, Brugha T, Farrell M, Jenkins R, Lewsi G (2000) The reluctance to seek treatment for neurotic disorders. *J Ment Health* 9:319–327
21. National Institute for Mental Health in England (2003) *Inside outside. Improving mental health services for black and minority ethnic communities in England*. Department of Health, London
22. Nazroo J, Fenton S, Karlsen S, O'Connor W (2002) Context, cause and meaning: qualitative insights. In: Sproston K, Nazroo J (eds) *Ethnic minority psychiatric illness rates in the community (EMPIRIC)*. National Centre for Social Research, London, pp 137–158
23. Odell S, Surtees PG, Wainwright NWJ, Commander MJ, Sashidharan SP (1997) Determinants of general practitioner recognition of psychological problems in a multi ethnic inner city health district. *Br J Psychiatry* 171:537–541
24. OPCS (1992) *Census definitions Great Britain*. HMSO, London
25. Smith P, Sheldon TA, Martin S (1996) An index of need for psychiatric services based on in-patient utilisation. *Br J Psychiatry* 169:308–316
26. Spitzer RL, Williams JBW, Gibbon M, First MB (1992) The Structured Clinical Interview for DSM-III-R (SCID): 1. History, rationale, and description. *Arch Gen Psychiatry* 49:624–629
27. SPSS (1993) *SPSS for windows. Release 6.0*. SPSS Inc, Chicago
28. Tarlov AR, Ware JE Jr, Greenfield S, Nelson EC, Perrin E, Zubkoff Z (1989) The Medical Outcomes Study: an application of methods for monitoring the results of medical care. *JAMA* 262: 925–930
29. Wilson M, MacCarthy B (1994) General practitioner consultation as a factor in the low rate of mental health service use by Asians. *Psychol Med* 24:113–119

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.