Abstract

Objectives: This chapter examines issues related to research and policy on common mental disorders in South Asian communities in Western countries, including depression, anxiety, and somatic distress. The prevalence, social context, symptom expression, treatment utilization, and conceptual representations of common mental disorders are reviewed, as well as the relevance of current treatment approaches. Strategies are suggested for creating culturally appropriate treatments that address the social adversity underlying common mental disorders in South Asian Americans.

Key Findings: Several key findings emerge from current research. First, multiple social factors have been shown to be associated with common mental disorders, including low acculturation, discrimination, and immigration stress. Second, evidence suggests differential vulnerability of subgroups within the South Asian community. For example, South Asian American children are more psychologically resilient as compared to White children, which is likely to do with benefits associated with traditional extended family life. Evidence also shows that South Asian women experience higher rates of depression, anxiety, and somatic distress, in addition to self-harm and completed suicide rates, when compared to White women and South Asian men. Social factors, particularly marital and family conflict, are the key cause of a woman’s increased burden of distress and disorder. A third key finding indicates very low mental health treatment utilization among South Asian immigrants. Review of the evidence suggests that the key factor underlying low utilization is a lack of ‘match’ between the types of treatments currently available—psychotherapy and medication—and the social models of distress and suffering held by many.
South Asian immigrants. The weakness of current treatment models to address social suffering in low income South Asian groups is also described.

**Recommendations:** There is an urgent need to adapt current mental health treatment models to better address the public health burden of common mental disorders in vulnerable subgroups. A promising strategy is the development of culturally appropriate treatment models that can achieve a conceptual match with South Asian models of distress and address underlying social causes of common mental disorders. This chapter describes innovative treatment models currently under development in both the United Kingdom and the United States.
Introduction

In 2002, authors of *The Brown Paper*’s chapter on mental health deplored the lack of data on South Asian mental health issues in the United States and emphasized the need for more research (Rastogi & Suthakaran, 2002). Nearly 15 years later, however, little has changed in this regard, even while the South Asian community in the United States has continued to grow substantially. In fact, from 2000-2010, the number of South Asian Americans (SAA) increased by 81%, and now reaches more than 3.4 million (South Asian Americans Leading Together [SAALT], 2012). Despite this growth, the SAA population receives little attention from the public health community and only a small fraction of research dollars from the National Institutes of Health.

In seeking to report on issues informing research and policy on mental health in South Asian communities in the United States, this chapter draws, by necessity, on the substantial research literature from Canada and the United Kingdom, as well as the available U.S. studies. This chapter focuses on common mental disorders (CMD), which include everyday symptoms of psychological and physical distress that are common in societies across the developed and developing world. The CMD approach does not distinguish between diagnostic categories such as major depression or generalized anxiety disorder because it is not clear whether such diagnostic categories are comparable and valid across cultural settings (Beals, Manson, Mitchell, Spicer, & AI-SUPERPFP Team, 2003; Bhugra & Hicks, 2004; Cheng, 1989; Marsella, 1987), or if they represent different disorders (Slade & Watson, 2006). It is perhaps for these reasons that the CMD classification has been widely used internationally in cross-cultural mental health research.

Despite its wide prevalence, CMD is a toxic condition associated with social and psychological dysfunction, adverse health outcomes, and is a leading factor in the global burden
of disease (Ferrari et al., 2013; Patel & Kleinman, 2003). It is also, however, a local phenomenon, one that is best understood in its social context. CMD arises from disturbances in what anthropologists have called “local worlds,” or communities and social networks such as families, workplaces, schools, and neighborhoods. Loss, deprivation, social conflict, and violations of moral codes underlying everyday experiences in local worlds create the conditions for CMD (Kirmayer, Young, & Robbins, 1994; Kleinman & Good, 1985; Ware & Kleinman, 1992).

As the South Asian population in the United States becomes increasingly varied, South Asian immigrants today have come to occupy vastly disparate local worlds. Examples include the local worlds of the Silicon Valley engineer vs. the new immigrant taxi driver; the elderly Gujarati couple living with adult children in an Atlanta suburb vs. the teenager struggling with language barriers in an urban high school; or the second generation physician married to a classmate from medical school vs. the young village woman brought to the home of a husband she has never met. Just as social roles and social networks, resources, support, and privilege vary across local worlds occupied by these individuals, so too does the type of mental distress and disorder. These differences are not only in the prevalence of CMD, but also in the multitude of symptoms, the ways in which symptoms are conceptualized and understood, and in the types of solutions sought to manage the disorder.

Prevalence of CMD

Few population-based health studies in the United States report findings on the health and mental health of the SAA population. In fact, those who are most likely to be at high risk for CMD—recent immigrants, non-English speakers, and undocumented residents—are also those
who are least likely to be included in these studies. As a result, findings are difficult to interpret. In two population-based surveys from the United States, the 2004 National Latino and Asian American Study and the California Health Interview Study, lower rates of mental health symptoms were found among affluent, highly educated South Asian samples, when compared with several other Asian groups, and with rates similar to White respondents (Masood, Okazaki, & Takeuchi, 2009; Sorkin, Nguyen, & Ngo-Metzger, 2011). In the United Kingdom, population-based studies examined the prevalence of CMD but reported varied results with no clear pattern. This included two large-scale surveys that found few differences in prevalence between South Asians and Whites (Nazroo, 1997; Weich et al., 2004).

Conversely, community-based studies in low income, deprived areas have consistently found higher levels of distress in women, a key subgroup, when compared with their White counterparts (Bhui, Bhugra, Goldberg, Sauer, & Tylee, 2004; Williams, Eley, Hunt, & Bhatt, 1997). In the United Kingdom studies, Pakistani women, in particular, tended to report more distress (Anand & Cochrane, 2005; Creed et al., 1999). Varying results may also be due in part to differences in the communities that were under study. Finally, the lack of cross-cultural validity of measurement tools and strategies may also be a problem (Anand & Cochrane, 2005). South Asians tend to underreport psychological symptoms in survey studies, when compared with Whites (Williams et al., 1997), thus common psychological measures of CMD likely underestimate true prevalence.

Social Context and Precipitants of CMD

In this section, social factors that are believed to account for CMD in South Asians are discussed.
Acculturation

Acculturation research indicates that the process of acculturation takes different trajectories in different social contexts. According to a widely cited model by Berry (1997), individuals who choose an ‘integrative’ path toward acculturation seek to maintain their ethnic identity while at the same time seeking active engagement with the host culture. As a result, they enjoy better adjustment than those who reject either of these options (Berry, 1997). Empirical evidence comparing measures of acculturative adaptation also supports this view (Berry, 1997; Krishnan & Berry, 1992). In a study of South Asian children in the United Kingdom, results showed that those who made ‘integrated’ choices regarding clothing and friendships—choices that reflected an identification with both the host culture and their own ethnic group—reported fewer mental health issues (Bhui et al., 2005). Other research also suggests that those with a strong ethnic identity enjoy greater well-being (Heim, Hunter, & Jones, 2011). Overall, those who have stronger ties and greater engagement with the majority community are found to be younger, better educated, higher income individuals with greater language fluency, and experience less distress (Maker, Mittal, & Rastogi, 2006).

Racism and Discrimination

South Asian immigrant groups in the West have long been the target of racism in their host societies. In the United States, in particular, post 9/11 racist persecution and violence have been widely experienced across South Asian immigrant communities and directed specifically toward Muslims and Sikhs (South Asian Youth Action, 2013). Thus, the hypothesis that racism and discrimination have an adverse effect on CMD is a highly plausible one. A substantial amount of literature on perceived racism/discrimination and mental health, including a large
scale population-based study (Kessler, Mickelson, & Williams, 1999), documents a strong relationship between the two (Chakraborty & McKenzie, 2002; Heim et al., 2011). These studies do, however, share a common weakness in their cross-sectional design. The correlation between perceived racism and mental health problems does not mean that racism causes mental problems. In fact, it could just as easily mean the opposite—that people experiencing depression, anxiety, and psychosis are more likely to perceive racism and discrimination in their everyday lives. In order to untangle the causal association, more intensive and costly research approaches are needed, including longitudinal designs or non-subjective indicators of racism/discrimination.

**Immigration**

In recent years, many middle class and lower class South Asian families have immigrated to the United States. Unfortunately, they come unfamiliar with the realities of life in post-recession America, including unemployment, crime, and housing shortages. As a result, many immigrants are profoundly shocked and unsettled by the reality of their new lives. In a study of new South Asian immigrants living in New York City, researchers examined social status indicators of parents prior to and following immigration. They identified a clear pattern of downward mobility. Fathers who had been bank managers and business owners in South Asia were now driving taxis, while mothers who had been teachers or housewives were working in menial jobs. Immigrants were shocked to learn they did not have the resources to seek higher education or training in the United States in order to better their circumstances (Bhattacharya & Schoppelrey, 2004). Adding to these difficulties was the burden of family expectations from their homeland. In many cases, relatives who provided funds for travel to the United States
eagerly anticipated repayment in the form of ongoing financial support. Sending remittances home is a common practice and places a significant burden on struggling families (Kulkarni, 2013; South Asian Council for Social Services, 2004).

The immigration experience can be especially stressful for women. Women are less likely than men to speak English or to have marketable job skills (South Asian Council for Social Services, 2004). In New York City, studies conducted with Bangladeshi women found that the immigration experience was associated with extreme disappointment, isolation, and a sense of loss. Separated from family and friend networks in their home country, these women were now caring for small children in small crowded apartments, with no access to employment or education, and an uncertain future. As a result, depression, somatic distress, and other health problems, including obesity, have been found commonplace among recent female South Asian immigrants (Gupta, 1999; Karasz, 2005; Khanlou & Peter, 2005; Naidoo & Davis, 2001; Raj & Silverman, 2003).

CMD among South Asian Subgroups

Children

Studies from the United Kingdom suggest that school-aged South Asian children experience better psychological adjustment and fewer behavior problems than White children (Cochrane, 1979; L. Hackett, R. Hackett, & Taylor, 1991; Newth & Corbett, 1993). Evidence suggests there are a number of cultural factors that influence better adjustment among South Asian children, one of which is a less punitive disciplinary style (Newth & Corbett, 1993). Traditional extended family structure has also been shown to be beneficial for these children (Shah & Sonuga-Barke, 1995).
Adolescents

For adolescents, defined as ages 10-19 (Age limits and adolescents, 2003), the protective effects of traditional extended family life may not extend to them—at least, not to adolescent girls. In South Asian and White adolescent girls, the rates of self-harm and suicide attempts are similar and are far higher than rates among adolescent boys (Bhugra, Thompson, Singh, & Fellow-Smith, 2003). In fact, evidence suggests that these differences are related to higher rates of parental coercion directed toward adolescent daughters. In keeping with the cultural concept of izzat, or honor, some conservative parents may impose restrictive gender role norms on girls as they approach the end of childhood. In extreme and rare cases, forced marriages and forced emigration back to the home country have also been documented (Abraham, 2000; Ayyub, 2000).

A study of women’s explanatory models of depression found that conflict with parents regarding marriage was a common explanation for depressive symptoms (Karasz, 2005). Further research found that such conflicts can push young women who are dependent on their parents to desperation (Naidoo, 2003), which can lead to suicide attempts (Bhugra, 2002; Cooper et al., 2006).

Adult Women

Across cultures, women are characterized by very high rates of CMD as compared to men, including depression, anxiety, and somatic distress (Ferrari et al., 2013). Evidence suggests, however, that there is a wider mental health gender gap in South Asian societies than is found in the West. For example, a recent review of studies examining the prevalence of depression in
Pakistan found an astonishing average prevalence rate of 45% for depressive symptoms among women, compared to 21% among men (Mirza & Jenkins, 2004). Evidence also suggests that South Asian women immigrants continue to experience very high rates of CMD compared to their male counterparts (Sorkin et al., 2011). Consequently, immigrant women are much more likely to engage in self-harm and suicidal behaviors, including completed suicides, than either South Asian men or White women (Bhugra, Corridan, Rudge, Leff, & Mallett, 1999; Cooper et al., 2006; Nathan Kline Institute, 2005).

Studies have consistently found that family conflict is most strongly associated with CMD in adult women. In a United Kingdom study, Gater and colleagues (2009) found a prevalence rate of 65% for depression in elderly Pakistani women, compared to 21% in White women of the same age, even when controlled for age and socio-economic status. Excess distress and symptoms were also associated with isolation, family conflict, and a lack of social support (Gater et al., 2009). Other studies have found that domestic violence is also a factor in a woman’s suffering (Abraham, 2000, 2005; Ayyub, 2000; Kallivayalil, 2010). Results of the California Health Interview Survey indicated that while demographic risk factors such as poverty, explained depressive symptoms in South Asian men, psychological distress among women was more often explained by social factors and, in particular, family problems (Sorkin et al., 2011).

Traditionally, early married life is a vulnerable time for South Asian women (Rastogi, 2007). The mother-in-law and daughter-in-law relationship is often a conflictual one in which the daughter-in-law experiences a considerable disadvantage. As the newest and lowest status member of the family, a young married woman in a joint family is expected to devote herself to her husband and his parents, while her own well-being is dependent upon securing their
affection. When she is mistreated by these significant authority figures, the sense of shame, isolation, and despair can be overwhelming (Abraham, 2000, 2005; Kallivayalil, 2010). Joint family settings are also associated with more distress and symptoms for married women than nuclear family settings (Sonuga-Barke & Mistry, 2000; Sonuga-Barke, Mistry, & Qureshi, 1998).

Because there are few culturally sanctioned avenues of escape for newly married women, women in coercive and conflictual family situations often feel trapped (Gask, Aseem, Waquas, & Waheed, 2011). Suicide attempts may be seen as a rational strategy for escaping a hopeless and unbearable situation (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002). In fact, South Asian women who have made suicide attempts are much less likely to carry a diagnosis of depression or other mental disorder than White women (Cooper et al., 2006; van Bergen, van Balkom, Smit, & Saharso, 2012).

**Postpartum Women**

Across cultures, the postpartum period, or the period of time after a woman gives birth, is a vulnerable period for women. Studies in South Asia identify very high rates of postpartum depression among women (American Psychological Association, n.d.). Not surprisingly, postpartum depression in South Asia is associated with poverty, hunger, giving birth to a female child, a lack of social support, and marital conflict (Patel, Rodrigues, & DeSouza, 2002). Studies of immigrant communities in Western societies have found a similar association with poverty, substandard housing, enforced isolation, coercion, marital conflict, and a lack of social support (Husain et al., 2012; Husain, Gater, Tomenson, & Creed, 2004; Parvin, Jones, & Hull, 2004; Zelkowitz et al., 2004).
**Somatization**

Many studies have found that, like many non-Western, non-White or non-middle class individuals, South Asians are more likely to present with physical symptoms such as pain or fatigue when they are feeling distressed, than are Western White middle class individuals (Lin, Carter, & Kleinman, 1985; Weiss, Raguram, & Channabasavanna, 1995; Weiss et al., 1986). Physical symptoms may be more understood as an idiom, or language for communicating distress and social problems, also known as somatization (Bhugra & Hicks, 2004; Nichter, 1981). Of note, South Asians who express distress physically are not unaware or in denial of such psychological disturbance (Rastogi, 2009a). In a study comparing emotional responses to stressful situations, researchers found that South Asian women and White women reported similar feelings of anxiety, sadness, and hopelessness when interviewed about their feelings (Karasz, Dempsey, & Fallek, 2007). However, when telling stories about these events, South Asian women were more likely than White women to include physical symptoms in their illness narratives. Symptoms including fainting, dizziness, and sensations of hot and cold, were all used to emphasize the impact of these stressful situations and the moral culpability of those persons responsible for the narrator’s distress (Karasz et al., 2007).

**Treatment Utilization**

An abundance of evidence indicates that South Asian immigrants underutilize mental health treatment when compared to Whites. They are less likely to consult or be referred to a mental health professional (Commander, Odell, Surtees, & Sashidharan, 2004; Karasz & Dempsey, 2008; Lloyd, 1992; Sorkin et al., 2011), less likely to share their mental health problems with a physician (Gillam, Jarman, White, & Law, 1989; Sorkin et al., 2011), and less
likely to take antidepressants (Cooper, Booth, & Gill, 2003; Hull, Aquino, & Cotter, 2005). Even when patients are active in mental health treatment, South Asians receive less treatment (Cornwell & Hull, 1998), miss more appointments, and accept fewer prescriptions (Agius, Talwar, Murphy, & Zaman, 2010).

A variety of explanations have been suggested for the low rates of treatment utilization in South Asian communities. One is the lack of access to services, particularly in the United States, where financial and structural barriers limit access to care (Grote, Swartz, & Zuckoff, 2008). Still, even in Canada and the United Kingdom, where most people have access to mental health referrals and treatment, utilization among South Asians remains much lower than in the general population. There is a broad perception that that the use of folk treatments, including prayers, faith healing, and culturally-specific medicinal treatments, also serve as a barrier to treatment for mental health disorders. Here again, however, although use of such healers and treatments is quite high in India (Halliburton, 2004; Shankar, Saravanan, & Jacob, 2006), studies of immigrant communities in Western societies have found that the use of traditional treatments for mental disorders is low and that these treatments did not appear to serve as a barrier to care (Bhopal, 1986; Commander et al., 2004).

A number of studies report that stigmatizing attitudes do exist toward mental illness among South Asians (Nieuwsma, Pepper, Maack, & Birgenheir, 2011; Rastogi et al., 2014; Sadavoy, Meier, & Ong, 2004). In fact, research suggests that South Asian families with mentally ill members may be concerned with gossip, sometimes fearing that this may affect their social standing or ability to marry their children (Bradby et al., 2007). As a result, South Asian patients who are concerned with stigma in the community are less willing to seek mental health treatment (Cinnirella & Loewenthal, 1999).
Explanatory Models of CMD

An important factor that can explain the low rates of mental health and low rates of treatment utilization among South Asian immigrants lies in the explanatory models associated with depression that are common among South Asians (Chaudhury, 2011). Standard mental health treatments available in Western societies are predicated on a bio-psychiatric model of illness. According to this explanatory model, symptoms of distress are viewed as evidence of underlying pathology—dysfunction and disorder at the brain or behavioral level (Bolam, Murphy, & Gleeson, 2004; Saltonstall, 1993; Shilling, 2002). These “Western” assumptions are, however, at odds with explanatory models of common mental disorders in many South Asian societies. Emotional experiences in South Asian communities, including depression and anxiety, are generally characterized as a relatively normal response to life’s problems and situations.

In 2014, a review of 19 studies of explanatory models of depression in South Asia found that biological and behavioral/cognitive explanations for symptoms were rare among participants experiencing these conditions (Aggarwal et al., 2014). Depression was attributed most frequently to familial issues including marital problems, lack of social support, social isolation, financial problems, and health issues. Notably, supernatural or ‘folk’ explanations for depressive illness were rare. Additionally, while a similar review does not exist for the South Asian diaspora, numerous qualitative studies, as well as theoretical papers from counseling literature, reflect similar themes (Bhui, Bhugra, & Goldberg, 2002; Chew-Graham et al., 2002; Ekanayake, Ahmad, & McKenzie, 2012; Karasz, 2005; Rastogi, 2007; Shankar et al., 2006).

A number of researchers have examined conceptual representations of depressive symptoms. These studies identify South Asian conceptual models of depression as problems of
the social world, due largely to disruptions in core relationships. In fact, conceptual
representations of depression as a problem of social origin are a major reason that professional
and psychological treatment are not viewed as appropriate strategies for managing depressive
illness. As an example, when asked about suitable treatments or management strategies for
managing depression, participants in one series of studies conducted in the United States
suggested more pragmatic solutions (Karasz, 2005; Karasz et al., 2007, Rastogi, 2007). These
solutions included suggesting that a depressed woman who is dealing with marital conflicts ask
for help from influential family members who could then influence her husband’s behaviors
Likewise, depression caused by a woman’s humiliating financial dependence might be addressed
by finding a way for her to have income. Finally, establishing or repairing close social
connections was seen as a solution to returning to emotional well-being (Karasz, 2005; Karasz et
al., 2007).

These findings regarding conceptual models of depression have important implications
for the design of interventions that address CMD. As the evidence suggests, the answer to
solving the problem of untreated CMD does not lie simply in providing better access to
conventional mental health services. Instead, as seen in therapeutic healing practices around the
world, congruence between patients and healers is necessary in order for therapies to be effective
(Benish, Quintana, & Wampold, 2011; Kleinman, 1980). Unfortunately, this type of congruence
does not always occur in Western treatment settings. Patients who conceptualize their depression
in social and situational terms are skeptical as to the efficacy of conventional technical
treatments that focus on the individual (Karasz, Patel, Kabita, & Shimu, 2013; Karasz, Ragavan,
Patel, Akhter, & Kabita, in press; Karasz & Watkins, 2006; Nadeem, Lange, & Miranda, 2009).
As a result, they see less need for care (Karasz & Dempsey, 2008; Karasz et al., 2012). Though
this is often labeled pejoratively as a problem with mental health literacy (Lauber, Nordt, Falcato, & Rossler, 2003), it should instead be recognized as a lack of conceptual synchrony—a clash between professional and technical models and the situational models that are common in low income communities (Karasz et al., in press).

Studies suggest that South Asian immigrants conceptualize CMD symptoms as a natural or unavoidable reaction to severe life stress, a problem that exists in the local social world. Research suggests, however, that for South Asian immigrants, treatments that involve medication or talk therapy appear inadequate to address problems in core social relationships, particularly when the problem is within hierarchical relationships. Whether the precipitating factor is marital abuse, coercion from in-laws, or separation from close family members, conventional bio psychiatric treatments that are aimed at correcting thoughts and behaviors or balancing neurotransmitters often seem inadequate. Similarly, when the problem is poverty and deprivation, medication and therapy may not be as effective as directly addressing the problem at hand (Karasz et al., 2013; Karasz et al., in press; Karasz, 1998).

**New Directions in Treatment**

It can be argued that new models of mental health treatment are needed in order to effectively address the widespread problem of CMD among vulnerable South Asian subgroups. Evidence has been presented that conventional mental health treatments lack relevance for South Asian immigrants who are experiencing CMD. Still, even if the conceptual gap between community models and current treatment paradigms did not exist, there would be good reason to propose that new treatment models are needed.
Growing evidence suggests that conventional treatment models for CMD, including antidepressants or psychotherapy, are much weaker than were previously thought. For example, commonly prescribed antidepressant medications are largely ineffective in treating CMD, particularly when compared to placebos (Kirsch, 2000, 2009; Moncrieff & Kirsch, 2005). Additionally, evidence suggests that standard treatments currently available may be inadequate to address depression among the socially and economically vulnerable. In fact, evidence from large comparative trials in the United States found a strong link between socioeconomic status and treatment response, with patients with lower socioeconomic status achieving worse outcomes than other groups (Howland, 2008; Trivedi et al., 2006; Warden et al., 2009). Other large research studies have also found that poverty-related factors such as unemployment, economic adversity, and isolation all serve to reduce the effectiveness of both pharmacological and psychotherapeutic treatments (Brown et al., 2010; Kendrick, 2000).

**Promising New Treatment Models**

Based on the evidence among South Asian groups who are vulnerable to CMD, standard treatment approaches show limited effectiveness. A promising alternative model, though not yet tested in controlled trials, is marriage and family therapy. Clinical anecdotal evidence suggests that when distress and dysfunction are due to family disturbances, these may sometimes be addressed through marriage and family therapy. When relevant, such therapy can be culturally tailored without necessarily challenging traditional familial hierarchies (Rastogi, 2009a, 2009b).

Other novel treatment models for CMD have been described in the literature as well, including treatments that seek to address social-contextual stresses. One model, based on research demonstrating the role of social isolation in depression, uses a ‘befriending’ model to
provide companionship to depressed individuals (Harris, Brown, & Robinson, 1999). Similarly, another promising model developed in the United Kingdom for South Asian women, uses social support and network building strategies to address loneliness and isolation (Chaudhry, Waheed, Husain, Bhatti, & Creed, 2009; Gater et al., 2010). In the United States, a partnership consisting of South Asian immigrant women, clinicians, activists, and health researchers developed a depression treatment intervention model that addresses both social isolation as well as financial dependence among low income women. The model, called Action to improve Self-esteem and Health through Asset building (ASHA), provides depression treatment while helping women to build friendship networks. At the beginning of the program, participants open bank accounts, many for the first time in their lives, and begin saving money. Savings are matched at the end of the 6-month program and participants may use their funds to purchase assets that will contribute to their financial independence, such as job training or education. The program has shown promising results in both reducing depression and retaining women in treatment. Some graduates of the program have pooled assets to start business cooperatives (Karasz et al., 2015).

**Recommendations**

- More research. Due to the limited research on South Asians in the United States, this review drew largely on research from Canada and the United Kingdom. Although many inferences can be drawn from these studies, the need for more research on the SAA population is clear. Both quantitative and qualitative research is needed to better understand the risks, the contextual dynamics—including racism and discrimination, and the effective interventions to address mental health problems in South Asian
communities, particularly newer immigrants, the underserved, and those with increased needs.

- Better measurement tools. More attention should be paid to developing valid clinical tools, including those that measure cultural idioms of distress (Karasz et al., 2013). Without more data, it will be difficult to draw the attention of public health researchers and policy makers, or to attract the resources needed to address the current gap in services.

- Stronger, more culturally relevant interventions. The research reviewed in this chapter points to the need for a fresh approach to the development of clinical interventions. Conventional mental health treatments are based on a one-size-fits-all approach and are based on the faulty assumption that such treatments are universally effective and equally well suited to diverse communities. The programs described herein take a very different and promising approach, focusing on the idea that specific mental health treatment designs should address the social and contextual antecedents that cause distress and mental disorder within the target population. It can be argued that this contextual approach is necessary in order to address the problem of common mental disorders in South Asian immigrant populations. It is the authors’ hope that this chapter provides evidence to further support efforts to develop and test this approach.

Conclusions

This chapter summarizes themes that are key to understanding CMD in South Asian immigrant communities in the United States. These include the prevalence, manifestations, and some of the contextual and social issues shaping the CMD epidemic. Overall, this review
highlights the vulnerability of some subgroups of the population, particularly adolescent and adult women. Key social precipitants include poverty, discrimination, oppressive gender roles, and the stress and loss associated with immigration. South Asians who experience CMD such as depression, utilize treatments at very low rates. This underutilization may be due to the lack of conceptual match between social models of CMD that are common in South Asian communities, and the individual focus of standard Western treatments. Thus, the weakness of current mental health treatment models in addressing CMD is largely a problem of social origin and, again, calls for new treatment models that can better address these limitations.
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