J Immigr Minor Health. Author manuscript; available in PMC 2020 Aug 1.
Published in final edited form as:
J Immigr Minor Health. 2019 Aug; 21(Suppl 1): 7–14.
doi: 10.1007/s10903-016-0501-4

PMCID: PMC5643212
NIHMSID: NIHMS830187
PMID: 27848078

Mental Health and Stress among South Asians

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Background

Studies increasingly demonstrate that South Asian (SA) immigrants are experiencing high rates of mental health disorders, which often times go unaddressed.[1–3] Like many immigrant groups, SAs are susceptible to psychological distress due to migration, subsequent pressures to acculturate, and other social determinants that have a significant impact on functioning and quality of life.[1–3] In one UK study, middle-aged Pakistani men and older Indian and Pakistani women reported significantly higher rates of depression and anxiety (adjusted risk ratios of 2.38, 2.80 and 3.15, respectively) compared to similarly aged Whites, even after adjusting for differences in socioeconomic status.[4] Other studies have demonstrated particularly high susceptibility among SA immigrant females to self-harm and certain mental illnesses, including depression, anxiety, insomnia, and eating-related psychopathology.[5] Disproportionately high rates of mental illness among SAs may have implications for disparities found in chronic illnesses among this population, since psychosocial stressors have been linked to an increase in risk for the onset of cardiovascular disease (CVD) and cancer.[6–10]

Methods

This review focuses on the experiences of SA subgroups with unique mental health needs, including women, older adults (65+), youth, and certain occupational groups, with a geographical focus on the U.S.[2,11–13] Gaps in U.S. literature were informed by research in SA countries of origin and diaspora (e.g. the United Kingdom). A search of NCBI PubMed and Scopus databases using the following

primary key terms was conducted: Stress OR Anxiety OR Mental Health OR Depression OR Women only OR Men Only OR Occupation OR Migration OR Domestic violence OR Alcohol OR Substance Abuse 0R South Asia(n) OR India(n) OR Bangladesh (i) OR Pakistan(i) OR Sri Lanka(n). Additional articles were added based on Steering Committee suggestions. Articles were excluded from the review if they were not relevant to the mental health of SA populations.

Results

Mental Health Epidemiology and Social Determinants

The majority of studies on this topic have been conducted in non-U.S. SA countries of diaspora (e.g. the UK and Canada) and in South Asia (e.g. India), which may inform future research priorities in the U.S. Though limited, the available literature in the U.S. exploring mental health among SAs suggests similar themes.

Migration-related and acculturative stress Bhugra and Jones propose mechanisms by which migrant groups may experience high rates of mental illness based on findings from several UK studies.[14] Although substantial variation in mental disorder rates exists across disaggregated native, ethnic, and generational subgroups, these mechanisms may direct research hypotheses related to SA populations in the U.S. A clear association between mental disorders and migration related stress, which is common among many immigrant groups including SAs, alone is unlikely; however, migration may interact with social factors, such as unemployment or poverty, to produce stress levels that deteriorate mental health.[1–3,14] Research that explores these interactions among U.S. SAs is lacking.

Stress resulting from attempts to incorporate host country traits within one's own culture, referred to as acculturative stress, can also take a toll on mental health. Acculturative stress can include intergenerational conflict, discrimination, and depression.[15] Qualitative interviews with recent SA migrant families in New York City revealed that acculturative stress can impact multiple generational groups, including foreign-born parents and 1.5 generational children.[11,15,16] Kaduvettoor-Davidson and Inman found that, among national samples of first and second generation SAs ranging from 18 to 83 years old, perceived discrimination was positively and significantly associated with perceived stress.[15,17] With respect to gender, culture conflict has been identified as a major source of stress for SA women.[15,18–20] In-depth interviews with SA women who had lived in Canada for at least two years found that many of the women reported acculturative stress due to inter-generational conflict at home, which was correlated with depression and ability to cope.[15] Another study in the UK found a higher prevalence of eating disorders among SA women coming from the most traditional homes, which was associated with low levels of acculturation.[20] Although the role of culture on mental welfare, particularly among U.S. SAs, is still unclear, these studies highlight a potential relationship between acculturation or acculturative stress and mental illness.

Depression Major affective disorder, notably depression, is the most common of all mental health diagnoses among SAs in the UK.[2,4,12] Studies conducted in the UK, the U.S., and India that have examined predictors of depression and similar conditions concluded that older age, literacy, financial difficulties,[12] gender roles,[21] perceptions of illness,[3] social isolation, and poor physical health[1] were contributory factors. Language, feelings of isolation, and lack of adherence to mental health treatment regimens, which are often seen as unnecessary, inhibit proper treatment.[22] In one UK study, social stigma associated with mental health disorders was the underlying reason that a group of SAs caring for older adult relatives with dementia did not consult a professional for their relatives' care.[23]

Somatization SAs with mental health issues commonly interpret their symptoms as physical illnesses and often do not seek needed psychological help.[22,24] One Canadian study found that even when SAs present psychological difficulties to their primary care physicians, they are often untreated and undiagnosed because they are presented as somatic rather than depressive symptoms.[12] Somatization of stress has also been identified as an adverse health effect of abuse, and includes sleep abnormalities, bodily pains and gastrointestinal problems.[25–28] Somatization among SAs may also be understood within the concept of collectivism. In the West, individualism is emphasized, and independence, autonomy, self-reliance, and personal achievement are valued.[29,30] In contrast, SA communities are collectivist, emphasizing family cohesion, conformity, solidarity, and cooperation, with interdependence and group priorities valued over those of the individual.[29,30] While traditional, collectivist families may be considered to be strong, close, and resilient, shifting family structures, unjust distribution of money and resources to different family members, traditional gender norms, patriarchy, and an emphasis on "family harmony" and "obedience to elderly" to suppress women and younger family members, may lead to unexpressed stress and conflict, and a higher prevalence of somatization.[29,31] Further, members of collectivist societies are more likely to keep personal problems to themselves, and only seek professional mental health services as a last resort, as seeking outside help may be seen as a failure of the family to solve the problem.[29,31]

Disparities in South Asian women A significant disparity exists in depression rates between SA men and women, especially younger married women and older adult women.[32–35] Although in the West the rate of suicide is found to be higher among men, the suicide rate, as well as overall self-harm prevalence, is much greater among SA immigrant women than among SA immigrant men. Limited understanding of the purpose of mental health services has been found among many SA women.[3] One recent UK study compared illness perceptions and treatment-seeking patterns between North Indian immigrant women and white women. North Indian women were more likely to report that treatment for depression would not be beneficial, and did not believe a visit to a general practitioner for referral to mental health services was necessary.[3] Several reasons for these disparities in mental health morbidity and health-seeking behaviors exist.[34–38] One of the predictors of mental distress among young SA women is a history of domestic violence. Studies have found depression, anxiety, post-traumatic stress disorder, loss of self-esteem and suicidality to result from verbal and physical abuse.[25–28] Additional forms of marital conflict, including financial coercion and forced isolation, also contribute to the gender disparity in depression and are often a result of a perceived inferior status of women.[39–41]

Explanatory Models While Euro-North Americans typically understand depression and other mental illness in a biomedical framework, SAs often attribute these illnesses to life circumstances.[42–45] In one Canadian study, a group of SA women with depression were interviewed to assess the explanatory models they used to understand their illness.[43] Participants largely felt that their depression was an outcome of personal, family, cultural, and social circumstances.[43] Stresses in familial relationships, aging, isolation, migration, stigma, economic difficulties, and discrimination were all cited as reasons for depression.[43]

Disparities in South Asian Youth Among SA youth in the UK and U.S., poor acculturation and discrimination, coupled with high parental expectations and pressure, can lead to increased stress.[11,35] Diekstra et al. proposed that suicidal behavior could be due to the interplay of "socialization of a particular problem-solving behavior repertoire, socioeconomic conditions and attitudes towards suicide".[38,46] Poor self-esteem, domestic violence, relationships with parents and boyfriends, alcohol and drug use are other motivators for attempted and completed suicide in young SA women.[38]

Disparities in South Asian Older Adults (65+) SA older adults, especially women, also face a disproportionate burden of psychosocial stress in the community.[12,47–52] Predictors of depression among SA older adults include abuse and neglect, social isolation, and acculturative stress.[12] In one study, poorer physical health and a more traditional ethnic identity were correlated with depressive symptoms in a group of older SAs in the U.S.[50] These factors persisted in both limited English proficient and English proficient study groups.[50] Depression in older adults has been associated with slower recovery from physical illness,[51] and can exacerbate their already increased risk for CVD and poor cancer outcomes.

CVD Risk and Mental Health/Stress While there are studies that have examined the impact of depression and stress on cardiovascular disease risk in the general population, no such research has been conducted on SA immigrant communities in the U.S. or the UK.[6–10]

Alcohol Abuse and Cancer In recent years, alcohol abuse has been implicated in increasing the risk of both oral and breast cancer among SAs.[9,53,54] Heavy alcohol intake is a major risk factor for the development of oral cancer, in particular, for squamous cell carcinoma.[55] For alcohol consumption of 25 grams/day, there is an 80% increased risk of developing oral cancer, a three-fold risk increase for 50 grams/day, and a six fold increased risk for alcohol intake of 100 grams/day.[55] A study conducted in 2000 by Vora et al. found significant differences in the prevalence of risk behaviors and cancer risk awareness between Hindus, Sikhs, Jains and Muslims; and significant differences in alcohol, paan, and tobacco use.[56] Hindus had the highest risk of developing oral cancer due to their use of all three substances. Alcohol is prohibited in Muslim and Jain faiths, and there is very low consumption in first generation immigrants.[56] However, this trend changes for second generation Jain immigrants, while it remains consistent for first and second generation Muslims. Alcohol consumption is highest among first and second generation Sikh male immigrants. This group also has the lowest awareness of the risk of developing cancer with heavy drinking.[56]

Findings from a study conducted in the UK indicated that there has been an increase in breast cancer incidence (up by 8% in a decade) among SA women.[57] Researchers implicated increased alcohol intake - due to acculturation among second and third generation SAs - as one of the causative factors for this increase.[57]

Cancer and Coping Strategies Psychiatric distress among cancer patients is typically caused by grief about loss, fear of death, concern for loved ones, and the effects of some chemotherapeutic drugs on mood. If mental health issues are left untreated among cancer patients, patients have increased pain and disability, and a stronger desire to die. Studies have shown that physicians do not give sufficient attention to cancer patients with psychiatric issues.[58] In one study among SAs, who may already face disproportionate rates of depressive and anxiety disorders, mental health issues can be further exacerbated by a cancer diagnosis.[59] Lord et al. recently studied the coping strategies of SA cancer patients in the UK. Ninety-four British SAs (BSA) and 185 British White (BW) cancer patients completed questionnaires rating their coping mechanisms, using the Mini-Mac scale,[59] and were screened for depressive symptoms using multiple instruments, including the PHQ-9. A positive screen for depressive symptoms was associated with maladaptive coping strategies. At baseline, BSA had two times the incidence of depression than BW and had a higher prevalence of depressive symptoms.[59] BSA patients had a higher prevalence of maladaptive coping strategies, including helplessness/hopelessness (33% BSA, 12.4% BW), fatalism (based on indicators such as “I’ve put myself in the hands of God”; 75.5% BSA, 32.4% BW), and denial of having cancer (20.2% BSA, 4.3% BW).[59] After nine months, the disparity in the prevalence of depressive symptoms between the two groups remained the same. Compared to BW, BSA reported significantly more physical symptoms, including more pain, mouth sores, nausea, and fevers. Lord et al. suggests that BSA’s higher levels of physical pain may have confounded the increase in depressive symptoms over the 9-month study period.[59]

Access to Mental Health Services in the Community

Barriers to Use of Mental Health Services The lack of access to mental health services is a barrier to care for many low income immigrant groups. However, among SAs, evidence suggests that patient level factors act as a further barrier to utilization. Although utilization rates among SAs in the U.S. are lacking, several sources indicate that Asian Americans, especially those that are foreign-born, underutilize mental health services to a greater extent than the general U.S. population.[60,61] Among a sample of Asian Americans diagnosed with a psychiatric disorder, only 40% of U.S.-born and 23% of foreign-born subjects reported using mental health services.[61] Furthermore, among a nationally representative sample with probable DSM-IV diagnoses, 34.1% of Asian Americans sought care within a 12-month period compared to 41.1% of the general population.[60]

Several studies have found culturally-linked stigma regarding mental health service utilization within immigrant SA communities in the UK and U.S., which may impede health-seeking behavior.[62–66] It is often believed that disclosure of a mental illness will bring shame upon the family, and is a sign of weakness.[62] As a result, individuals may keep problems within the immediate family and not

utilize health services.[62] Rehman's 2013 study on accessing mental health services among Pakistani Muslim women in the U.S. found that family and personal reputation were important reasons for not seeking professional help.[5] Studies on the role of cultural stigma in seeking out mental health services are lacking among other SA subgroups residing in the U.S.

Religion, which is often a central part of an individual's culture, may also mediate the utilization of mental health services among U.S. SAs. Religious followers of SA origin, including Muslims, Hindus, Sikhs, and Christians, have been shown to turn to prayer and counsel from religious leaders to deal with mental distress.[5,67,68] Religion can provide a valuable way of dealing with mental health concerns, but in some cases, it may deter those who require professional help from seeking it.[5,66–68] Sheikh and Furnham found that religion was a significant predictor of attitudes to seeking professional help for mental health issues across various cultural and religious groups, with Muslims demonstrating the least positive attitude to seeking professional help.[66,68]

As noted above, a lack of cultural responsiveness among providers may also prevent SAs in the U.S. from utilizing health services, particularly for mental health issues. Mental health providers who do not share their patients' cultural background may hold certain assumptions of normative family life or gender roles that differ from those of their patients, thereby undermining the effectiveness of psychological treatment or patients' willingness to seek it out.[69] Rehman found that mental heath professionals' lack of understanding of Pakistani cultural values and religious beliefs was the primary reason for participants' resistance towards continuing treatment.[5]

Overcoming barriers to accessing mental health services among U.S. SAs can be fostered by the provision of relevant cultural responsiveness training to mental health service providers as well as medical professionals, especially primary care providers who serve as the first line of service, treating SA populations. Volunteers and social workers of the same culture or religion as patients can also effectively mediate interactions with health care personnel.[5] Because religion has played a central role in addressing mental health issues, spiritual values should be considered when developing mental health services for the SA community. This can be accomplished through collaboration between health care providers and religious leaders.[67,70,71]

Current Approaches to Mental Health Services and Potential Treatment Models A limited number of robust national and local efforts have been launched in recent years to tackle the issue of scarce and inadequate mental health services for SAs, which may serve as models for future initiatives. Counselors Helping South Asian Indians (CHAI), based in the DC Metropolitan area, provides a holistic approach to mental health services referral and dissemination of general information. Apna Ghar, based in Chicago, also provides holistic services to SA women, offering education, transitional housing, counseling, and legal services, to foster self-sufficiency. SAPNA NYC, formerly known as Westchester Square Partnership, is based in New York, and facilitates access to healthcare services, including counseling, and promotes self-sufficiency and empowerment among SA women. The South Asian Council for Social Services, also based in New York, organizes workshops and provides support to SA older adults facing social isolation and other psychological stressors that put them at risk for depression. Since 2002 SAMHAJ (South Asian Mental Health Awareness in Jersey) has provided

support groups, educational workshops, and referral services to the SA community in New Jersey. India Home, based in New York, is committed to improving the quality of life for seniors and people with special needs. Several other community-based organizations around the nation continue to address the mental health service gaps among SAs, especially for women, youth, and older adults, though there still remains unmet need.

Given the differences in explanatory models of mental illness between SAs and other ethnic groups, treatment models incorporating social interventions, rather than cognitive or medicinal therapy, have been found to be effective.[72] In one UK randomized controlled trial, a cohort of women with depression were randomized into one of three intervention arms: social group intervention, antidepressant, or both social intervention/antidepressant arm.[72] The social intervention group consisted of a small network of women participating in social activities together.[72] By 3 and 9 months, there was significantly greater social functioning among women in the social intervention arm and the social intervention/antidepressant arm when compared to the antidepressant alone arm.[72] In this study, improvement in social functioning was attributable to social intervention rather than medicinal therapy, and is likely a more effective, culturally appropriate treatment model for SAs suffering from depression alone, or comorbid to other conditions, including cancer and heart disease.[72] The "Action to Improve Self esteem and Health through Asset building" program in New York City also demonstrates the potential for interventions based on social frameworks to effectively treat SAs suffering from depression.[73] The program is designed to address financial disempowerment, social isolation, and depressive symptoms through an integrative, multi level model.[73]

Conclusions

Mental health among SAs in the U.S. has emerged as an urgent yet understudied issue[74]. Future efforts to improve the mental health of this population will first necessitate more data across various subgroups to help researchers better understand the nature of mental illness in SA communities. Although the limited pool of available data indicates that certain SAs in the U.S., including women and older adults, suffer from disproportionate rates of mental illness, its prevalence, potential risk factors (e.g. poverty, unemployment, isolation, domestic violence, and discrimination), potential protective factors (e.g. social support and acculturation), and potential associations with chronic diseases (e.g. cardiovascular disease and cancer) across SA subgroups remain unclear. Future analyses should focus particularly on disaggregating data according to immigration (or generational) group, socioeconomic factors, and gender.

Second to addressing these data gaps is defining the range of cultural and personal conceptualizations of mental health in the U.S. SA community. As research in the UK, Canada, and South Asia have indicated, SAs, particularly foreign-born individuals, may more commonly perceive mental illness through social or family-based frameworks than a biomedical one.[42–45] For example, certain SA individuals may tend to understand their depression as a result of poor social support more than a serotonin imbalance. On the contrary, certain SAs with greater degrees of acculturation may identify with Western diagnostic models that focus on biological mecha-

nisms and are more individualistic. Considering the likely significant interaction between social issues and mental health among the SA community, more research should focus on violence, substance abuse, and other factors that mediate or contribute to mental illness.

Clearer understandings of the epidemiology and conceptualizations of mental illness among SAs in the U.S. will allow researchers to test appropriate interventions that promote mental wellbeing. Engaging culturally responsive providers and community members is particularly important in testing and implementing interventions, since cultural barriers to care, such as mental health stigma, have been shown to reduce mental healthcare utilization among SAs.[5,74,75]

Acknowledgments

This publication was supported by the National Institute on Minority Health and Health Disparities of the National Institutes of Health under Award Number R13 MD007147–01A1. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health. SAHI staff would like to thank the Steering Committee members, all working group co-chairs, the Memorial Sloan Kettering Cancer Center Library, Rohini Rau-Murthy and the SAHI interns for their assistance in assembling this document.

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