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Cultural stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression

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Abstract

Low rates of treated depression and high rates of suicide in women from some South Asian communities are evident in epidemiological studies in the UK. It is argued here that explanations for these apparent differences are likely to be located in stereotypes of repressive South Asian cultures. This small scale study, utilising focus groups and individual interviews, sought to explore the construction of cultural stereotypes within mental health discourse with specific reference to stereotypes of women from South Asian communities. Mental health carers from a UK inner city area of relatively high social deprivation were targeted. Focus groups were conducted with a range of mental health care professionals who worked in both inpatient and outpatient mental health care services. In addition, individual interviews were conducted with consultant psychiatrists and General Practitioners. Extensive reference is made in this paper to the content of focus groups and interviews and how health carer's knowledge about and experience of South Asian cultures and caring for women from these communities was contextualised. Mental health care professionals constructed cultural difference in terms of fixed and immutable categories which operated to inferiorise Britain's South Asian communities. It is argued that their knowledge is constructed upon stereotypes of western culture as superior to a construction of eastern cultures as repressive, patriarchal and inferior to a western cultural ideal. Ultimately, it is argued that these stereotypes become incorporated as 'fact' and have the potential to misdirect diagnosis and therefore, also misdirect treatment pathways.

Keywords: South Asian communities; Stereotypes; Racism; Mental health; UK

Introduction

In primary care in the UK, rates of depression and anxiety among populations of South Asian origins are held to be the same as, or lower than, the general population (Cochrane & Bal, 1989; Balarajan & Soni Raleigh, 1993). The household survey of 10,000 adults commissioned by the Department of Health on the other hand revealed that depression appeared to be twice as prevalent among 'Asian and Oriental' women compared to White women (OPCS, 1995, p. 34). Lower rates of neurotic disorder among migrant South Asian groups in the UK were also a finding in the Fourth National Survey reported by Nazroo (1997) although non-migrant South Asian groups had the same rates as their white counterparts.

In addition, Balarajan and Soni Raleigh (1993) have identified trends in national mortality rates which demonstrate a higher rate of suicide in women from the Indian subcontinent. The standardised mortality ratio (SMR) is particularly raised for the age group 15 to 24 years, where it is more than twice the national rate. Findings from local studies on suicide are also in keeping with this research, with apparent higher rates of suicide in young women born in South Asia (Karmi, Abdulrahim, Pierpoint, & McKeigue, 1994).

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Soni Raleigh and Balarajan (1992) locate the cause of suicide in the pathology of South Asian cultures. Essentially, they argue that suicide in South Asian women in the UK is the result of:

> Their rigidly defined roles in Indian Society. Submission and deference to males and elders, arranged marriages, the financial pressures imposed by dowries, and ensuing mental and family conflicts (Soni Raleigh and Balarajan, 1992, p. 367).

This small-scale exploratory study using qualitative methods sought to explore the construction of cultural stereotypes in mental health discourse with reference to the apparently low rate of reported depression and the high rate of suicides. Following focus groups and semi-structured interviews with mental health care professionals, it is argued that cultural stereotypes form a racist discourse. Cultural stereotypes are predicated upon an idealised notion of a homogenous Western culture which is presumed superior to simplistic perceptions of an inferior, tradition bound, primitive and repressive Eastern Culture. The power of stereotypes of South Asian cultures is that they become incorporated as pseudo scientific explanations that are then incorporated as fact and used to account for different patterns of health and illness.

Racism and the construction of stereotypes

The term racism remains controversial particularly the concept of 'institutional racism' which is the subject of intense debate in relation to a number of policy areas including policing and immigration policy. A useful working definition of racism however, is that provided by Bulmer and Solomos (1999, p. 4). Racism is described as an ideology of racial domination based on (1) beliefs that a designated racial group is either biologically or culturally inferior and (2) the use of such beliefs to rationalise or prescribe the racial group's treatment in society, as well as to explain its social position and accomplishment.

Racism is identified in the construction of cultural stereotypes. With reference to Britain's ethnic communities, stereotypes have been shown to be predominantly negative and operate to direct attention to particular characteristics and away from others, thus, in some circumstances, leading to erroneous attributions and social injustice (Fernando, 1989, 1995; Thomas, 1995; Augoustinos & Walker, 1995). Furthermore, stereotypes derive their content from their social context, but operate as objectified knowledge. Therefore, stereotypes have an essentially social function: 'notably the justification of the social position of the stereotyped group and of the system that produces that position' (Augoustinos & Walker, 1995, p. 211). In emphasising the role of a unitary or stereotypical 'cultural difference' the source of ethnic differences in health is located within the minority culture itself.

The concept of culture has become a central theme in a wide range of current debates about the changing meanings of racism in which there has been a shift away from the study of structure to an increased critical interest in language and how it is used to produce meaning in social life. Said (1978) highlighted the heterogeneous nature of these processes of cultural production. Said's work on *orientalism* has been a major critical influence referring to how Anglo-European scholarship constructs the Orient as exotic and 'other'. Essentially Said has described the Far East and portrayals of Islam in his descriptions of the Orient, and how colonial and historical domination by the West has constructed a portrayal of the Orient as a culture which is inferior, repressed and 'tradition bound'.

Orientalism can be understood as forms of discourse which assumes and projects a fundamental differences between Western, occidental 'us' and an Eastern, Asiatic, oriental 'them'. *Orientalism* presents a form of thought in which Western discourse is presumed as having status epitomised in 'scientific' knowledge which is seen to justify and legitimise the domination of Western culture and values over Eastern culture and values. *Orientalism* typically is a form of thought for dealing with 'the other' and is essentially based upon the construction of Western superiority and eastern inferiority. Said's work is particularly scholarly but remains historically sensitive arguing for an understanding of power as necessary in a thorough comprehension of the production of racist knowledge. *Orientalism* has emerged as a significant theme in recent media discussion in the UK of the Middle East, including the Gulf War and Islam generally (Mac an Ghaill, 1999).

The need to identify racism as existing beyond a single monolithic ideology and the need to acknowledge the wide range of contemporary racism and different varieties of *orientalisms* is receiving increasing critical attention. However, there still remains a need to go beyond simplistic notions of colour racism. Current sociological debate focuses upon how particular institutional sites may be subject to a range of contextually based racist discourses. These racialised processes articulate in complex ways with other categories of social knowledge, for example gender, social class and the construction of the mental illness categories (Fernando, 1989; Busfield, 1996). There is a need to highlight the diverse ways in which discourses of race are contextualised and situated in specific localities.

The empirical study: context, design and methodology

The broad aim of the research was to explore how far the perceptions and understandings that members of the

mental health care professions have about women from South Asian communities[1] are derived from cultural stereotypes. These perceptions were to be explored within the context of mental health carer's experience of caring for women with depression.

The use of qualitative research methodology was considered to be essential to uncover the values, beliefs and attitudes which were the focus of the investigation. Accordingly, the main tools of data collection were focus group interviews and semi-structured interviews.

Focus groups were chosen for their potential to highlight respondent's attitudes, priorities and framework of understanding in a way that would not be as easily accessible in a one to one interview (Albrecht, Johnson, & Walther, 1993; Kitzinger, 2000). However, whilst focus groups constituted the primary research methods, individual, semi-structured interviews were also utilised to access the views of psychiatrists and GPs. The choice of semi-structured interviews for these professionals was a pragmatic consideration based upon the anticipated difficulties in arranging a mutually convenient time for a disparate group of professionals such as psychiatrists and GPs.

A white female researcher conducted the research with a background as a medical sociologist. All the respondents were informed that the purposes of the research were to explore experiences of caring for women from South Asian communities and perceptions of their mental health needs.

Mental health care professionals: sampling and access

The research was conducted in the inner city area in the North of England in 1997. According to the 1991 Census the population classed as South Asian is small, constituting less than 1% of the population. The city offered little in terms of health care specifically for women from South Asian communities.

Mental health carers were targeted who were working in the inner city area, an area of relatively high social deprivation that, according to the 1991 Census, also housed the largest population classed as 'Asian'. The professionals targeted included: Registered Mental Health Nurses (RMN) currently working in psychiatric inpatient hospital services; Community Psychiatric Nurses (CPN) who were providing community psychiatric support and advice and also Approved Social Workers (ASW) who also provide community psychiatric support and advice.

Recruiting respondents from these groups of professionals proved difficult. Mental health nurse managers in the locality stated that staffing levels were in crisis and could not release staff to participate in the project. Out of the five managers contacted one manger gave permission to contact RMNs across several wards in one location, with a suggestion that the focus group could follow on from a clinical seminar, but with the understanding that it was at the discretion of the individuals concerned whether they attended. A group was arranged which comprised eleven RMNs, some of who worked together, out of the forty who were approached.

Similarly, there where problems of gaining active cooperation from senior managers to talk to CPNs and ASWs. However, a further two focus groups were organised. The second focus group consisted of seven CPNs working together from one location, who agreed to participate in a focus group discussion following their weekly meeting. Similarly, a third focus group, containing five ASWs who also worked as a team, was also organised to follow on from their group meeting.

Two consultant Psychiatrists, both recommended by professionals already interviewed as potentially willing to co-operate, were also contacted. General Practitioners were contacted on an individual basis and refused to participate. It was only with the assistance of a colleague in the profession that four GPs agreed to individual interviews. GPs were chosen to represent both the English and South Asian communities and included: a white female and white male and an Asian female and an Asian male who had trained in Pakistan.

The Consultant Psychiatrists were both male, but the other health carers presented a mixture of males and females. Focus group 1, of RMNs, contained only one male of South Asian origin and one male of Afro-Caribbean origin.

A topic guide was designed to operate as a series of open questions which evolved from general to more specific questions. The following questions structured both focus group and interviews:

1. How far do you think social environment and stress effects mental well being?
2. How far do you think coming from a different culture effects the presentation of 'mental illness'? Have you any experiences which may be relevant?
3. What experiences, if any, have you had in caring for women from the Asian community?
4. What, if any, do you think are the particular stresses for Asian women in British society?
5. What issues do you think might effect the high suicide rate in women from South Asian communities?

[1] South Asian communities' includes a heterogeneous group of women in terms of culture and historical experiences. The use of 'South Asian' incorporates women who identify with, or whose countries of origin are in, the Indian subcontinent including India, Pakistan and Bangladesh and who are differentiated according to religion, linguistic group, caste and sect.

6. In what ways, if any, do you think South Asian women have different mental health care needs from British women?

Altogether twenty-nine mental health care professionals took part in this research. Focus groups and interviews took between forty-five and ninety minutes and were transcribed and field notes taken. All interviews took place within the health professional's place of work.

Analysis

An inductive process of coding the data and identifying analytical categories as they emerged from the transcribed data was employed. The questions outlined above provided a structure for breaking down the data. For example, all references to discussion about the impact of social environment and stress and on mental well-being were coded together. All references to the possible impact of cultural differences and the presentation of 'mental illness' were coded together. All references made to women were coded to produce the themes relating the construction of stereotypes that are recounted here. Therefore, the themes incorporate both actual experience of caring for women as well as professionals perceptions of the life experiences of women from South Asian communities living in Britain. Once a broad thematic framework had been identified that incorporated references to women these themes where further broken to down into how the professionals interviewed described this group of women.

The development of categories that described the content of mental health care professionals stereotypes were informed inductively, as they emerged from the data, but also through a theoretical backdrop of the sociological work on racism.

Within the focus group data particular attention was given to types of interaction, including whether participants challenged or reinforced other participants ideas. The coding of data included that of any discrete incidents and was inclusive of all accounts provided by participants.

Within the themes discussed by mental health carers are the perceptions that South Asian women have particular problems because of their cultures. Women from South Asian cultures were widely perceived as being particularly isolated and victims of stressful relationships. However, the majority of mental health carers who participated in this research felt that they had little, or no direct experience of caring for women from South Asian communities. Psychiatrists and GPs reported more regular contact. Direct experience was not considered necessary for participating in this research, especially considering the difficulty in recruiting. Respondents would still be in a position to discuss whether they felt caring for women from South Asian communities would raise particular issues. However, the possible implications for the research findings of mental health carers lack experience in this area must be acknowledged. It may be the case that if more mental health care professionals with direct experience of regularly caring for women from South Asian communities had participated that the stereotypes reflected in the present study would have been challenged. Nevertheless, the study still reflects the tenacity of cultural stereotypes and may serve as a reminder about the possible power and impact of such stereotypes.

The software package QSR NUD*IST (version 4) was used to facilitate the analytical process. With the assistance of NUDIST the emergent categories were grouped together to form broad inductive categories which incorporated how mental health care professionals accounted for and described their perceptions about these groups of women.

The aetiology of depression and 'personal predisposing factors'

There was a general recognition from the mental health carers in this study, particularly in focus groups with ASWs and CPNs (who by and large provided care in the community) and by both psychiatrists, that social factors influenced mental well-being and the impact on mental health of poor social conditions. For example:

> I think that living in very poor, squalid conditions, then that would positively have an adverse effect on mental health (male CPN 2).

> If you are struggling with poverty and damp housing plus your husband is beating you etc. etc. it's going to have a more profound effect, but I think it's a mixture (female CPN 3).

> A lot of our work is recognising the extent to which poverty and particularly in our area, I guess, poor housing is a major feature of the work we have with people with mental distress (male ASW 3).

One member of the focus group with ASWs commented several times on the possible psychological effects of racism. He described it in these terms: *That is how our society, whatever that is, reacts to Asian women. They get spat at. Now, that would make you feel pretty depressed if it's expressed in different ways all the time* (male ASW 4).

Social factors were described as possibly influencing whether or not an individual may develop a depressive disorder. However, mental health carers described the aetiology of depression within the context of personal predisposing factors which the individual may have towards depression.

Predisposing personal factors were described by the psychiatrists interviewed in terms of biological and psychological factors. Psychiatrist 2 explained that '*genetic*', '*accidental*' and '*environmental factors*' may affect the aetiology of depression. Other mental health carers, specifically in focus groups with CPNs and RMNs, viewed predisposing factors in relation to the '*individual's ability to handle stress*' (female RMN 9). For example, the aetiology of depression was described as '*people's susceptibility to their social environment or to the stresses that happen to them*' (female CPN 3). The notion of predisposing factors, therefore, actually concedes very little to the consideration that social factors, such as poverty and racial harassment, may contribute significantly to the aetiology of depression for the majority of mental health professionals interviewed.

The perceived impact of cultural difference on depression

Mental health care professionals who participated in this study felt that culture would influence the experience of mental distress. For the majority of mental health carers, cultural background was viewed as giving structure and meaning to the experience of mental distress. As one RMN stated: '*the reasons for the symptoms are different and until you get to those reasons you haven't treated the depression*' (male RMN 6). Ultimately, mental health carers felt that they would need some understanding of the background and reasons why an individual may be experiencing depression. For example, one RMN stated that with reference to culture:

> It probably would be harder to try and assess somebody purely on the basis of their behaviour and how they present if you are not sensitive to the issues that are going on for that particular person (female RMN 4).

In addition, culture was also seen to '*impact on how that mental illness might present*' (psychiatrist 2), however, this view was only expressed by psychiatrists.

Kleinman (1980) has described how the cultural meanings of illness and its treatment need to be located within the cultural group itself. He described how 'explanatory models' (EMs), which are the beliefs about an episode of illness and its treatment, are culturally specific. The description of a certain experience as 'illness', and the presumed course of treatment developed in one cultural group, may not be applicable to people who share a different set of cultural beliefs about illness and treatment. Past qualitative studies conducted in the UK have revealed the cultural context of mental distress. For example, Krause (1989) explored the cross-cultural validity of Western psychiatric categories through descriptions of 'sinking heart', a 'syndrome' of heart distress described by Punjabis. Fenton and Sadiq-Sangster reported that South Asian women in their study described feelings in terms of 'thinking-too-much-in the heart' (1996, p. 77).

Kleinman's description of the possibility of EMs raises questions about the presumed universality of the Western category of depression, which may in fact be a Western artefact (Lee, 1999). There is, however, implicit within the descriptions provided by the health carers in this study, the presumption that the category 'depression' is real, even though the reasons for its manifestations may be different. One GP, for example, described the impact of culture as:

> Some will find it easy to talk; some will find it difficult. Some will see it as acceptable; some will see it as not something you should be talking about. Some would see it as a medical problem. Some would see it as non-medical problem. Beliefs make a difference (male, Asian GP).

Whilst beliefs do make a difference this GP fails to question the universal applicability and validity of the diagnosis of depression.

From a theoretical standpoint the idea of predisposing factors may have a more invidious consequence and are likely to be used to support stereotypes of those social groups who are deemed in some way socially inferior. Women, for example, are frequently assumed to be more prone to mental disorder than are men because of the predisposing factor of their hormones and reproductive organs (Chesler, 1972; Russell, 1995; Busfield, 1996). Ethnic minority groups are presumed to be more susceptible to mental illness because of defective genes or a defective culture (Fernando, 1989; Littlewood & Lipsedge, 1989; Ahmad, 1993). In the following discussion mental health care professionals utilise the notion of cultural difference as a form of predisposing factor in the aetiology of depression.

South Asian women, subordination and isolation

In attempting to provide a definition of racism it was argued above that racist discourse articulate in complex ways with other categories of social knowledge.

It is evident from the empirical data presented here that distinctly racialised discourses conflate with those on gender in the assumption that South Asian women were particularly subordinate and isolated through the perception of South Asian patriarchal culture. Women were described as subordinate because of the association with traditional feminine roles. For example:

> They are culturally encouraged in their own environments to be the housewife, the mother, the carer. Same as maybe fifty, a hundred years ago in this

country, women were seen as homemakers. That is their fundamental role in life (male RMN 1).

Traditional feminine roles within South Asian cultures were also viewed as resulting in isolation:

I think the roles of women and sort of gender roles within Asian society, the expectations and because there is quite a lot of pressure to conform and so on, that Asian women might find themselves quite isolated certainly if things aren't going quite right, they might become quite isolated (psychiatrist 1).

Therefore, it was assumed that women would also be more likely to suffer depression. The uncritical assumption that women from South Asian communities were more likely to suffer from depression because of cultural expectations would appear to result directly from the pathology of Asian cultures. Furthermore, there is a lack of discussion of women's roles within Western society and the link with depression. There already exists a range of literature which supports the notion that gender differences in depression in Western societies are largely the result of differences in roles and the stresses and expectations that go with them (Brown & Harris, 1989; Nazroo, Edwards, & Brown, 1998).

The image of women from South Asian communities as mysterious, quiet and living in the dark was evident. As one ASW stated:

You get the family on the corner and the women there almost literally live in the dark. Men are very much to the fore. So my feeling about Asian women is that they are very much in the dark, almost literally, on the corners (white male ASW 4).

The idea that South Asian communities live in corner shops was also used by one GP. She stated:

I don't know what other sort of economy they contribute to. The more academic ones would try and move on and do degrees and things, but then they would think, maybe, there is prejudice against them in the job market. I don't know. I don't think there is so much. I think people accept them on their worth now (white female GP).

The disadvantage faced by Britain's ethnic minority groups is frequently ascribed as inherent to their cultural difference rather than recognised as a result of social disadvantage or the way that their ethnicity is perceived by others (Nazroo, 1999). Evident in the stereotypes presented by health care professionals in this study is the pathologising of Asian cultures in which Asian cultures are presented as a form of 'predisposing factor' for depression. Mental health care professions described isolation, inflicted by their culture as a cause of depression.

It is important to concede that the psychiatrists interviewed did recognise the potential for stereotypes and generalisations about women from South Asian communities, which was not evident with the other groups of professionals. Both psychiatrists demonstrated awareness that there existed a range of unhelpful stereotypes about women from South Asian communities, especially with regard to the notion that they were subservient. Psychiatrist 1 acknowledged that women running the home were '*fairly atypical of a large group of the population*' and therefore, may constitute an unhelpful generalisation about South Asian women. However, and as has been illustrated, both psychiatrists offered a view of the lives of these women that, nevertheless, were still grounded in common stereotypes which were prevalent throughout all the groups that were interviewed.

'*Culture conflict*'

The concept of *orientalism* has been used to refer to a form of racist discourse which assumes and projects a fundamental superiority of Western 'us' and an Eastern, oriental 'other'. This dichotomy between East and West was evident in the construction of 'culture conflict' which was viewed, almost universally by the mental health carers sampled, as a possible source of depression in South Asian women. The crude use of the concept of culture conflict is evident in literature which attempts to explain the high suicide rate in women from South Asian communities (for example Soni Raleigh and Balarajan (1992) as quoted earlier).

Within the present study culture conflict was presented as a personal conflict between liberated Western values and rigid Eastern values. One RMN operationalised *orientalism* in the form of culture conflict thus:

You would be in a bit of a conflict because you are your own person, you're of British culture in one sense, but you're of Asian culture in another, a culture that you don't really know about but your parents do. So it would be really hard to strike a balance. But then, if people's families adapted and sort of, to a more British culture and perhaps their Asian or ethnic values weren't as rigid, then it may be easier (female RMN 3).

Invariably, South Asian cultures were portrayed as rigid and repressed against the liberated and morally superior West. Resolution of culture conflict was assumed to be met only through South Asian cultures becoming more westernised as is evident within the focus group with RMNs:

The children become more Anglicised there will be problems then, with children wanting to go out with their friends, or for a drink or anything else which is

in our culture, which might not be in their home culture (white female 5).

Evident was the assumption that Western ideals are superior and the ideal to which South Asian people should ascribe to and that South Asian people should change their way of life to fit in with the white majority. The various degrees of conflict were described by one GP as:

> There are the ones who have been brought up in this country and in a Western culture and who want to be westernised. They think like a Western person and they are not allowed to because of the parental influences. And there is the ones who come in, who want to cling to their old traditions and they are forced the other way because of all the people around them who are in a Western culture. So it's a tussle the whole time, whichever way you look at it really (white female GP).

Accordingly, women would be in a 'no win' situation through a portrayal of Asian cultures as pathological if they maintain traditional values and equally pathological if they adopted Western values. Asian cultures were essentially portrayed as tradition bound, and the perceived unwillingness of members of South Asian cultures to adopt more Western lifestyles was itself viewed as the possible cause of depression.

Orientalism was evident in the expression by mental health carers sampled of ideas about South Asian cultures as fixed and rigid in comparison to an idealised vision of Western culture. Psychiatrist 1 referred to the 'ghetto mentality' of members of South Asian communities.

However, one GP expressed the impact of culture conflict in these terms:

> They all try and, they try to carry on their tradition in an alien culture really aren't they? So you can quite see how there is conflict. I'm amazed that they are not all depressed really. I think that they should all go back home. I mean that is my very sort of bottom line philosophy, but they don't fit in here. They should all go back home again (white female GP).

Evident in the notion of 'ghettos' and returning 'back home' is a form of racism identified in the 1970s. British racism of the 1970s was articulated through identifying Britain's ethnic minority communities as the 'enemy within' (Hall et al., 1978). This is also evident in the following quote:

> They are swamping the country; they are going to the sort of ghettos now. They are just descending on to these areas and they are probably coming thinking that the streets are paved with gold and they are going to be mightily disappointed (white, female GP).

South Asian cultures are portrayed as pathological, backward and a possible threat to the social stability of Britain through the notion that the county is being 'swamped'. As Stuart Hall has previously argued (1992), racism operates by constructing impassable symbolic boundaries between racially constituted categories. The construction of binary systems of representation marks the difference between belonging and otherness. A particular form of exclusive English national identity, evident above, remains one of the characteristics of British racism today (Mac an Ghaill, 1999).

A direct implication of the ideas expressed above are that the health needs of South Asian communities are more generally being dismissed and unrecognised through the assumption that they 'don't fit in' and exist in a haze of cultural conflict. In recognising *difference* what is also being asserted is that the dominant communities needs are normative (Husband, 1996). This is marked by a marked sense of 'English' ethnicity from which Britain's ethnic minority communities are routinely defined as outside the national community (Husband, 1996).

'*Arranged*' *marriages*

Within the present study mental health care professionals' perceptions of cultural differences between East and West, evident in the construction of 'culture conflict', also informed attitudes towards marriage in South Asian communities. The preconception that Asian women were '*forced into marriage*' was evident (white male GP).

'Arranged' marriages were discussed as a perceived cause of stress and depression for women from South Asian communities. The following is an extract of focus group discussion with CPNs who discussed arranged marriages in these terms:

Male CPN 2:	You wonder if some of that is to do with arranged marriages, whether the communication and the dialogue is as prevalent in marriages in our society as well.
Male CPN 4:	(nodding in agreement) It must be more difficult for second-generation Asian women to accept it. I mean they are brought up in a different culture. In our culture you take relationships as you find them.
Male CPN 2:	(leaning forward and addressing CPN 4) It's probably quite depressing if you get landed with someone (pause) well humiliating to be told,

especially if you don't like that person.

Female CPN 4: (addressing group) What happens if they say 'No I don't want to go through with this'? Are they forced into that situation? Which would be very grave indeed, wouldn't it really?

Female CPN 3: (addressing group) I imagine it would be very lonely as well. I didn't realise how many people lose their families, their own families as well, when they go into an arranged marriage, you know, and their husband's family is more their family then you know? In some cases people don't often see their parents anymore, or their other brothers and sisters like. It must be, I just think it would be horrible.

The example of focus group discussion demonstrates how the notions of the pathological 'arranged marriage' become legitimised through group reinforcement. The idea that arranged marriage is inherently psychologically damaging remains unquestioned. Again a form of orientalism is evident in which a Western idealised version of romantic marriage is presumed as normative. Moreover, a stereotyped vision of South Asian cultures is constructed as a predisposing factor for the development of depression in South Asian women.

South Asian cultures, expectations and awareness

Evident in the focus groups with CPNs and RMNs was the perception that people from South Asian communities may not experience depression because their life expectations may be lower than people brought up in a Western culture. Two CPNs agreed that:

Female CPN 3: I think in Western society people feel that they've got a right to be happy, and if they're not something needs doing about it. Whereas, I imagine poorer countries, if that's the culture, people often expect life to be pretty tough and not necessarily think someone is going to do something about it.

Male CPN 5: Yeah (addressing CPN 3 and nodding) I think it's more that they just totally accept it if they are miserable.

Similar ideas were expressed by RMNs:

> It's also about expectations as well isn't it? In our society we have quite high expectations of how life should be. Obviously, we would be really depressed at some conditions that some cultures are faced with, but they just get on with it (female RMN 7).

The higher status of Western values was again presumed as one RMN stated that: '*it's not until women come to Britain that symptoms of depression would actually manifest*' (male RMN 1). This respondent goes on to state that:

> What tends to happen is I think they (Asian women) are socially conditioned to take all these blows. They are the ones to take all the heavy load … they can't say that they are depressed or anything … I think that what normally happens is that when they come over to a place like this, well it's a different thing all together, it's, I think that's when we start to see the symptoms (male RMN 1).

The persistence of a form of racism that ascribes primitiveness to non-European cultures has been exposed in Western psychiatric thinking (Fernando 1989; Littlewood and Lipsedge 1989). Although such views are not stated overtly in psychiatric discourse what is evident in the stereotypes presented here is the assumption of *primitiveness*. The perception that depression did not exist, or that people from South Asian communities may not be aware that they were suffering from depression, was expressed. One RMN stated that: *with this society people are aware that they are depressed but with other cultures they might not even know that they are depressed* (Male RMN 6). Another RMN, in discussing the low uptake of services in the city by women from South Asian communities inquired as to whether it was: *because they don't get depressed?* (Female RMN 4). As a form of orientalism the construction of a primitive South Asian culture assumes the superiority of a Western Anglo European culture.

The inherent racism in Western psychiatric concepts and models of treatment has been exposed in the assumption of a global relevance that subsumes other models of health and treatment (Pilgrim & Bentall, 1999). Perceptions that people from South Asian communities may not be aware that they were depressed were conflated with ideas that there is more stigma associated with 'mental illness' in South Asian communities, and that they have exotic and unscientific belief systems which operate to disguise mental illness. This was evident in interaction in the focus group with CPNs:

Female CPN 1: They are also very family orientated aren't they? So they try to (pause).

Male CPN 4: (Interrupting) Disguise it.

Researcher: Why do you think 'disguise'?

Male CPN 4: (addressing group) Because of the family orientation and the level of support that they get within the families as opposed to our sort of

family set-ups in the Western society. I can imagine they take the chance to deal with it themselves and maybe because of stigma among other things. Though, perhaps disguise, more deal with it themselves.

Female CPN 1: It's the way they perceive it as well, isn't it? (addressing CPN 4) Do they perceive it as illness or part of a cultural, spiritual thing that's happening to them, you know? If they can go to someone, do they have sort of, I don't know what they're called, but some sort of spiritual guide who can help out the same way we would go to a GP or something like that.

Male CPN 4: Well the Djinns apparently, they believe, help me out here J., (leans across to face colleague CPN 1) they, like a spiritual belief they have, and the Djinns are there, sort of, like an unlucky omen and they can get things to protect them from that, like amulets.

The focus upon spiritual guides and Djinns illustrates what can be identified as a form of *orientalism* in the continued fascination with what, in the West, has been defined as exotic. The result is, as is evident above, the tendency to reduce complex social phenomena to an exotic quirk. In addition, as Ahmed has pointed out, peculiar cultural quirks are more likely to be the subject of research projects and lectures than racism in mental health and the impact of racism on general well being (Ahmad, 1993).

While the perception that women from South Asian communities would be more likely to hide their distress was evident, the contradictory notion that they were also likely to exaggerate symptoms was mentioned by one GP. He stated that from his observations of South Asian women they had: *a greater tendency to react in a hysterical fashion and to exaggerate symptoms, and also to exaggerate or invent physical symptoms* (white male GP). In addition, this GP felt that women from South Asian communities were: *fairly hypochondriacal and come to the doctor's for the slightest thing*.

Therefore, women were perceived as either hiding their symptoms or exaggerating their symptoms. Either way they would be perceived as likely to be depressed because of their culture.

The Stigma of mental illness and 'looking after their own'

The stigmatisation of mental distress was referred to by one RMN who stated that: *there is enough stigma in our culture about mental illness, but presumably it could be more so in a society that is patriarchal for the woman to actually admit and tell her husband* (female RMN 3). It was also felt by one GP that there was a lack of sympathy for mental distress: *and that a great deal of blame would be attached to it* (Asian female GP). She stated that: *doctors need to be aware that maybe they (Asian women) are depressed and not saying anything*. It is clearly perceived that women from South Asian communities are likely to be depressed simply because they are from South Asian cultures.

The perception that people from South Asian communities *look after their own* was expressed (female RMN 2) and that *unless someone is very disturbed behaviourally they will deal with things themselves* (psychiatrist 1). However, and in apparent contradiction, whilst the family was portrayed as over protective and as having a distinct part to play in the aetiology of depression the lack of traditional family structure in Britain was also perceived as initiating depression. One male RMN stated that because women from South Asian communities in Britain no longer lived in extended families, as they did not: *fit into the social norm*, that they were more likely to experience depression. He stated that: *if they could get together and form the original extended families they would be much better off* (male RMN 1).

The likely consequence of the notion that Asian families will 'look after their own' results in a lack of provision to support people from these groups. These racist stereotypes often exacerbate the general invisibility that already exists (Atkin & Rollings, 1996). Therefore, the recognition of cultural difference becomes the basis of a distinct racist discourse that may operate to actively discriminate against Britain's South Asian communities.

Summary

This small-scale study using qualitative methods sought to explore the construction of cultural stereotypes in mental health discourse with reference to the apparently low rate of reported depression and the high rate of suicides in the UK. This paper has explored the themes that have emerged from focus groups and individual interviews with a range of mental health carer professionals. The broad aim of the research was to explore how far the perceptions and understandings that members of the mental health care professions have about women from South Asian communities are derived from cultural stereotypes.

The impact of social inequality on mental well being was acknowledged by mental health care professionals in this study, but was described in the context of personal predisposing factors, which included a genetic or psychological predisposition towards developing

depression. Social factors, therefore, were generally viewed as precipitants and not the cause of mental distress. However, whilst the aetiology of depression was viewed as 'predisposing factors' mental health carers also utilised a fixed and immutable notion of cultural difference in articulating the possible causes of depression in women from South Asian communities. Therefore, South Asian culture was pathologised as a form of predisposing factor in depression.

In what has been recognised as the 'racialisation' of health issues the disadvantaged faced by Britain's ethnic minority groups is frequently ascribed as inherent to their cultural difference rather than recognised as a result of social disadvantage or the way that their ethnicity is perceived by others (Nazroo, 1999). The idea of cultural difference is utilised without recognition of the disadvantage and discrimination that faces most ethnic minority groups in Britain. Inherent within the stereotypes described above is how an abstracted idea of culture is used in scientific discourse reinforcing the notion of cultural difference (Sashidharan, 1993). Pathological cultural difference contrasted against an idealised European norm is therefore viewed as the cause of both a low rate of reported depression and a high rate of suicide.

The present empirical findings help illustrate how contemporary racisms have evolved and developed beyond a concept of racism as a homogeneous ideology. Said's concept of 'Orientalism' has been intrinsically useful in an analysis of the construction of stereotypes referred to by mental health care professionals in the present study (1978). With reference to the present study *orientalism* manifested itself in how mental health carers construct a range of stereotypes of Asian culture predicated upon binary oppositions between East and West. The East was constructed by mental health carers as repressive, the West, liberated: the East superstitious and primitive, the West, scientific and modern. Axiomatically, Eastern cultures were viewed as inferior to superior Western cultures.

Essentially South Asian cultures are portrayed as *other,* as alien and unusual in the form of exotic and unscientific health beliefs and as patriarchal and repressive in contrast to the implicit portrayal of Western culture as 'liberal'. Within the views expressed in this study there was little consideration of the often repressive roles of women within Western culture and the impact of patriarchal social structures on mental well-being. In this sense Said's concept of Orientalism is also relevant in how notions of Western culture gains its strength and identity against the ideological construction of South Asian cultures.

The findings in this exploratory study would suggest that women from South Asian communities are likely to be viewed as suffering from depression by mental health care professionals whose pre-conceptions are rooted in stereotypical assumptions about repressive Asian cultures. In addition, just as the possible aetiology of depression was frequently assumed to be located in Asian cultures, the treatment for depression was therefore, to be found in the adoption of a more Western lifestyle.

Whilst this is recognised as a small-scale study with distinct problems with generalisability there are still implications for British mental health care. A starting point is the need to recognise that cultures are essentially dynamic and contested domains (Brah, 1996). Second is the need to re-establish and reinforce the ethnocentric nature of Western psychiatry (Fernando, 1995). The construction of South Asian cultures as 'pathological' may direct assessment, diagnosis and treatment in that the potential cause of mental distress is located within culture itself. The result is that other causes for distress, diagnoses and treatment pathways are dismissed. The present study would suggest that the power of cultural stereotypes in Western mental health care discourse should not be over estimated.

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