

Portfolio including Thesis

Volume 1 of 2

Volume 2 contains confidential information and is not available.

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A portfolio submitted in partial fulfilment of the requirements of the University of Hertfordshire for the degree of Degree of Doctor of Clinical Psychology including a Thesis entitled:

**Identification of vulnerability to psychological difficulties  
in second generation South Asian women**

The programme of study was carried out in the  
Department of Psychology  
University of Hertfordshire  
November 2003

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# **Mental health and Asian immigrants to the UK. Is there a generational effect?**

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Literature Review  
January 2003**

There has been a great deal of research focusing on the mental health of immigrant populations within the UK. The aim of this review is to examine the studies on affective disorders, psychoses and deliberate self-harm within the Asian population. One of the main difficulties with research on this population is that the term “Asian” is used to refer to individuals originating from anywhere in the Indian subcontinent, which includes countries as diverse as India, Pakistan and Bangladesh. Therefore, the term Asian will be used in this review to reflect the language used in much of the British literature, but details of cultural group, religion and place of birth will be included wherever possible (Bhui, 1999). It is acknowledged that other immigrant populations, particularly the Irish and Caribbean, have rates of disorder and health service needs which are significantly different from the native British population (Cochrane and Bal, 1989; Harrison, Owens, Holton et al., 1988) but it is beyond the scope of this review to examine this research in any detail. This review will discuss UK studies, starting with hospital based studies, followed by community and primary care based research; and will examine a number of hypotheses proposed to account for the rates of disorder found within the Asian population. The second aim is to demonstrate that existing research has limited applicability to second generation, or UK born, Asians.

### *Hospital studies*

One of the earliest hospital studies was by Cochrane (1977) who studied admission rates for Indians and Pakistanis over the whole of England and Wales over a one year period in 1971, and found that prevalence rates for schizophrenia in both Indian and Pakistani men and women were higher than for the native British. These figures were not standardised for age which is a criticism of several early cross cultural studies as immigrants have a younger age structure due to the nature of migration, as often young men would migrate for economic reasons and would be joined by their families at a later stage (London, 1986). Also, the rates were calculated using the diagnoses recorded in the case notes at admission which may not present an accurate picture of the exact nature of a client’s difficulties.

Carpenter and Brockington (1980) monitored first admission rates of Asian, African, West Indian and native British groups in three Manchester hospitals between 1973 and 1975, and found that all three of the immigrant groups had significantly higher rates of schizophrenia than the native British group. However, the native British group consisted of those who were born in the UK regardless of parentage and included some individuals born to immigrant parents. A more detailed examination of a sample of the case notes using the

Present State Examination (PSE; Wing, Cooper and Sartorius, 1974) to rate psychopathology indicated that the immigrant groups did not have higher rates of auditory hallucinations or the “nuclear syndrome” of schizophrenia than the native British group. However, the immigrant groups did have higher rates of delusions of persecution which led the authors to conclude that the symptoms in these groups may be suggestive of paranoid psychosis not “true” schizophrenia. These results suggest that the high rates found may be due to misdiagnosis. Unfortunately, all of the immigrant groups were combined so it is not possible to draw out specific findings relating to the Asian population.

Dean, Walsh, Downing and Shelley (1981) analysed first admissions to psychiatric hospitals in South East England by age, sex and place of birth. They used data from the 1971 Census and Labour Force Surveys to determine the age and sex structure of native British and immigrant populations. Using the rates for UK born patients to calculate the expected number of admissions for each age, sex and diagnostic category, they found that the actual rates of admission for schizophrenia for patients born in India were 3-5 times higher than expected for both men and women. The finding that a significantly lower than expected rate for schizophrenia was found in the Pakistan and New Commonwealth Asian sample must be viewed with caution as the sample includes patients born in Pakistan as well as countries such as Hong Kong and Singapore. Another criticism is that first admission rates may be misleading as clients may not report admissions in their country of origin or in other parts of the UK. Also they do not allow an examination of trends in psychopathology in a particular population, as would rates for all admissions.

All first and subsequent admissions to a psychiatric hospital in England during 1981, based on country of birth were examined by Cochrane and Bal (1987;1989) who found that rates of admission for schizophrenia were slightly higher among Indian men compared to English men, whereas Indian women had a significantly higher rate than English women. The reverse was true for Pakistani men who had substantially higher rates than the English men, whereas Pakistani women were found to have a significantly higher first admission rate compared to English women, but a surprisingly low readmission rate. Several early studies use place of birth to categorise people as data on ethnicity was not routinely recorded on admission to hospital. Similarly, the 1991 Census was the first census to ask people to define their ethnic origin (Nazroo, 1997). Therefore, in some study samples, people who are born abroad may be ethnically English and vice versa which complicates the attribution of differences in rates of disorder to ethnicity. Also, large numbers of

ASIANs who migrated from East Africa during the 1960's may be excluded from such studies.

Hospital admission statistics for affective disorders provide a less consistent picture of the rates of disorder among Asians. Carpenter and Brockington (1980) found that Asian immigrants had significantly higher admission rates for depressive neuroses and other neuroses than the native British sample. Dean et al (1981) partially supported this finding as they also found high rates of admission for other disorders amongst Indian men and women. However, they found lower rates amongst Pakistani and New Commonwealth Asian populations. It is difficult to interpret these findings as Dean et al (1981) fail to specify exactly which non-psychotic disorders are encompassed by the term "other psychiatric conditions". Cochrane and Bal (1989) found all admission rates for depression and neuroses were lower for Indian and Pakistani populations compared to the native British population.

It has been argued that hospital admission data is quite representative of prevalence rates for schizophrenia as the disruptive nature of the illness means that most cases will require hospital admission at some stage. However, admission statistics are thought to underestimate the true rates for less severe disorders as these may be treated in an outpatient or primary care setting or, they may not receive any treatment at all (Cochrane and Bal, 1987; 1989); and they do not include those with sub-threshold disorders, that is, people who may have significant functional impairments but do not meet formal diagnostic criteria. Admission rates are influenced by factors such as both formal and informal alternative sources of help, the tolerance level of the local community, stigma, variation in hospital practice (Cochrane and Stopes-Roe, 1981), and attitudes towards help-seeking. For example, some Asian cultural groups hold the belief that feelings of worry are outside of individual control and are an inevitable part of life (Krause, Rosser, Khiani and Lotay, 1990) therefore they may be less likely to seek help for feelings of anxiety or depression.

Another criticism of hospital based studies is that if the standards for hospitalisation are different in the country of origin, a person may have been ill at home for some time without receiving any inpatient treatment. Therefore, he/she may have been admitted to hospital not long after arriving in the UK thus artificially increasing the admission rates for immigrants (Dean et al., 1981). Alternatively, a person may have been hospitalised on

arrival in the UK due to a culturally different perception of what constitutes disturbed behaviour.

Hospital studies looking at rates of deliberate self-harm differ from those focusing on specific psychiatric disorders as the criteria for diagnosis or categorisation are often less ambiguous. Merrill and Owens (1986) compared Asian and native British groups in an investigation of ethnic differences in self-poisoning, and found that Asians were less likely to have self-poisoned previously, have a psychiatric history or be diagnosed as having a psychiatric illness. Asian males were significantly less likely to have self-poisoned than native British males, whereas the rates for Asian females were significantly higher than for native British women, and three times higher than those of Asian men. Although Merrill and Owens (1986) took care to exclude people of Irish origin from their native British sample, they were not as strict with their Asian sample which included people from throughout the Indian sub-continent, East Africa and a substantial number of second-generation Asians.

Bhugra, Desai and Baldwin (1999) also looked at deliberate self-harm in Asians. However, they use the terms deliberate self-harm and attempted suicide interchangeably, and their inclusion criteria covered acts such as gestures, manipulative attempts and attention seeking therefore the target behaviour is not as well defined as in the Merrill and Owens's (1986) study. They recruited people via Accident and Emergency departments, GP surgeries and psychiatric units and found that the rates were 1.5 times higher for Asian women than native British women, and this difference was even greater among 16-24 year olds. In a second study, Bhugra, Baldwin, Desai and Jacob (1999) found that Asians who self-harm were less likely than the native British sample to have a mental illness, and despite taking less of an overdose were more likely to regret that the attempt had been unsuccessful. These studies raise interesting questions about why there are such high rates of deliberate self-harm among young Asian women despite relatively low levels of psychiatric disorder.

### ***Community studies***

Cochrane and Stopes-Roe (1977) conducted a community based study using the Langner-22 item Questionnaire (Langner, 1962) to measure psychiatric symptoms in a sample of Indian and Pakistani born residents selected in age and sex categories which reflect the demographic characteristics of the total Indian and Pakistani communities in the UK. One

One of the strengths of the study is that it uses separate native British comparison groups for the Indian and Pakistani samples matched for age and sex in recognition of the demographic differences between these two groups. They found that the Pakistani group had significantly lower scores on the Langner-22 than the comparison native British sample; the Indian sample also had lower scores, although this failed to reach statistical significance. However, the native British group are drawn from the same area as the two Asian samples and the authors acknowledge that they are not representative of the native British population, as it is unusual for a native population to remain in an area of high immigrant concentration because the area is likely to be characterised by poorer housing, dereliction and some social problems. Therefore, these rates may be an underestimate of psychiatric morbidity in the Indian and Pakistani groups as the native British comparison groups may have had unusually high levels of psychiatric symptoms.

In 1981, Cochrane and Stopes-Roe conducted a similar study to their earlier study but this time they only recruited people originating from India, the majority of whom were Sikhs. They selected a comparison group from a comparable working class residential area to overcome the difficulties of a distorted sample outlined above. Their earlier finding of lower rates of psychological difficulties amongst Indians was replicated. This was still evident even when three different cut-off scores were used for the Langner-22. Interestingly, a significant relationship between SES and Langner scores in the Indian sample was thought to be accounted for by the Indian women in non-manual occupations, as upward social mobility was associated with higher symptom levels, whereas for the native British women, work appeared to act as a protective factor. Therefore, similarly to the deliberate self-harm studies, these results suggest that high levels of distress among Asian and British women have a different aetiology. Although, comparing social mobility between these two ethnic groups is problematic as both have different social structures and the status of particular occupations, for example a farmer, varies between countries (Ananthanarayanan 1994).

Williams, Eley, Hunt and Bhatt (1997) used data from the Twenty-07 Study (Williams, Bhopal and Hunt, 1993) which used the General Health Questionnaire (GHQ; Goldberg and Williams, 1988), Scale of Psychosomatic Symptoms (PSS; Dressler, 1985) and a measure of self-assessed distress. They compared a sample of Asians categorised into Muslims and non-Muslims aged 30-40 years with a native British sample aged 35 years, and found a moderate correlation between the GHQ-12 and self-assessed distress; and a



significant correlation between the four scales of the PSS and self-assessed distress. There were no differences on the GHQ-12 scores when compared to the same sex general population group, but all Asian women combined scored higher on the PSS and self-assessment. Muslim women scored higher than Hindu and Sikh women on the PSS and self-reported distress measure.

Williams et al (1997) concluded from these findings that as Asian women had higher scores on the PSS and self-reported distress measure they could argue that if self-reported distress and somatic symptoms are valid estimators of distress, then South Asian women have higher levels of distress in comparison to the general population, and may have been missed by clinically validated measures. The authors acknowledge that the PSS has not been as well researched as other measures of somatic symptoms such as the Bradford Symptom Inventory (Mumford, Bavington, Bhatnagar et al., 1991). It is not clear if validation data exists for the PSS as it has been developed from an existing measure, and the assessment of self-reported distress is thought to lack reliability and validity as it is only based on responses to a single question. Finally, the authors do not explain the use of such a narrow age range of participants which limits the generalisability of the results. The study highlights that existing clinical measures may underestimate levels of disorder in Asians as they may be insensitive to alternative expressions of distress. This is important to bear in mind when examining epidemiological studies that report varying rates amongst this population.

Nazroo (1997) reported results from one of the largest prevalence studies on the mental health of minority ethnic groups in the UK using the methods of measurement developed for the OPCS National Psychiatric Morbidity Survey (Meltzer, Gill, Petticrew and Hinds, 1995), and the samples included in the Fourth National Survey of Ethnic Minorities (Modood, Berthoud, Lakey et al., 1997). Participants were screened using a sub-set of items from the Clinical Interview Schedule (CIS-R, Lewis, Pelosi, Araya and Dunn, 1992), excluding somatic symptoms, and the Psychosis Screening Questionnaire (PSQ; Bebbington and Nayani, 1995). A sample of those who met the broad criteria for mental health problems took part in the Present State Examination (Wing et al., 1974) by an ethnically matched psychiatric nurse or doctor. The estimated prevalence rates for neurotic depression were similar amongst Pakistani and native British samples but were lower for Indians and Bangladeshis. Although, when the results were examined by sex, Indian men were found to have comparable rates to native British men. The estimated prevalence for

psychotic disorders was found to be similar for native British, Indian and Pakistani samples but was significantly higher amongst Irish and Caribbean populations. There was a larger discrepancy between CIS-R scores and the PSE in Asians compared to the other groups which implies that the CIS-R does not work uniformly across populations. When combined with the exclusion of somatic items, this suggests rates of non-psychotic disorders may have been underestimated, particularly as previous research indicates that Asian populations may communicate psychological distress through somatic symptoms (for e.g. Bal and Cochrane, 1990).

When interviewing participants an important issue is that of translation and use of appropriate languages. Several community studies interviewed participants in their first language even if they spoke English fluently. This is a strength as conceptualisations of emotional distress are thought to be linguistically constructed (Bhui, 1999); therefore even though many Asians speak English, their conceptual ability to express symptoms in English is questionable as language is culture based (Ananthanarayanan, 1994). When considering the technicalities of translation, there may be a reduction of issues in the search for equivalent words as the absence of words in certain languages does not mean that those emotions do not exist (Kleinman, 1987; Bhugra, 1996). Unfortunately, not many studies give details of the translation procedure they use, therefore the quality of translation is questionable particularly when standardised scales are being administered.

### *Primary Care studies*

Brewin (1980) argued that the low rates of disorder found amongst Asians in community studies should be reflected in studies of primary care attendance. However, he found that GP consultation rates were not different between Asian and native British groups. Brewin suggests that GPs are poor at detecting disorders in the Asian population due to a failure in communication which results in fewer referrals to specialist services. The native British comparison group contained people of Irish and West Indian origin which weakens Brewin's conclusions. Gillam, Jarman, White and Law (1989) carried out a study in North London looking at GP defined psychological problems. Similarly to Brewin (1980), they found that native British patients were most likely to consult their GP regarding psychiatric problems and in turn were more likely to be diagnosed by their GP as having significant non-psychotic mental health problems, than Asian and Caribbean patients.

Maase, Kosser, Khiani and Lotay (1990) compared Punjabi GP attendees to a native British sample matched on age and sex using the GHQ-28. They found that although Punjabi men were more likely to consult their GP than native British men there were no significant differences in caseness between the two groups. There were also no significant differences between the group's scores on the somatic sub-scales; however the Punjabi sample had significantly higher scores on the depression sub-scale. They concluded that Punjabis were just as able to express themselves psychologically as the native British sample and that their results did not support the view that Punjabis somatise. One of the interesting points about this study is the use of a sample defined by cultural group as findings based on groups defined by country of birth or ethnic origin are difficult to generalise due to the cultural heterogeneity between people originating from India or Pakistan (Senior and Bhopal, 1994).

Wilson and MacCarthy (1994) asked GP attendees to complete a Self-Report Questionnaire (SRQ), which is a screening questionnaire for non-psychotic mental health problems, and their reasons for consulting their GP were divided into physical problem or "other problem". Asian attendees scoring above the cut-off were more likely to say that they were consulting about a physical problem than native British attendees. However, the term "other problem" is quite vague and does not necessarily mean a mental health problem therefore this finding is of limited validity. They also found that GPs detected higher levels of psychiatric morbidity in the native British sample than the Asian sample. The results suggest that GPs are more likely to interpret the communication of native British patients in terms of a mental health problem but that of Asian patients in terms of a physical health problem, resulting in poor detection of mental health problems in Asians.

In summary, these primary care studies indicate that Asians are not underrepresented in specialist services due to an unwillingness to seek help as they consult their GP even more frequently than their native British counterparts. Therefore, low rates of referrals by GPs to specialist services for this population imply that the interface between primary care and specialist services is problematic for Asians, resulting in Asians being less likely to pass through the filter of care and receive hospital admission (Commander, Sashi-Dharan, Odell and Surtees, 1997b), especially in the case of non-psychotic disorders. It has been suggested that the low referral rates by GPs may indicate that patients are being treated within a primary care setting (Bhui, 1999). However, the above studies do not support this as they found that GPs are generally poorer at detecting psychiatric morbidity in Asian and

Caribbean populations than in the native British population. Therefore, primary care and hospital based data on rates of disorder may just be reflecting differences in pathways into care.

### ***Migration stress***

One hypothesis used to explain the rates of mental health problems in immigrant populations is that of high levels of stress immediately after migration. Often the process of migration may lead to social isolation and loss of social networks. Immigrants may experience feelings of “culture shock” as their norms and values may clash with those of the country to which they have migrated resulting in confusion and stress (Al-Issa, 1997). This would be further impacted on by an inability to speak the language. Immigrants may have their confidence undermined due to difficulty finding employment as their qualifications are not recognised and they are required to learn new skills. Also, the distribution of social class is skewed downwards when moving to developed world countries for economic reasons resulting in greater uncertainty, more difficult working conditions, substandard housing and overcrowding (Cochrane and Bhugra, 2001; Cochrane and Sashidharan, 1996). Goal striving, that is, the discrepancy between one’s aspirations and actual achievement in the country to which one has migrated, may result in stress (Al-Issa, 1997), and the development of stress related psychiatric disorder, especially when the person has moved for economic reasons. However, it is important to acknowledge that sources of stress such as difficulty finding suitable employment, low confidence and feeling deskilled, may affect mental health independently to ethnicity.

McGovern and Cope (1987b) argue that the relationship between stress and major psychoses is not as well established as for non-psychotic disorders. They are supported by Cochrane and Bal (1987) who claim that research indicates only people vulnerable to schizophrenia are likely to develop it when exposed to environmental stress. Therefore, it is unlikely that living in a stressful environment following migration will be the sole cause of psychoses. It is extremely difficult to draw conclusions about high levels of stress immediately after migration as defining this type of stress is problematic, and it is even harder to measure. Assessing this type of stress is complicated by the fact that individuals may develop stress related problems after a few years in the UK when they realise that their goals are unachievable (Littlewood and Lipsedge, 1982), which would not be directly related to the process of migration. Also, the level of stress experienced following migration would be hugely influenced by the circumstances surrounding migration as the

needs of refugees and asylum seekers would be clearly different to those who have migrated for economic reasons. However, it is beyond the scope of this review to consider this issue in detail.

### ***Selection Hypothesis***

The selection hypothesis was first proposed in a classic paper by Odegaard (1932) who argued that high rates of schizophrenia are due to people choosing to migrate to overcome social adversities and failing interpersonal relationships in their country of origin during the incipient phase of illness. He based this theory on a study which compared Norwegian immigrants to the USA with a USA born sample and Norwegians in Norway. After correcting for age, he found that Norwegian immigrants had higher rates of mental health problems than both the USA (30-50%) and home samples.

McGovern and Cope (1987b) argue that the selective migration hypothesis is an unlikely explanation as many studies (e.g. Littlewood and Lipsedge, 1981a) show that the onset of illness often occurs years after migration, and there is no way to determine whether or not the person had any psychological problems before emigrating (Cochrane and Bal, 1987). A study by Creed, Winterbottom, Tomenson et al (1999) which compared Hindu, Muslim and Sikh immigrants with their siblings in India found no differences between scores on the Self-Rating Questionnaire (SRQ). This implies that there are no significant differences between those who did not migrate compared to those who did. Further evidence against the selection hypothesis is the view that a person with premorbid symptoms of schizophrenia such as passivity, withdrawal and lack of adaptability would not possess the ambition or ability to search for work abroad (Cochrane & Bal, 1987); and that the process of migration is so complex that only the most determined individuals will manage it (Cochrane, 1977). Support for this view is provided by Cochrane and Stopes-Roe (1977) who found Indian and Pakistani immigrants to be socially and psychologically better adjusted than their native British counterparts.

### ***Acculturation***

Acculturation is adaptation to a different culture. The experience of acculturation, events during migration and contact with the dominant society in the country to which a person has migrated, may result in acculturative stress manifested in the form of anxiety and depression, feeling alienated and marginalized. This may result in poor adaptation thereby affecting the daily life of a person (Berry, 1995). According to Berry (1995) there are four

possible outcomes of acculturative stress assimilation, integration, separation, and marginalisation. Assimilation is adoption of the dominant society's characteristics. Integration involves becoming an integral part of larger society whilst maintaining cultural integrity, that is, positive relationships with the dominant group are encouraged and one's own cultural identity is valued and retained. Whereas, separation is (voluntary) withdrawal from dominant society and marginalisation, accompanied by marked collective and individual tension, results in features of the culture of origin being lost; and due to lack of integration in the dominant society these are not replaced. Szapocznik and Kurtines (1980) claim that acculturation has a U shaped relationship with psychiatric disorder, that is, the most and least acculturated individuals will have a low risk of developing mental health problems. This theory is particularly relevant when examining studies on deliberate self-harm, as the struggle between upholding the traditional values of one's culture of origin and adapting to a new culture have often been highlighted as possible causes of suicide and attempted suicide.

### ***Misdiagnosis/under-diagnosis***

It is difficult to diagnose psychiatric disorders when there are language barriers and when different cultural beliefs are held by the client and psychiatrist, resulting in a tendency to misdiagnose disorders such as schizophrenia in certain ethnic groups. For example, in native British clients, hallucinations and delusions are usually indicative of schizophrenia, but this is not necessarily true of all cultures. Therefore, some thought processes might be misinterpreted as disordered or pathological if not viewed in the appropriate cultural context (London, 1986; Rack, 1982; Cochrane and Bal, 1987). Bhugra (1996) highlighted that the feelings of depression are universal, but the clinical features are different across cultures, and a client's perception and communication about symptoms is influenced by culture, as is the interpretation of these by a clinician.

One of the main criticisms about the diagnosis of psychiatric disorders in immigrants is that most psychiatric clinical interviews and screening measures were devised on populations living in Euro-American environments and cultures, and so they reflect the language and assumptions of western psychiatry (Williams, Eley and Hunt, 1997; Bhui, 1999). This leads to what Kleinman (1987) terms a "category fallacy", that is, the application of a diagnostic category to a cultural group other than the one it was developed in, for which the validity has not been established. The result could be distortion of pathology or, non-western culture bound syndromes (for example, "sinking heart"; Krause,

1997) being missed despite accurate translation of measures. The latter point is highlighted by the poor detection rate for non-psychotic mental health problems in primary care, indicating that under-diagnosis is as much of a problem as misdiagnosis in the Asian population.

### ***Discrimination***

A potentially controversial explanation for the rates of psychiatric disorder found amongst Asian groups is that of discrimination. It is difficult to measure discrimination as it is not always overtly expressed in the form of verbal abuse or physical attacks and may be more subtle, for example, difficulty securing work that reflects qualifications, less opportunity for promotion, and earning a lower wage than native British people doing similar work (Rack, 1988; Fernando, 1984). Based on this it could be argued that paranoid ideation and an external locus of control overlap with discrimination. Therefore in an environment with discrimination, “paranoia” may represent a healthy coping strategy (Chakraborty and McKenzie, 2002). Alternatively, a person may equate negative experiences with the health service to discrimination (Adebimpe, 1997), and the result of such experiences may discourage a person from being forthcoming about his/her psychiatric history resulting in an overestimation of rates (Nazroo, 1997).

### ***Demographic differences***

A criticism of early studies is that demographic differences between immigrant and native British populations such as age, SES, marital status and sex are not acknowledged. For example, Cochrane and Bal (1987) argue that if rates are not standardised for variables such as age, they would be elevated due to high concentrations of immigrants in certain age groups. Support for this argument is provided by their finding that when the admission rates for schizophrenia were standardised for age and SES, the rates for the Indian born were reduced and became more similar to those of the native British. Similarly, a sampling weakness of several studies is that the Pakistani sample often contains people originating from Bangladesh who are quite different demographically and are more likely to be disadvantaged (Bhui, 1999).

When standardising rates the calculation of population parameters are important. Often statistics are calculated using data from Censuses, Labour Force Surveys and the Department of Health and Social Security, which may lack information about the SES of individuals. Also, the earlier versions of these data sources only record a person's country

of ethnic minority groups do not contain information about the age structure, sex or SES of second generation minority ethnic groups. Therefore until the 1991 Census, data on the true size of ethnic minority populations was largely unreliable.

### ***Second generation Asians***

Studies which have categorised immigrants according to country of birth as opposed to ethnicity have neglected second generation ethnic minorities (Ananthanarayanan, 1994). Existing research suggests that the rates of disorder in second generation minority ethnic groups are in fact significantly higher than for the first generation. Nazroo (1997) found that rates of anxiety, depression and psychotic disorders were higher in Indian and African Asian non-migrants than migrants. Furnham and Sheikh (1993) found that second generation Asians whose parents live in the UK had higher levels of distress. Several of the hypotheses outlined above, such as migration stress, selective migration and demographic differences, are not applicable to second generation Asians, therefore alternative explanations for the differing rates of disorder between generations need to be explored. A related issue is whether or not the standardised screening tools used to assess psychiatric symptoms that have been validated with first generation populations are equally applicable to second generation Asians. This is because the experience of “dual socialisation” in Asian and British culture may result in the understanding of, and attitudes toward mental health being significantly different amongst second generation populations, which in turn would impact upon detected rates of disorder.

It is argued that second generation Asians growing up in the UK as a minority group, differ from the first generation with regard to the expectations placed on them, and their attitudes towards social support, as community support, for example, might be viewed as intrusive and/or restrictive (Furnham and Sheikh, 1993). A study by Bhugra, Bhui, Desai and Singh (1999) compared Asian adolescents who attended Accident and Emergency after an episode of deliberate self-harm with a group of Asian women attending their GP and found no significant differences. Interestingly, those adolescents who self-harmed had less traditional attitudes to work and marriage than their parents. Mumford, Whitehouse and Platts (1991) found Asian schoolgirls were significantly more likely to have an eating disorder than native British schoolgirls, and that “traditional” girls were more likely to exhibit higher scores on the Eating Attitudes Test (EAT; Garner and Garfinkel, 1979) and the Body Shape Questionnaire (BSQ; Cooper and Fairburn, 1987). Although their sample size was very small, Mumford et al (1991) suggested that these differences may be due to



culture conflict. That is, the idea that traditional values of collectivism and interdependence conflict with Western goals of individualism and independence (Ballard, 1979), and that exposure to both traditional family values and more “liberal” western values can cause confusion and distress. However, despite using it as an explanation for their results, a limited number of studies have actually attempted to explore this concept of “culture conflict” in any depth highlighting an important gap in the literature.

In conclusion, high rates of psychoses and deliberate self-harm, but inconsistent rates for affective disorders have been found amongst people originating from India, Pakistan and Bangladesh in hospital, community or primary care settings. Although several potential explanations have been forwarded, no one hypothesis has been able to satisfactorily account for the results obtained. This picture is complicated further by more recent studies looking at second generation Asians which have emphasised our lack of understanding of the needs of younger minority ethnic groups.

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**Identification of vulnerability to psychological difficulties  
in second generation South Asian women**

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A Thesis submitted in partial fulfilment of the  
requirements of the University of Hertfordshire  
for the degree of Degree of Doctor of Clinical Psychology

The programme of research was carried out in the  
Department of Psychology,  
University of Hertfordshire  
November 2003



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## Acknowledgements

I would like to thank all the participants who gave up their time and took part in this study. I am grateful to the following people for their help and support in setting up this research project: Tim Acton, Sim Roy-Chowdhury, Rod Holland, Richard Parkin, Dr. S. Patel, Bob Ryan, Dr. Shah, Dr. Sumners, Roger Turner, and Sue Watson. I would like to thank my supervisors David Winter and Barbara Mason for their guidance and assistance at every stage of the process; and Joerg Schulz, Peter Weinreich and Wendy Saunderson for their advice and comments. Special thanks to Mads, Dr. (Heather) Mason, Ad and Ally for keeping me sane and for being so supportive. Last but not least, a huge thank you to Mum, Dad and Sam (My generous landlord), for their encouragement and for always believing in me.

## Abstract

Existing studies suggest that the high rates of mental health problems among second generation or UK born Asians are due to "culture conflict", that is, the idea that individuals are stuck between two incompatible cultures. The aim of this study was to explore how the experience of being raised in both Asian and native British culture impacts upon the mental health of second generation Asian women. Thirty women participated in this study and were categorised into two groups (clinical vs. non-clinical) according to 'caseness', which was determined on the basis of a screening questionnaire, the General Health Questionnaire (GHQ-12; Goldberg, 1972). A more detailed psychological profile of participants was provided using the Brief Symptom Inventory (BSI; Derogatis and Melisaratos, 1983). These groups were compared on a range of identity parameters drawn from Identity Structure Analysis (ISA; Weinreich, 1979, 1980), which is a meta-theoretical framework designed to investigate cultural identity and acculturation.

The results indicated that both the clinical and non-clinical groups identified closely with Asian and native British culture, which suggests that both groups viewed themselves as being bicultural. There were no differences between the groups in the extent to which they wished to dissociate from the values of their parents and representatives of Asian culture. The clinical group were significantly more likely to view fathers and first generation Asian females as having some qualities which they identified with and some which they wished to dissociate from, thereby creating a conflictual state (identification conflicts), than the non-clinical group. When these identification conflicts were considered across a range of significant others (identity diffusion), there was no difference between the groups. Identity diffusion was positively correlated with some of the BSI symptom dimensions for the clinical group and negatively correlated for the non-clinical group.

The results imply that even women who consider themselves to be bicultural experience psychological distress, which is in contrast with much of the literature. The results also suggest that potential psychological stressors include the experience of integrating the conflicting demands of home and wider society. When identifications with a range of significant others were highly conflictual in nature this was associated with a negative effect on one's sense of well-being, however when this was experienced to a milder degree it appeared to serve as a trigger for identity development.

## 1. Introduction

The findings of the 2001 Census revealed that 7.9% of the population of England and Wales belongs to a minority ethnic group. Of these, 4% are people originating from the Indian sub-continent. Approximately half of this group immigrated from India and Pakistan during the 1960's and from East Africa during the 1970's. However between 45-55% of this population was born in England and Wales and may be regarded as second generation Asian or British Asian (Office for National Statistics, 2003). Although the social and political context within the UK is one of multiculturalism, "race" related discrimination is widespread which has prompted various government initiatives to promote equality, integration, improved policy design and service delivery (CRE, 2003; Office of Deputy Prime Minister, 2003). Within the National Health Service (NHS), the ultimate aim is to provide an equal service and choice of access to all members in a multi-ethnic society that best meets the needs of the individual. However, NHS policy makers are starting to acknowledge that the idea of universal health service provision that is "colour blind" is inadequate, as it results in inequalities with regard to access and also leads to needs not being met as rates of health vary across groups in society (Olajide, 1999). This study aims to provide a better insight into the impact of cultural identity on the mental health of second generation Asians, which will in turn be useful in developing strategies for providing culturally sensitive care and improving access to services.

### *1.1 Epidemiology*

There has been a great deal of research focusing on the prevalence of mental health problems of the Asian immigrant, or first generation, population within the UK (See Patel (2003a) for detailed review of epidemiology). The term "Asian" is used in much of the UK literature to refer to individuals originating from the Indian sub-continent, that is, India, Pakistan and Bangladesh. One of the earliest hospital studies was by Cochrane (1977), who studied admission rates for Indians and Pakistanis and found that prevalence rates for schizophrenia in both Indian men and women were higher than for the native British population. This finding was supported in several later studies (Carpenter and Brockington, 1980; Cochrane and Bal, 1987; 1989).

The rates of affective disorders for Asians are less consistent. Carpenter and Brockington (1980) found significantly higher admission rates for depressive neuroses and other neuroses amongst Asians than the native British group. Some support for this finding is offered by

Dean, Walsh, Downing et al., (1981). However, compared to the native British sample, Cochrane and Bal (1989) found lower admission rates for depression and neuroses among Indian and Pakistani populations. Cochrane and Stopes-Roe (1981) conducted a community based study and found that the Indian group had lower rates of psychological difficulties than the age and sex matched native British group; and a primary care study by Krause, Rosser, Khiani and Lotay (1990) found no significant differences in caseness between Punjabi and native British GP attendees.

It has been argued that existing clinical measures may be insensitive to alternative expressions of distress and as a result may underestimate levels of disorder in Asians (Williams, Eley, Hunt and Bhatt, 1997). Similarly, it has been suggested that GP's are poor at detecting mental health problems in Asians due to a failure in communication which results in fewer people being referred to specialist services especially in the case of non-psychotic disorders (Brewin, 1980; Commander, Sashidharan, Odell and Surtees, 1997b; Gillam, Jarman, White and Law, 1989; Wilson and MacCarthy, 1994).

### ***1.2 Epidemiology for second generation Asians***

Studies that have categorised immigrants according to country of birth, as opposed to ethnicity, have tended to neglect second generation groups (Ananthanarayanan, 1994). Despite the fact that second generation or UK born Asians constitute almost half of the total Asian population in England and Wales, there is a limited amount of research on the mental health needs of this group. Existing studies suggest that the rates of disorder in second generation ethnic minorities differ from those found for the first generation.

#### *Affective disorders*

One of the largest prevalence studies on the mental health of minority ethnic groups was conducted by Nazroo (1997) using the methods of measurement developed for the OPCS National Psychiatric Morbidity Survey (Meltzer, Gill, Petticrew and Hinds, 1995), and the samples included in the Fourth National Survey of Ethnic Minorities (Modood, Berthoud, Lakey et al., 1997). He compared the rates of disorder between first and second generation minority ethnic groups and found that non-migrants originating from India had significantly higher rates of anxiety than migrants. However, this rate was lower than for the native British population. The second generation samples from both India and Pakistan/Bangladesh also had higher levels of neurotic depression than the first generation. This rate was equal to that of the



native British group for the Pakistan/Bangladesh group, whereas the Indian group had a slightly higher rate.

One of the measures used within this study was a sub-set of items from the Clinical Interview Schedule (CIS-R; Lewis, Pelosi, Araya and Dunn, 1992), which excluded somatic symptoms. The implication of this is that rates of non-psychotic disorders amongst the Asian groups may in fact be an underestimate, as there is a large body of literature that indicates that Asian populations may communicate psychological distress through somatic symptoms (for example, Bal and Cochrane, 1990). A criticism of this study is that the minority ethnic samples also included people of mixed heritage, which is of relevance as this particular group will experience different stressors, and consequently will have different needs.

Furnham and Shiekh (1993) used the Langner-22 (Langner, 1962), which is a measure of non-psychotic symptoms of psychological distress, in two generations of Asians. They found that women had higher Langner-22 scores than men in both first and second generation samples. However, overall the first generation group had slightly higher levels of distress than the second generation, and this was related to employment, children living at home and forms of social support. Similarly, Krause et al., (1990) used the General Health Questionnaire (GHQ-28; Goldberg, 1972) to compare Punjabi GP attendees with an age and sex matched native British sample. They found no significant differences in caseness between first and second generations.

### *Eating disorders*

Mumford, Whitehouse and Platts (1991) investigated eating disorders among 14-16 year old Asian and native British school girls in Bradford using the Eating Attitudes Test (EAT; Garner and Garfinkel, 1979), which is a screening instrument for eating disorders, and the Body Shape Questionnaire (BSQ; Cooper and Fairburn, 1987), which is a measure of dissatisfaction with body shape. They found that Asians exhibited higher scores on both the EAT and BSQ than the native British sample. A diagnostic interview with high scorers on each of the questionnaires indicated one year prevalence for bulimia to be 3.4% for Asian adolescents and 0.6% for the native British sample. This replicates the findings of an earlier study by Mumford and Whitehouse (1988), which found a prevalence rate of 3.6% for bulimia within the Asian sample, compared to 0.4% for the native British group.

Choudry and Mumford (1992) found that unhealthy eating attitudes in Asian adolescents are specific to UK residents. They compared a sample of UK born Asians to native British and Pakistani born samples using the EAT. They found that the UK born Asians had unhealthier eating attitudes and a higher estimated prevalence for bulimia nervosa than the Pakistani sample, and that the eating attitudes of both Asian samples were unhealthier than those of the native British sample.

### *Deliberate Self-harm*

Bhugra, Desai and Baldwin (1999a) looked at rates of deliberate self-harm and attempted suicide amongst different ethnic groups over a one year period, and assessed them using the GHQ-28 and the CIS-R. When all ages were considered together, the rate for Asian women was 1.5 times higher than for native British women. The difference was much more apparent when women aged 16-24 year old were compared, as the rate for Asian women was 2.6 times higher than for native British women, and 7.5 times higher than for Asian men of the same age. When different age groups within an ethnic category are considered, the rate for Asian women under the age of 34 years was much higher than for those aged over 34 years. However, it must be noted that an assumption is being made that women in the 16-24 year old age category are second generation Asians, as Bhugra et al., (1999a), like many other researchers, fail to distinguish between first and second generations, and have combined the results for both groups, making it difficult to draw conclusions.

In a study by Kingsbury (1994) South Asian and native British adolescents aged 12-18 years were interviewed by a child psychiatrist after attending Accident and Emergency following an overdose. He found that Asian adolescents had lower suicidal intent but had higher rates of depression and feelings of hopelessness. They were also likely to have spent longer premeditating prior to the event and were more socially isolated than the native British sample. Asian adolescents were also significantly more likely to experience their parents as controlling and confided in them less. A comparison of suicidal ideation between generations by Nazroo (1997) found both Indian and Pakistani/Bangladeshi second generation groups to have higher levels than the first generation, and this difference reached statistical significance for the Pakistani/Bangladeshi group. The rates were also higher than for the native British sample. An interesting finding in light of the literature on deliberate self-harm, which indicates higher rates amongst Asian women, was that there was no effect of gender, and both men and women had similar levels of suicidal ideation.

A difficulty associated with studies focusing on second generation Asians is that definitions of "second generation" tend to vary. Some studies would categorise people who immigrated to the UK before the age of 18 years to be second generation, whereas others (for example, Nazroo, 1997) would argue that the influence of school and the ability to speak English fluently are important variables, and consequently only consider those who were born in the UK or immigrated before the age of 11 years to be second generation. As a result, interpretation of findings becomes more complex. This study aims to overcome this criticism by defining second generation as being those individuals who were born in the UK or immigrated here before the age of 5 years, in an attempt to account for the importance of language ability and early socialisation effects of school.

To summarise, the rates of affective disorders reported for second generation Asians indicated higher rates of anxiety and neurotic depression than for the first generation (Nazroo, 1997), whereas other studies found the first generation to have higher rates (Furnham and Shiekh, 1993), or no difference (Krause et al., 1990). When compared to the native British population, the rates of anxiety were lower for both Asian groups, and the rates of neurotic depression were equal to that of the native British group for the Pakistan/Bangladesh group, but higher for the Indian group (Nazroo, 1997). Studies examining eating disorders found Asian schoolgirls to have a significantly higher prevalence of bulimia, compared to native British schoolgirls (Choudry and Mumford, 1992; Mumford, et al., 1988, 1991). Similarly, rates of deliberate self-harm and attempted suicide were found to be much higher for Asian females than native British females (Bhugra, et al., 1999a; Kingsbury, 1994).

### ***1.3 Explanatory models***

A number of models or hypotheses have been proposed to explain the rates of mental health problems among first generation populations. These include issues relating to the stress of migration such as social isolation, difficulty finding suitable employment and feeling deskilled (Cochrane and Bhugra, 2001; Cochrane and Sashidharan, 1996); discrimination in areas including employment and health services (Adebimpe, 1997; Rack, 1988); misdiagnosis/under-diagnosis of mental illness (London, 1986; Rack, 1982); demographic differences (Cochrane and Bal, 1987); and the self-selection hypothesis that those in the early stages of mental illness, such as schizophrenia, may be more likely to migrate due to a breakdown in their social networks (Odegaard, 1932). (See Patel (2003a) for review of explanatory models for first generation immigrants).

As the above studies illustrate, the rates of disorder differ between generations, with second generation Asians suffering from higher levels of psychological distress than the first generation. When considered in conjunction with the findings that the rates of disorder in this group are equivalent to, if not higher than, those for the native British population, the importance of addressing the mental health needs of this population are evident. Not all of the explanatory models noted above are necessarily applicable to individuals who have grown up in the UK as they are unlikely to have experienced the stressors associated with migration and resulting problems firsthand. However, those relating to racism and discrimination, and also to misdiagnosis are likely to apply to second generation populations as well. It is therefore necessary to distinguish between first and second generation Asians based on the view that aetiological or explanatory models play an essential role when working therapeutically.

There are numerous possible reasons for the high levels of disorder amongst second generation Asians, such as a true difference in morbidity, variation in help-seeking behaviour and consequently detection of mental health problems, or the use of different case definitions (Bhugra and Bhui, 1998). However, the most common explanation is that of "culture conflict", that is, the idea that individuals are "stuck" between two incompatible cultures. Culture conflict is regarded as stress inducing as its psychological consequences include threats to a person's identity, beliefs and values. Symptoms generated from the impact of culture conflict may include feelings of hostility, loneliness, anxiety, low self-esteem and depression. Consequently, culture conflict is felt to be a predisposing factor for many forms of psychological and physical illness (Cuéllar, 2000). However, the term "culture conflict" has received much criticism for being too simplistic. In the use of this term, identification with a cultural group is portrayed as an either/ or situation, whereby individuals are portrayed as identifying with one culture and hence being in "conflict" with the other. In reality the process of cultural identification is probably far more complex, involving a synthesising of values of both cultures (Ali and Northover, 1999; Ballard, 1979). The aim of this study therefore is to examine this idea of synthesising values from both British and Asian culture in more depth. In order to do this it is necessary to start with an examination of two main areas: firstly how the experiences of living in "western society" differ for first and second generations; and secondly to outline contrasts between British and Asian culture in an attempt to identify potential areas of conflict and psychological distress for second generation Asians.

#### *1.4 Experiences of first and second generation Asians*

It has been argued that living within both Asian and British cultures is experienced differently by first and second generation Asians. This may be partly because many first generation Asians immigrated for economic reasons and therefore perceive the UK as a country of opportunity and regard the Indian sub-continent as home, whereas the second generation may be more likely to regard Britain as home as they were born and raised here (Srinivasan, 2001). The first generation may be more likely to live in an area with a high concentration of immigrants and work in an "ethnic niche", whereas the second generation are more likely to cross ethnic boundaries (Waldinger and Perlman, 1998). One view is that second generation Asians might be expected to be less vulnerable to psychological distress due to fewer obstacles with regard to language and qualifications as they are born, socialised and educated within British culture (Hirschman, 1996; cited in Abouguendia and Noels, 2001). However, it could be argued that the first generation have a more secure identity with roots in family values, religion and community, and therefore do not usually suffer the same difficulties as UK born Asians in developing a self-identity and an ethnic identity that fits with both cultures (Farver, Narang and Bhadha, 2002b; Stopes-Roe and Cochrane, 1990).

Ghuman (1999) argues that social and psychological development is likely to be more problematic for Asian adolescents than for their native British peers due to the differences between British and Asian culture. He highlights that it is difficult to develop a coherent identity when faced with conflicting social and emotional expectations from home and school. A potential consequence is feeling alienated or experiencing psychological conflict if the self-concepts of the individual are not approved by parents or native British peers (Weinreich, 1997). As a result, one may use compartmentalisation to maintain self-esteem and personal identity, that is, identify with British culture and values outside of the home and Asian culture within (Ghuman, 1999). A Canadian study by Abouguendia and Noels (2001) indicated that the effect on mental health of general and acculturation related hassles differed between generations. They found that for second generation Asians, experiencing stressors through contact with one's own ethnic group was a predictor for low self-esteem, and difficulties with mainstream society predicted depression. The first generation, on the other hand, were significantly less likely to experience in-group hassles, but when these occurred they predicted greater depression.

### *Prejudice and discrimination*

It has been argued that the mental health status of an individual may be affected by the attitudes of larger society as not all minority ethnic groups are regarded in an equally favourable way (Berry, 1986; Fernando, 1984). This view is supported by Furnham and Shiekh (1993), who found a significant correlation between Langner-22 scores and experience of racial prejudice/ abuse. Although both first and second generation minority ethnic groups may experience prejudice, it has been suggested that the second generation may respond more strongly to rejection and discrimination and have their self-esteem and confidence undermined (Bhugra and Cochrane, 2001; Ghuman, 1999). Modood, Beishon and Virdee (1994; cited in Ghuman, 1999) conducted interviews with UK born Asians in London, Birmingham and Leicester on attitudes regarding language, religion and identity. They found that over half of the people interviewed considered themselves to be culturally British but did not feel accepted by majority society and often felt under pressure to minimise their ethnic identity.

Another qualitative study with second generation Bangladeshis used discourse analysis to explore the concept of racism (Ahmed, 2000). The results indicated that people felt less discriminated against than their parents' generation in some areas, for example housing, and that they believed increased education and contact between cultures had led to a reduction of racism. They also expressed the slightly contradictory view that they believed that racism was ever present but was more difficult to challenge than previously as it was hidden (Ahmed, 2000). These findings support the idea of "disguised discrimination" which may occur in relation to employment, that is, arguing that decisions are made based on objective criteria, but the end result being that a person from a minority ethnic group is at a disadvantage (Cochrane, 2001). The experience of prejudice and discrimination, in the area of employment for example, is thought to be particularly stressful for a second generation Asian as the associated feelings of rejection may be more pronounced than for the first generation. This is because he/she is likely to have a British education and qualifications, which are equivalent to those of his/ her native British peers.

### *Family*

For most children, parents, extended family and general representatives of a person's own ethnic group are responsible for their primary socialisation (Kelly, 1989). Within Asian culture the structure of families is different to that of British culture and children are raised with a strong sense of obligation to their parents and extended family, not just their nuclear

family. The needs of the family are emphasised over those of the individual and this collectivist value system has implications for within family relationships and relationships with outsiders (Ahmed and Lemkau, 2000; Durvasula and Mylvaganam, 1994). Western or British cultures may be regarded as holding values which are conflicting with Asian culture as they place an emphasis on personal responsibility and individual autonomy, especially during adolescence (McCourt and Waller, 1996), whereas it has been argued that within Asian cultures, the idea of adolescence in terms of autonomy of decision making, role and status does not exist (Dasgupta, 1998).

In the UK, schools encourage children to develop critical thinking and a questioning attitude, as opposed to unquestioning respect for elders (Ghuman, 2000). They also promote equal opportunities and gender equality, which contrasts with the Asian patriarchal family structure, and perception of men as having more power and authority than women (Ahmed and Lemkau, 2000; Durvasula and Mylvaganam, 1994). As a result, parents may regard schools as challenging the values of home (Ghuman, 2000).

Second generation Asians may be able to adapt more easily to British culture than the first generation. However this may create family strain as parents and extended family try to preserve the culture of origin. As a result UK born Asians may find themselves caught between the values of older family members and same age peers in the dominant society, which is a potential source of intergenerational conflict (Ahmed and Lemkau, 2000). Ballard (1979) suggests that there may be too much of a focus on second generation individuals as being "rootless" and stuck between two cultures. She argues that wanting the same level of freedom as one's peers and resenting the authority of parents is often assumed to be due to culture conflict amongst Asians, but in other cultures there may be similar levels of conflict between parents and children over these very issues. However, she also states that as second generation Asians get older the differences between their own family and British norms become more obvious and this may result in second generation youth being critical that their parents are rejecting of British culture. As a result they may be less likely to accept views and beliefs of parents unquestioningly. Interestingly, Stopes-Roe and Cochrane (1990) found that second generation individuals wanted more freedom to live life outside of the family but did not necessarily want to cut or loosen family ties. This is important as it highlights that second generation Asians do value aspects of their cultural heritage, such as collectivism.

## *Gender*

It has been argued that there is a great deal of pressure on Asian females to maintain traditional roles and identities as they are believed to be the "carriers" of cultural values and tradition within families (Dasgupta, 1998). They may be exposed to freedom and opportunities in the UK that may not have been available in South Asia, and which conflict with role expectations of the family (Ahmed and Lemkau, 2000). As a result Asian females may be more restricted than males due to fears that they will become too westernised and will want, for example, to engage in dating and premarital sex, which could be damaging to family honour (Dasgupta, 1998). A related view is that women have more problems than men due to the patriarchal structure of Asian families (Ghuman, 1999). This hypothesis is given some support by Stopes-Roe and Cochrane (1989), who looked at traditionalism between cultures and found both Asian and native British women to be less traditional than men. Therefore, a potential source of stress for women is the expectation that they will behave in Indian gendered ways which may conflict with personal values of gender equality (Dasgupta, 1998).

The review of the literature so far has examined various facets of the concept of "culture". It is important to acknowledge at this stage that culture is a dynamic process and consequently it is difficult to define as there is no unitary "British" or "Asian" culture. Therefore generalisations must be made with caution as there are significant differences between communities or groups within each culture with regards to religion, language, historical roots and value systems. However, bearing these limitations in mind it is believed that broad generalisations can be made about British culture being rooted in a "western" world view which tends to emphasise individual responsibility and autonomy, whereas Asian culture is rooted in a broadly "eastern" world view which places greater emphasis on interdependence and community.

### ***1.5 "Culture conflict"***

The concept of negotiating two contrasting cultures and the impact of this on emotional well-being, or "culture conflict", may be studied from a variety of perspectives including an examination of cultural values, adaptation of behaviour and attitudes, ethnic identity and identification with one's own and other ethnic groups. Some of the research in this area will be reviewed below.



### *Acculturation*

One of the best known models in relation to the concept of culture conflict is that of acculturation. Acculturation is a change in attitudes, values and behaviours which occurs as a result of prolonged contact between two cultural groups, and may happen at both a group and/or individual level. Although changes may arise in either direction, it is more common for the non-dominant group to change due to the influence of the dominant group (Berry, 1995). The domination of one group over another implies that contact may be conflictual; therefore within this interacting system, adaptation is used as a strategy to reduce conflict (Berry, 1980).

This model was used by Mumford et al., (1991) to explain the high rates of eating disorders amongst second generation Asian adolescents. They assessed "western" (British) and "traditional" (Asian) cultural orientation using four questions relating to language, dress and food. They found a significant relationship between high scores on the "traditional" questions and both the Body Shape Questionnaire (BSQ) and Eating Attitudes Test (EAT), but there was no relationship between scores on the "western" questions and either questionnaire. Multiple regression analysis indicated that traditionalism influenced eating attitudes independently to BSQ scores, which suggests that these females had concerns about eating and their weight but this was not necessarily related to dissatisfaction with body shape.

Mumford et al (1991) argue that a possible explanation for these results is that females from traditional backgrounds were more likely to experience internal conflict and anxiety due to a greater difference between the cultural values of home and wider society, or that there may be higher levels of intergenerational conflict due to more rigid family functioning in traditional households. They found only a modest inverse correlation between "traditional" and "western" scores, which indicates that the two are not at opposite ends of a cultural continuum. The assessment of cultural orientation in this study is thought to be quite basic as it is based on a small number of questions pertaining to limited aspects of cultural behaviour. The authors also suggest intergenerational or culture conflict as a possible cause of eating disorders but fail to assess family relationships, and do not clearly define or quantify this notion of cultural distance.

As noted in the critique of the above study, there are problems with a simplistic one-dimensional model of acculturation, for example, in the recognition that people may identify with both Asian and British cultures in terms of values, knowledge, membership and lifestyle

(Sue, Mak and Sue, 1998). A multidimensional model of acculturation is therefore proposed as a more satisfactory alternative to the simple linear model. According to Berry (1986; Berry, Kim, Power et al., 1989) there are four possible acculturative strategies, namely, assimilation, integration, separation, and marginalisation. Assimilation is adoption of the dominant society's characteristics. Integration involves becoming an integral part of larger society whilst maintaining cultural integrity, that is, positive relationships with the dominant group are encouraged and one's own cultural identity is valued and retained. By contrast, separation is (voluntary) withdrawal from dominant society; and marginalisation, accompanied by marked collective and individual tension, results in features of the culture of origin being lost, and due to lack of integration in the dominant society these are not replaced. These four acculturation strategies are adopted as a function of two main issues: whether or not it is important to maintain one's cultural identity and whether or not maintaining relationships with other cultural groups is thought to be of value (Berry, 1986).

A study by Farver, Bhadha and Narang (2002a) explored the relationship between acculturation and psychological functioning in second generation adolescents in the US based on this multi-dimensional model. They used self-esteem and school performance as measures of well being and psychological adjustment, and assessed acculturation using the Bicultural Involvement Questionnaire (Szapocznik, Scopetta, Kurtines et al., 1978). Farver et al., (2002a) calculated two subscales, "Americanism" and "Indianism", and used these to divide people into the four acculturation styles. They found that adolescents with integrated acculturation styles were more likely to have high self-esteem and good school performance than those who had marginalised or separated acculturation styles. Integration is thought to be the most adaptive form of acculturation because a person is comfortable in relating to both cultures. The least adaptive form of acculturation is thought to be marginalisation as a person may have problems with self-identity and feel culturally alienated, which would have a negative impact on self-esteem. The results of a related study by the same authors indicated that when there was no acculturation gap between adolescents and their parents, adolescents experienced less anxiety and family conflict and had higher self-esteem (Farver et al., 2002b).

Ghuman (1975) developed the Aberystwyth Bi-culturalism Scale, which is embedded in Berry's theory of acculturation, to assess the attitudes of second generation Asians towards acculturation. It is a scale which consists of items along three main dimensions, namely collectivity/ individuality, religion and gender roles. Half of the items relate to attitudes

towards native British culture and the other half to Asian culture, and factor analysis revealed two factors, acculturation and traditionalism. The results across several studies by Ghuman (1991a; 1994) indicate that second generation Asians have positive attitudes towards both cultures, that is, they favour a form of bi-culturalism, which would correspond to Berry's notion of integration. This supports the findings of Stopes-Roe and Cochrane (1990) that second generation Asians value aspects of both Asian and British culture. A strength of this scale is that it is not based on the assumption that living within two cultures will inevitably be a negative, conflictual experience. However, it is limited in that it does not provide information about attitudes towards specific others, for example parents, and talks about both cultures in a general way. Also, the wording of the items is quite basic, which is thought to restrict the application of the scale to adolescents.

The four stage model of acculturation is a useful framework when looking at the relationships between cultures. However, it does not include details on the process of change in identity structure, self-concepts, and aspirations specifically in one culture (Ali and Northover, 1999). These are important to consider in relation to mental health as one of the consequences of culture conflict is threat to a person's identity. According to Berry et al., (1989) acculturation includes attitudes towards both a person's own and other ethnic groups. This has been criticised by Ghuman (1999), who says that the attitudes of people in dominant culture are often ignored and the onus for acculturation is placed on the minority group.

Weinreich (1999) argues that the term "enculturation" is more appropriate than acculturation. He defines enculturation as change which results from incorporating aspects of another culture, where a person retains aspects of their own identity with some newly created and unique characteristics that are created following a synthesis with existing values and beliefs. This is differentiated from acculturation on the basis that a person is not simply moving or changing in the direction of the dominant culture. It is a useful concept as it allows for the development of new and alternative cultural idioms which vary according to socio-political context, and it moves away from the notion that identifying with more than one culture is problematic and negative. Weinreich (2003) argues that this is different from Berry's notion of integration as enculturation perceives the self as an active agent, not passive and reactive.

### *Ethnic identity*

Some researchers argue that ethnic identity and acculturation are separate, but interrelated constructs (Phinney, 1990; Sue, et al., 1998). Acculturation focuses on the relationship between dominant and non-dominant culture resulting from contact between the two cultures (Berry, 1980). There is no widely agreed definition for ethnic identity and one suggestion is that it may be thought of as the relationship between an individual and his/ her own cultural group in terms of a sense of belonging, and attitudes towards and extent of involvement with one's own cultural group, as a subgroup of larger society (Phinney, 1990). This is of relevance to the study of mental health issues for minority ethnic groups as an important part of a person's self-concept is the feeling of belonging to an ethnic group (Tajfel, 1981; cited in Dasgupta, 1998), the level of commitment to the values and beliefs of that group and the emotional significance of a relationship with one's own ethnic group. For second generation Asians, trying to retain an ethnic identity is more complex as the dual influence of western and Asian culture increases the risk of culture being lost (Dasgupta, 1998; Phinney, 1990).

Bhugra, Bhui, Desai et al., (1999c) explored the notion of culture conflict in relation to attempted suicide using this concept of ethnic or cultural identity. They devised the Asian Cultural Identity Schedule (ACIS) following discussions with community leaders, to assess cultural identity in the areas of religion, leisure activities, language, marriage and family, aspirations, food, attitudes towards one's own ethnic group and work. The ACIS was administered to Asian adolescents who attended Accident and Emergency (A&E) departments following a suicide attempt, and the parent of the adolescent. The control group was a sample of Asian adolescents attending A&E for reasons other than attempted suicide, and their parent. They found that both groups of adolescents differed from their parents in several areas. However, areas unique to those who attempted suicide were less traditional attitudes to work and marriage than their parents. Adolescents in the attempted suicide sample had equivalent attitudes to aspirations (an admired person) to their parents and the control group, whereas those in the control sample were found to have less traditional attitudes than their parents. Based on this finding Bhugra et al., (1999c) argue that parents having more traditional views in the area of aspirations than their children has a protective effect. This finding contrasts with the implicit view presented in much of the research that traditionalism has a negative effect on mental health.

Each of the items in the ACIS scale was rated on a Likert scale; however these were then recoded into "English" or "Traditional" (Indian) views. This is thought to oversimplify and reduce the information available. Also, by rating each item in a way that forces a choice between Asian or native British culture, participants were not allowed the opportunity to identify with or express a preference for both cultures within a single area. The items in the scale were devised based on discussions with community leaders, which is a limitation of the scale as they are based on the experiences and values of first generation Asians and may therefore be of limited relevance to second generation Asians.

Srinivasan (2001) explored the meaning of "Being Indian" and "Being American" and how this relates to stress and attitudes towards gender roles. She compared second generation Indian women living in the US with a sample of White US women and Indian women from India using the Brief Symptom Inventory (Derogatis and Melisaratos, 1983) to assess psychological stress and found that both of the Asian groups had higher scores than the White US group. Srinivasan (2001) argues that most second generation women viewed themselves as bicultural as they related to being both Indian and American. She found that identifying with Indian culture was associated with less stress and identifying with American culture was related to holding more egalitarian attitudes. Based on these results Srinivasan (2001) suggests that the high levels of stress found in second generation women are due to non-egalitarian or more traditional gender roles, being imposed on them by their families. This index of biculturalism is simplistic as it is only based on two questions. However, when combined with qualitative data obtained from interviews, it raises the notion that second generation Indian women have different definitions of what it means to be Indian than their parents. She argues that the second generation view being Indian in relation to heritage and history, and do not associate it with being restricted and arranged marriages. Evidence from music and literature is said to support the idea that many second generation Indians want to blend their knowledge of cultures.

### ***1.6 Identity Structure Analysis (ISA)***

As the above review illustrates, to claim that "culture conflict" is the result of a person being unsuccessful in fully identifying with either Asian or British culture is simplistic. This is because it does not adequately encompass the complexity of living in a multi-cultural society as research suggests that a person will identify with different attributes from both cultures. Consequently, many of a person's identifications with others will be incompatible with one

another, for example, a child of Asian origin whose early socialisation was within a traditional Asian context but who starts to become exposed to British culture through education and media.

Identity Structure Analysis (ISA) is a meta-theoretical framework which can be used to measure the extent to which a person identifies with significant others, and people from his/ her own and other ethnic groups. ISA uses ethnographic pilot work to elicit the beliefs and values of participants, and identity is examined by assessing the extent to which significant others share qualities which one attributes to oneself (empathetic identification), and which one would wish to dissociate from (contra identification). Weinreich (1979) argues that identification conflict (or conflicted identification) occurs when a person views a significant other as having some qualities which he/ she identifies with and some which he/ she wishes to dissociate from: for example, an Asian woman who shares cultural values relating to duty and obligation with her parents, but dissociates from the idea of arranged marriages. The term conflicted identification is thought to be a better term than "culture conflict" as the conflict in identity can be located more precisely in relation to others (Ali and Northover, 1999). The extent of identification conflicts across a range of significant others is termed identity diffusion. One of the strengths of ISA is that it encompasses ideas relating to both ethnic identity and acculturation as it is examining to what extent a person identifies with both their own and native British culture. That is, it is assessing membership of a particular cultural group, but by measuring qualities a person would wish to dissociate from across native British and Asian culture it is also assessing cultural distance.

The ISA framework was used with Asian, native British and Caribbean school leavers in Bristol, in a study in which significant others were defined as their parents and general representatives of each these three ethnic groups (Weinreich, 1979). Weinreich (1979) found that Asians had a high level of identification conflict with members of their own ethnic group, but a low level of identification conflict with their parents. This suggests that these adolescents have some acceptance of their early heritage. Although they viewed themselves as being ethnically distinct from the native British group, they did identify with some aspects of British culture, and were found to have a great deal of respect for authority figures across ethnicities. The high level of identification conflict with general representatives of Asian culture was explained in terms of the influence of the two cultures in the process of socialisation. That is, early socialisation was with parents and members of their own ethnic

group, but increasing exposure and identification to British culture through education and media was thought to be in conflict with these earlier identifications. The low level of conflict with parents was attributed to the high level of respect for authority.

Kelly (1989) studied second generation Pakistani Muslims and Greek Cypriots in Britain and further divided the Muslim sample into "progressive" and "orthodox" groups based on the extent to which they identified with native British culture. He found that both male and female progressive Muslim groups identified most closely with the native British group and had the highest level of identification conflict with own ethnic group representatives in mosques, Muslim centres etc. Therefore, identification with aspects of both cultures and a simultaneous desire to dissociate from some qualities was used to explain the high level of identity diffusion in this group. The female Muslim progressive group had the highest level of identity diffusion overall and this was attributed to them identifying strongly with native British culture, but only moderately with their own ethnic group. All of the groups had a high self-evaluation. This does not support the view that "culture conflict" has a detrimental effect on self-evaluation or self-esteem, as in this study high identity diffusion was not accompanied by low self-evaluation.

### ***1.7 Rationale for study***

This study intends to explore how the experience of being raised in both Asian and British culture impacts upon the mental health of second generation Asian women. The main aims of the study are to use the ISA framework to develop an understanding of whether or not identifying with more than one culture is related to psychological distress. Previous research has not always been based directly on the experiences and the values of the population of interest and consequently has become slightly decontextualised as it neglects socio-cultural issues such as relationships with wider society and the influence of prejudice. The present study attempts to improve on this by exploring identity issues in relation to the cultural values and experiences of living in the UK of second generation Asian women.

One of the main disadvantages of existing research in this area is that participants are forced to identify with, or choose between, Asian or native British culture. This study attempts to overcome this limitation by demonstrating the degree of identification with general representatives of both Asian and native British culture, as opposed to using dichotomous variables. Also, it offers participants the opportunity to identify with more than one culture in

a single area, for example religion. In doing so it aims to highlight that women born in the UK are likely to be bicultural as opposed to traditional or acculturated. Although the present study does not directly assess the attitudes of representatives of dominant culture, it does measure the extent to which Asian women are able to identify with native British culture. This provides some indirect information based on the view that the extent to which minority ethnic groups are able to integrate with majority culture is influenced by the reaction they receive from dominant society (Ghuman, 1999).

Some authors also suggest intergenerational conflict stemming from the differences between Asian and native British culture as a possible cause of psychological difficulties, but fail to assess family relationships. This study aims to overcome this criticism by assessing participants' level of conflict with their parents and first generation Asians, or representatives of the extended Asian community; and will measure cultural distance by examining the extent to which participants view themselves as dissociating from Asian culture. It is proposed that experiencing identification conflicts with several significant others, termed identity diffusion, will be related to psychological distress. This is based on the premise that second generation Asian women will be bicultural and will identify with both Asian and British culture. However, not all of these identifications will be compatible with one another; therefore how well these identifications are integrated or synthesised will be related to psychological distress.

Based on the rationale that part of making a service more accessible is developing an understanding of the needs of the group to be targeted, it is hoped that gaining an insight into how cultural identity impacts upon mental health may be incorporated into strategies aimed at promoting mental health amongst minority ethnic groups. It would also be useful in informing direct clinical work, staff training and support.

### ***1.8 Research Hypotheses***

1. There will be no differences in the extent to which women with high (clinical) and low (non-clinical) levels of psychological distress empathetically identify with Asian and British culture
2. The clinical group will have a higher level of contra-identification with parents and representatives of Asian culture than the non-clinical group



3. The clinical group will have higher levels of conflicted identifications with parents and first generation Asian individuals than the non-clinical group
4. The clinical group will have a higher level of identity diffusion than the non-clinical group
5. Identity diffusion will be positively correlated with level of psychological symptoms

## 2. Method

### 2.1 Design

This study employed a non-experimental, cross sectional design involving the completion of a battery of self-report questionnaires by two groups of second generation Asian women. The advantages of using a cross sectional design are that it is less time consuming and there is lower drop out rate for participants, but the main disadvantage is that no information on the development of participants over time is available. Group membership, clinical vs. non-clinical, which was determined according to a screening questionnaire, was conceptualised as an independent variable. More detailed profiles of psychological symptoms, patterns of identification with significant others and life events were conceptualised as dependent variables.

### 2.2 Participants

#### *Inclusion/ exclusion criteria*

All of the participants in this study were selected on the basis that they were female and self-identified as being of South Asian origin, that is, women whose families originated from the Indian sub-continent (India, Pakistan and Bangladesh). It was important that each participant considered herself to belong to the cultural group in question as this study was exploring issues relating to cultural identity (Farver et al., 2002b; Phinney, 1990). Women of mixed heritage were excluded as it is believed that the issues relating to cultural identity differ for this group. This study was specifically exploring the experiences of second generation Asians and so only women who were born in the UK or moved to the UK before the age of 5 years were included. This strict inclusion criterion was included to enable the early effects of school on socialisation to be accounted for. Additional exclusion criteria were the presence of a psychotic illness, organic mental disorder, or learning disabilities.

#### *Recruitment*

This study used a convenience sample of participants. The sampling strategy was designed to recruit two groups of Asian women. One group (clinical) needed to report moderate/ clinical levels of psychological distress, and the other group (non-clinical) no/ low levels of psychological distress. The initial strategy was to recruit both groups through primary care services, which is a common recruitment strategy used in research with Asian women, and clinical psychology services. However, this had to be extended to a student population given the low recruitment.

Before approaching potential research participants, permission was sought from the relevant departmental manager. Women in primary care were approached in the waiting room when attending their GP for appointments. All of the GP surgeries were in the North London area and were governed by the same Primary Care Trust. When attending a local Psychology Department for outpatient therapy, potential research participants were informed of the study by the appropriate clinician. Finally students were accessed via e-mail and through the Learning Resource Centre (LRC) at the University of Hertfordshire. In each case, participants were given an information sheet and covering letter detailing the purpose of the research (See Appendix A) and a further meeting at a mutually convenient time and location was arranged to complete the measures. Once a small number of women had been recruited the sample was allowed to snowball in order to maximise recruitment. Sample size was determined on the basis of a power calculation following Cohen's conventions. For a large effect size (Cohen's  $d$ ) regarding mean differences in identity diffusion, 26 participants are required. To detect this a power level of 0.80 with an alpha level of 0.05 (two-tailed) is needed.

### ***2.3 Measures***

#### *Demographic information*

Participants were asked a number of open-ended questions designed to collect socio-demographic information. These included questions on date of birth, self-defined ethnicity, religion, living arrangements, availability of social support, first and preferred language, and level of education (See Appendix B for item wording).

#### *Screening psychological distress*

One of the most widely used screening instruments for common mental disorders is the General Health Questionnaire (GHQ; Goldberg, 1972). It was designed to detect less differentiated forms of mental disorder and focuses on the area between healthy and disrupted functioning in order to discriminate between psychiatric cases and non-cases. It is said to be sensitive to recent onset and transient disorders (Goldberg and Williams, 1988), which makes it ideal for community and primary care populations. This study utilised one of the shortest versions of the GHQ, which consists of 12 items corresponding to two main areas, ability to carry out usual healthy functions and the appearance of distressing or disrupted functioning.

The GHQ requires participants to rate whether they have experienced a particular symptom over the past week on a four point scale ranging from 'less than usual' to 'much more than

usual'. Overall 'yes-saying' or response bias is reduced with the GHQ as it avoids a bimodal response scale. There have been various scoring methods developed for this scale, including the traditional (0, 0, 1, 1) GHQ scoring method, which is employed to indicate caseness based on a specified threshold. Another is the 'Likert scoring method', which assigns a value (0, 1, 2, 3) to the rating scale. This method can be used to produce a sum score with higher scores indicating higher levels of distress (Goldberg and Williams, 1988). The 'Likert scoring method' was used in this study to assess the distribution of scores.

The main purpose of administering the GHQ-12 was to estimate psychological symptom levels in order to categorise the sample into two groups according to 'caseness'. This short version of the GHQ was selected as it is brief and has been found to be just as effective at distinguishing between cases and non-cases as longer versions (Goldberg, Gater, Sartorius et al., 1997). Jacob, Bhugra and Mann (1997) validated the GHQ-12 on Indian women in the UK. They used the GHQ-12 to screen for psychiatric morbidity among women attending primary care, and psychiatric morbidity was confirmed using the Revised Clinical Interview Schedule, which is a standard semi-structured interview used to assess non-psychotic disorders (CIS-R; Lewis, Pelosi, Araya et al., 1992). The optimal threshold for indicating caseness was found to be 2/3, which had a sensitivity of 96.7% and specificity of 90%. In order to divide participants into two groups, namely clinical and non-clinical, the GHQ scoring method (i.e. 0, 0, 1, 1) was used. The threshold adopted to indicate caseness was 2/3 as in the Jacob et al (1997) study. That is, all participants scoring 3 or above were categorised into the 'clinical' group and those scoring 2 or below into the 'non-clinical' group.

The GHQ has been found to be equivalent to other measures of psychological distress commonly used with Asian populations such as the Langner-22 (Cochrane, Hashmi and Stopes-Roe, 1977). A study by Bhui, Bhugra and Goldberg (2000) with Punjabi and native British primary care attendees found the GHQ to have higher validity than the Amritsar Depression Inventory (Singh, Verma, Verma et al., 1974), which was developed in the Punjab to assess depression among Punjabis. The Guttman split-half reliability was 0.87 and Cronbach's alpha was 0.87 for the GHQ-12 when used with a Punjabi population (Bhui et al., 2000).

### *Measuring psychological symptom patterns*

The Brief Symptom Inventory (BSI; Derogatis and Melisaratos, 1983) is a measure that is derived from the Symptom Checklist (SCL-90; Derogatis, 1975). It has been found to have high scale by scale correlations with its parent scale, making it an appropriate brief alternative to the SCL-90. It has been widely used to assess psychopathology and psychological distress, and its main aim is to reflect multi-dimensional symptom patterns. The scale consists of 53 items which are rated on a 5 point scale (0-4) ranging from 'not at all' to 'extremely' across nine primary symptom dimensions: Somatisation, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation and Psychoticism. There are three global indices of distress. The Global Severity Index (GSI) is the most sensitive indicator of the current level of general distress, and the Positive Symptom Distress Index (PSDI) indicates the intensity of distress experienced, reflecting the average level of distress experienced and also the style (minimises distress versus exaggerates distress). Finally, the Positive Symptom Total (PST) is indicative of the number of symptoms endorsed and the extent of a person's emotional distress (Derogatis, 1993).

The main reason for using the BSI in conjunction with the GHQ-12 was to produce a more detailed psychological profile of participants. The BSI contains a greater number of symptom dimensions than does a longer GHQ scale such as GHQ-28. When the GHQ-28 was administered to an Indian sample of adults in a non-psychiatric setting in India, factor analysis of the scores revealed four main factors corresponding to the four sub-scales of anxiety, depression, general illness and inadequate coping (Bhogle and Prakash, 1994). The BSI is a flexible measure that can be used with psychiatric and medical patients, and community participants, making it ideal for use within the present study. It has been found to be both a highly reliable and valid measure of psychological distress, with Cronbach's alphas ranging from 0.71-0.85 and test re-test reliability scores ranging from 0.68-0.91 (Derogatis, 1993). Apart from the demonstrable validity and reliability of the scale it was also chosen because it is easily administered and takes a relatively short time to complete.

The BSI has been previously used successfully with an Asian population in a study comparing rates of psychological distress in Indian students attending Bihar University, in India, with Canadian students (Watson and Sinha, 1999). Francis, Rajan and Turner (1990) have established British norms for the BSI in a study which evaluated the mental health needs of the local community in Nottingham, therefore making the interpretation of scores more

meaningful when used within the UK. The BSI has also been widely used in a variety of clinical studies such as research screening for psychological distress among student populations (Cochran and Hale, 1985), as an outcome/ evaluation measure in several psychotherapy departments (Society for Psychotherapy Research, 1989; cited in Francis et al., 1990) and within many medical populations, for example cancer and HIV patients (Rabkin, Williams, Remien et al., 1991; Stefanek, Derogatis and Shaw, 1987).

### *Measuring life events*

Research on the relationship between affective disorders and life events is well established. Therefore the Life Events Inventory (LEI; Cochrane and Robertson, 1973) was included to consider the potential confounding role of life events when screening for psychological difficulties. There are many scales available which may be used to assess the impact of life events. The LEI was selected as it has been successfully used in previous studies with Asian immigrants to the UK (Cochrane and Stopes-Roe, 1977) and with Indian populations in North India (Bhugra, Gupta and Wright, 1997).

The LEI is a modified version of the Schedule of Recent Experiences (Holmes and Rahe, 1967). It is a retrospective measure of life stresses that aims to quantify the amount of disturbance and disruption caused by life events and therefore does not focus solely on negative life events. The LEI contains 55 items in total, each of which has been weighted on a scale of 1-100 using ratings from psychiatrists and psychologists, mental health service clients and students. High levels of agreement ranging from 0.74-0.94 were found between groups, with an overall coefficient of concordance of 0.89 for all three groups of raters. The LEI is divided into three sections. The first section, which consists of 35 items, is applicable to all participants; the second (16 items) is only applicable to married participants; and the third (4 items) to participants who have never been married. Only the first section was administered to overcome the problem of differing maximum scores between married and non-married participants. Participants were asked to indicate which, if any, of the life events listed had occurred over the past year. The scale was scored by summing of all the assigned weights with higher scores indicating a greater level of life disruption due to stressful events. Permission to use the scale was granted by Professor Raymond Cochrane.

The literature on minority ethnic groups highlights the salience of issues relating to racism and discrimination on mental health (Bhugra and Cochrane, 2001; Fernando, 1984). As the aim of

this research was to develop a better understanding of the experiences of Asian women, questions on prejudice/ discrimination were added in addition to the LEI as such experiences would be considered to be stressful and disruptive life events. These items were taken from a study by Cochrane and Stopes-Roe (1977) which investigated the psychological and social adjustment of Asian immigrants to Britain. Participants were asked if they had experienced prejudice in six main areas, namely, Employment, Housing, Education, Social, Police and Government (see Appendix C).

### *Measuring ethnic identity and acculturation using ISA*

Identity Structure Analysis (ISA; Weinreich, 1979, 1980) was used in this study as a theoretical framework to investigate the notions of ethnic identity and acculturation in second generation Asian women living in the UK. ISA has previously been used in a number of empirical studies examining ethnic identity and acculturation in a variety of cultural contexts including with the Hong Kong Chinese (Weinreich, Luk and Bond, 1996); Muslim youth in the UK (Kelly, 1989); and Gujarati/English bilinguals (Northover, 2000). It has also been increasingly applied in a variety of clinical contexts examining eating disorders (Saunderson and O'Kane, 1999, 2003; Weinreich, Harris and Doherty, 1985); anxiety and depression (Fox, 1996); and counsellors dealing with victims of trauma (Weinreich and Black, 2003). ISA draws upon a variety of theories in order to understand and analyse the development and maintenance of identity. It operationalises concepts in a way which integrates qualitative and quantitative aspects of identity by eliciting discourses associated with specific value systems which are quantified in the form of ratings given by participants (Weinreich et al., 1996). ISA is underpinned by psychodynamic theory (Erikson, 1968), personal construct theory (G. Kelly, 1955), cognitive-affective theory (Festinger, 1957) and symbolic interactionism (Mead, 1934). In order to define the identity parameters encompassed by ISA, each of these theories and their contribution to ISA will be briefly considered.

Weinreich (1979, 1980) re-defines Erikson's notion of identification by distinguishing between different types of identification. Current or *empathetic identification* is based on a person's current self-image:

the extent of one's *current identification* with another is defined as the degree of similarity between the qualities one attributes to the other (whether 'good' or 'bad') and those of one's current self-image (me as I am now) (Weinreich, 1983a; p.158).

Scores for empathetic identification range from 0.00 to 1.00, with values close to 0.00 indicating that the participant views him/ herself as having few characteristics in common with another person and values close to 1.00 indicating complete identification. *Contra-identification* is based on a person's ideal self-image:

the extent of one's *contra-identification* with another is defined as the degree of similarity between the qualities one attributes to the other and those from which one would wish to dissociate (Weinreich, 1983a; p.158).

Contra-identification scores also range from 0.00 to 1.00 with values close to 0.00 indicating that the participant views another as having few qualities from which s/he would wish to dissociate from, and values close to 1.00 indicating that another has many characteristics from which the participant wishes to dissociate from.

Erikson's (1959, 1968) psychodynamic theory of identity formation argues that in order to form a coherent identity a person needs to re-synthesise earlier identifications with significant others, with later identifications. This process of resynthesis is more complex than a simple amalgamation as many of these identifications will be incompatible with one another. An example would be, a child of Asian origin whose early socialisation was within a family environment that places an emphasis on interdependence and community who then attends school, which promotes the development of individual responsibility and autonomy. Weinreich (1989) argues that identifications with family would therefore become conflicted as the child will continue to identify with or share some values with his/ her family (current or empathetic identification), but will dissociate from others (contra-identification). *Identification conflict* (or conflicted identification) is the product of a person's current and contra identifications with another:

In terms of the person's current self-image the extent of a person's *identification conflict with another* is defined as a multiplicative function of that person's current- and contra-identifications with the other (Weinreich, 1983a; p.159).



Identification conflict scores range from 0.00 to 1.00 with values close to 0.00 indicating little or no identification conflict with a significant other, and values close to 1.00 indicating a high level of conflict in identification.

This process of resynthesis is central to identity development and formation of a coherent identity and Erikson termed failure to achieve this, and the resulting confused state of self, *identity diffusion*. ISA develops this notion further by attempting to explore the meaning of the underlying psychological processes that result in the surface symptoms described by Erikson (Weinreich, et al., 1996). Consequently it redefines identity diffusion as:

The degree of a person's identity diffusion is defined as the overall dispersion of, and magnitude of, his/ [her] identification conflicts with significant others (Weinreich, 1980; p.19).

Identity diffusion scores range from 0.00 to 1.00 with values close to 0.00 indicating low levels of identity diffusion and values closer to 1.00 indicating high levels of identity diffusion. ISA also recasts Erikson's stage specific task of achieving identity as being one which is important at any stage of transition, and argues that adolescence may be considered a major stage of transition.

ISA draws upon personal construct theory (G. Kelly, 1955) in order to translate these identity parameters into an empirical quantitative measure (Weinreich, 1979). At the core of personal construct theory is the idea of "man as scientist" who formulates and tests hypotheses about the meaning of events, and alters them based on experience in a way which facilitates the anticipation of events. According to Kelly, there are infinite alternative ways of interpreting or construing the world. Construct systems, which consist of hierarchically arranged bipolar constructs, are used to interpret and anticipate a widening range of experience throughout life (Neimeyer, 1985). Some constructs are considered more central or "core" than others and are therefore used to maintain a person's identity (Button, 1985). Constructs may also be associated with evaluative or affective connotations and are therefore not necessarily purely cognitive categories (Weinreich, 1989). A person's construct system incorporates their values; therefore ISA applies this concept of bipolar constructs when evaluating a person's view of self and others.

Based on the view that constructs may be associated with affective connotations, cognitive-affective consistency theory (Festinger, 1957) is of relevance. Cognitive-affective inconsistency occurs when one's cognitions towards another and one's evaluations of these cognitions are dissonant. This produces an uncomfortable psychological state and so one may realign either one's cognitions or affect to reduce this, for example, rejecting something negative about an admired person. ISA utilises this theory in relation to the concept of the *structural pressure* of constructs:

The structural pressure on a person's construct is defined as the overall strength of the excess of compatibilities over incompatibilities between the evaluative connotations of attributions one makes to each entity by way of the one construct and one's overall evaluation of each entity (Weinreich, 1980; p.23).

Structural pressure refers to the degree of stability and consistency with which a person makes a judgement, which may be either positive or negative, about another of whom the person approves or disapproves respectively. It is calculated by examining how consistently a construct is used to evaluate an entity as this evaluation may be compatible or incompatible with a participant's overall evaluation of the entity in question. If the construct is used to make evaluations about entities in a consistent way, that is, the overall evaluation of the entity is consonant with the evaluative use of a particular construct; the resulting structural pressure will be high. On the other hand, if the construct is used inconsistently, that is, there are many incompatibilities; the resulting structural pressure will be low or a negative value. Structural pressure values range from -100 to +100. For constructs with a core evaluative dimension structural pressure would be high (values close to +100; cognitive-affective compatibility), whereas if there is inconsistency between an individual's principles and appraisal of others in his/ her social world this would result in low structural pressure (values close to -100; cognitive-affective dissonance; Weinreich, 1992).

According to the theory of symbolic interactionism (Mead, 1934), the self is defined and continually elaborated through interaction with others. It suggests that the typical self conception of a person is a representation of the perception of others amalgamated over time. It refers to this as the "looking glass self". It follows from this that there would be no notion of self without interaction with others. This theory also argues that if a person's identity is in the form of socially defined roles, then a role defined by society as being low in status, for

example, a member of a minority ethnic group, would be reflected by the self-concept of that person. However, existing research has indicated that this is not always the case (Weinreich, 1983a). Therefore, ISA is based on the premise that an individual is an active agent, and is not a reflected self defined by the generalised other. Instead, each individual influences the perception of self held by others by presenting him/ herself in certain ways. That is, ISA incorporates the idea of meta-perspectives.

#### *Development of the identity instrument*

The raw data interpreted within the ISA framework is collected using an identity instrument that is specifically designed to be of direct significance to the participants in each study. This makes it appropriate for use across cultures as it incorporates the cultural and socio-historical context of participants and respects their world views and value systems. The identity instrument consists of a set of bipolar constructs and entities. Entities may be defined as individuals, groups of people or institutions which are of importance to participants and incorporate their social world (Weinreich et al., 1992, 1996). Although there are several ways of eliciting constructs which are outlined in Winter (1992), the constructs in this study were elicited using a semi-structured interview which was adapted from that used in the study by Weinreich (1980) with Bristol school leavers (See Appendix D). This method of eliciting constructs has been found to be both reliable and useful and has been successfully utilised in a number of previous studies implementing ISA (Irvine, 2003; Weinreich, 1980). Using the value systems of respondents also provided the opportunity to develop an understanding of the identity structures of second generation Asian women, as opposed to imposing research values (Ali and Northover, 1999).

In order to devise an identity instrument which assessed issues relating to ethnicity and culture within an everyday context, the interview questions related to the following areas: work, background/ family life (past), friends and significant others, other ethnic groups, opposite sex/ relationships, parents, present self, future self, socialisation and views on society. To ensure that the identity instrument was reflective of issues that may be stress inducing two interviews were conducted, one with a woman attending primary care and the second with a woman attending a Psychology Department suffering from depression. Both were second generation Indian women and were selected as they were believed to be representative of the sample to be studied. It was assumed based on the nature of their contact with health services that they would differ in terms of their level of psychological distress. In order for these

discourses to be transformed with minimum alteration of language into bipolar constructs, each of the interviews was audio-taped and later transcribed.

A list of constructs was generated from these interviews with participants by first highlighting adjectives used to describe experiences and significant others. Constructs are bipolar as they are used to discriminate between experiences and observations in terms of similarity and contrast. This is based on the view that one cannot tell what something is without being able to contrast it with something else. For example, it would be difficult to recognise the colour black if it could not be contrasted with white (Dalton and Dunnett, 1999). For a few constructs the contrast pole was apparent from the discourse of the interviewee. In some cases a contrast pole was assigned to constructs by directly asking the interviewees what they thought the opposite or contrast was. Finally for others, contrasts were assigned by simply by adding the prefix "not" to the construct. A number of constructs from this list were then selected for use within the identity instrument based on reference to the literature on cultural identity among second generation Asians. This is discussed in more detail below.

Within the present study the aim was to include constructs which drew out beliefs and attitudes relating to the experience of growing up in two different cultures. Therefore three constructs relating directly to this idea of cultural difference and being "stuck" between two cultures (Ballard, 1979; Ghuman, 1999) were included:

- 10. Cultural vs. Not cultural (behaviour)
- 12. Confused vs. Has a sense of self
- 17. Has different beliefs to me vs. Has same beliefs as me

As a large portion of the literature highlights the significance of families and family relationships (Durvasula and Mylvaganam, 1994; Farver et al., 2002b), three family related constructs were included:

- 5. Being who he/she wants to be vs. Being what people want him/ her to be
- 2. Rebellious vs. Conformist
- 7. Family orientated vs. Not family orientated

As this research study focused particularly on women, the inclusion of constructs dealing with issues relating to gender and gender roles within Asian culture (Ahmed and Lemkau, 2000;

Dasgupta, 1998) was an important requirement. The following three constructs were therefore included:

- 18. Traditional vs. Not traditional (beliefs)
- 15. Free vs. Boundaried
- 11. Strict vs. Lenient

An important part of defining ethnicity is religion, but this may be symbolic as people often do not practice religion (Ghuman, 1999). Bhugra and Cochrane (2001) argue that religion forms the basis of any identity and that a person may not choose to follow religion as an adult but a part of his/her identity will respond to religious feelings. Therefore, the following construct relating to religion was included:

- 9. Religious vs. Not religious

The literature on the relationship between prejudice/ discrimination and mental health highlights that this may be a particularly significant issue for the second generation (Bhugra and Cochrane, 2001), and therefore constructs pertaining to this topic were included:

- 4. Is picked on vs. Sticks up for self
- 8. Open-minded vs. Prejudiced
- 6. Mixes with all cultures vs. Just mixes with own culture

According to Weinreich (1992) when focusing on specific aspects of a person's identity, for example, cultural or ethnic identity, it is not possible to determine an understanding of the importance of this issue unless it is placed within the context of the person's general identity. Therefore, three constructs relating generally to a person's view of themselves and others in their social world were added:

- 14. Academic vs. Creative
- 13. Closed thinker vs. Accepting
- 1. Friendly vs. Doesn't have time

Leading on from this, in light of the fact that one of the main aims of this research is to develop ways of promoting services, attitudes towards seeking help were assessed using the following general constructs:

- 16. Doesn't turn to anybody vs. Needs to talk to somebody
- 3. A person who copes vs. A person who doesn't cope

A complete list of the constructs in the order presented in the identity instrument can be seen in Table 1.

Table 1. Constructs in the identity instrument

1. Friendly vs. Doesn't have time
2. Rebellious vs. Conformist
3. A person who copes vs. A person who does not cope
4. Is picked on vs. Sticks up for self
5. Being who he/ she wants to be vs. Being what people want him/ her to be
6. Mixes with all cultures vs. Just mixes with own culture
7. Family orientated vs. Not family orientated
8. Open-minded vs. Prejudiced
9. Religious vs. Not religious
10. Not cultural vs. Cultural
11. Strict vs. Lenient
12. Confused vs. Has a sense of self
13. Closed thinker vs. Accepting
14 Academic vs. Creative.
15. Free vs. Boundaried
16. Doesn't turn to anybody vs. Needs to talk to somebody
17. Has different beliefs to me vs. has same beliefs to me
18. Traditional vs. Not traditional

Once the constructs had been generated from the interview transcripts and had been incorporated with the entities the completed identity instrument was administered to the two interviewees. The constructs included were discussed in some depth to make certain that the identity instrument was meaningful and reflected attitudes and beliefs that would be relevant to the target group. This was done in order to establish face validity for the identity instrument.

The identity instrument contains a number of mandatory entities which are needed in order to compute the ISA indices. Three of these are entities relating to one's self-image, past self (me

as I was 5 years ago), current self (me as I am now) and ideal or aspirational self (me as I would like to be). Other mandatory entities include one's positive (a person I admire) and negative role models (a person I dislike). The remaining entities were selected to enable the investigation of gender, generation and ethnicity. In light of the literature on the importance of gender related issues for Asian women (Dasgupta, 1998), gender was specified for entities. Also, research suggests that it is easier for participants to imagine entities if gender is specified (Brand, Ruiz and Padilla, 1974). In order to investigate generational differences in identification, entities were divided into first and second generation. The wording of entity labels (my age, my Mother's/Father's age) was selected to aid participants when visualising entities. Finally, all of the entities were drawn from either Asian or native British culture to reflect the primary socialisation influences on an Asian child.

A complete list of the entities in the order presented in the identity instrument can be seen in Table 2.

Table 2. Entities in the identity instrument

1. Partner/ closest significant other
2. A typical Asian man of my age
3. Father
4. A typical Asian woman of my Mother's age
5. Mother
6. A person I admire
7. A typical Asian woman of my age
8. A typical White/ Native British man of my Father's age
9 A typical White/ Native British woman of my age
10. A typical White/ Native British woman of my Mother's age
11 A typical Asian man of my Father's age
12. Me as I am now
13. A person I dislike
14. A typical White/ Native British man of my age
15. me as I was 5 years ago
16. Me as I would like to be

Participants were required to rate each of the entities using each of the bipolar constructs on a 7 point zero centred scale (i.e. 3, 2, 1, 0, 1, 2, 3) (See Appendix E for sample sheet of instrument). The use of such a scale means that no assumptions are made about which pole of the bipolar construct is positive or negative. If a participant responds as zero, it is important to note that this is computed as a genuine null value and is not viewed as a mid-point value. Once these ratings are obtained, the evaluative connotations of constructs need to be obtained before the ratings can be converted into scores. This is done by anchoring each construct according to the participant's construal of her ideal self ("Me as I would like to be"), that is, the pole of the construct used to describe ideal self is defined as the positive pole of the construct. The alternative pole is viewed as the contrast pole. The polarities of all of the constructs combined are thought to represent a person's positive and contra value systems.

Each rating is then converted into a score ranging from -3 to +3 which is used together with the mandatory entities to calculate the various identity parameters. All of the psychological concepts used by ISA are represented by algorithms using Boolean (or set theory) algebra, that is, the algebraic algorithms are isomorphic with ISA definitions. The operationalisation of ISA is facilitated by the IDEXWIN (Weinreich and Ewart, 1999) computer program as it incorporates these algorithms enabling identity parameters to be computed from the ratings given by participants. Once these identity parameters have been calculated for each participant, a second computer program IDEXNOMO (Weinreich and Ewart, 1999) is used to perform nomothetic analyses.

As the study aimed to investigate the experiences of second generation or British born Asian women it was felt that English was an appropriate language to use and translation was not necessary.

#### ***2.4 Procedure***

At the start of each meeting written consent to participate in the study was obtained (See Appendix F). The measures were administered in the following sequence: demographic information, ISA, General Health Questionnaire, Brief Symptom Inventory and Life Events Inventory. The request for demographic information was administered first as a "warm up" to try and reduce any anxieties associated with participating in a research project as it is non-threatening. The ISA was administered before the questionnaires assessing mood in order to determine identification indices while the client was in a "neutral" mood state. Each of the



measures was completed directly by the participant and the researcher was available throughout to answer any questions. Completion of all the measures took approximately 45-50 minutes in total.

### ***2.5 Ethical issues***

This research was not thought to pose any major ethical issues as participation was voluntary and it does not involve the use of any treatment or intervention procedures. The most important ethical concerns were ensuring that participation was voluntary, participants gave informed consent and that the confidentiality of data was protected. Each participant was debriefed at the end of the research meeting. The GP's of women contacted through NHS settings were informed in writing of the participation of particular individuals (See Appendix G). Ethical approval for this study was granted by a Local Research Ethics Committee and University of Hertfordshire Ethics Committee (See Appendix H).

### 3. Results

This section will start by outlining the procedures that were used to guide the statistical analyses performed. It will then describe the General Health Questionnaire (GHQ) score distribution for the two groups. Following this will be a descriptive analysis of the socio-demographic characteristics of participants. The scores obtained by the sample on the various symptom dimensions of the Brief Symptom Inventory (BSI) will then be detailed. The various identity parameters generated by Identity Structure Analysis (ISA) will be reported and analysed in relation to the research hypotheses. Finally, this section will conclude with additional findings of interest.

#### *Statistical procedures*

The significance level for all of the statistical analyses performed was set at 5% (0.05) and several directional hypotheses were tested one-tailed. Non-parametric statistics were selected for the majority of analyses as the data do not meet the criteria for parametric statistics (for example, t-test), namely a normal sample distribution and approximately equal sized groups. No adjustments were made for multiple testing due to the small sample size lacking power.

#### ***3.1 Distribution of General Health Questionnaire (GHQ) scores***

As explained in the Method section, the GHQ scoring method (i.e. 0, 0, 1, 1) for the GHQ-12 was adopted to divide the participants into two groups. Participants scoring 3 or above were allocated to the clinical group and those scoring 2 or below to the non-clinical group. Of the 30 second generation Asian women who participated, 12 (40%) participants were allocated to the clinical group and 18 (60%) to the non-clinical group. The 'Likert scoring method' (i.e. 0, 1, 2, 3) for the GHQ-12 was also used in this study to assess the distribution of scores and the descriptive statistics for the GHQ-12 sumscores are reported in Table 3. As would be expected, the clinical group had a much higher mean and median than the non-clinical group. The GHQ sumscore distribution is shown in a boxplot for each group in Figure 1. A boxplot displays summary information about the distribution of values such as the median, 25<sup>th</sup> and 75<sup>th</sup> percentiles and extreme values. Examination of the data reveals that the distribution of GHQ scores for the non-clinical group is negatively skewed, and that for the clinical group is positively skewed. There was also one outlier case (extreme value) in the clinical group.

Table 3. Descriptive statistics for GHQ sumscores for the clinical and non-clinical groups

Group	Mean	Median	SD	Minimum	Maximum	Skewness
Clinical (n = 12)	19.33	18.00	7.27	10	35	0.99
Non-clinical (n = 18)	6.89	6.50	3.10	0	12	-0.44

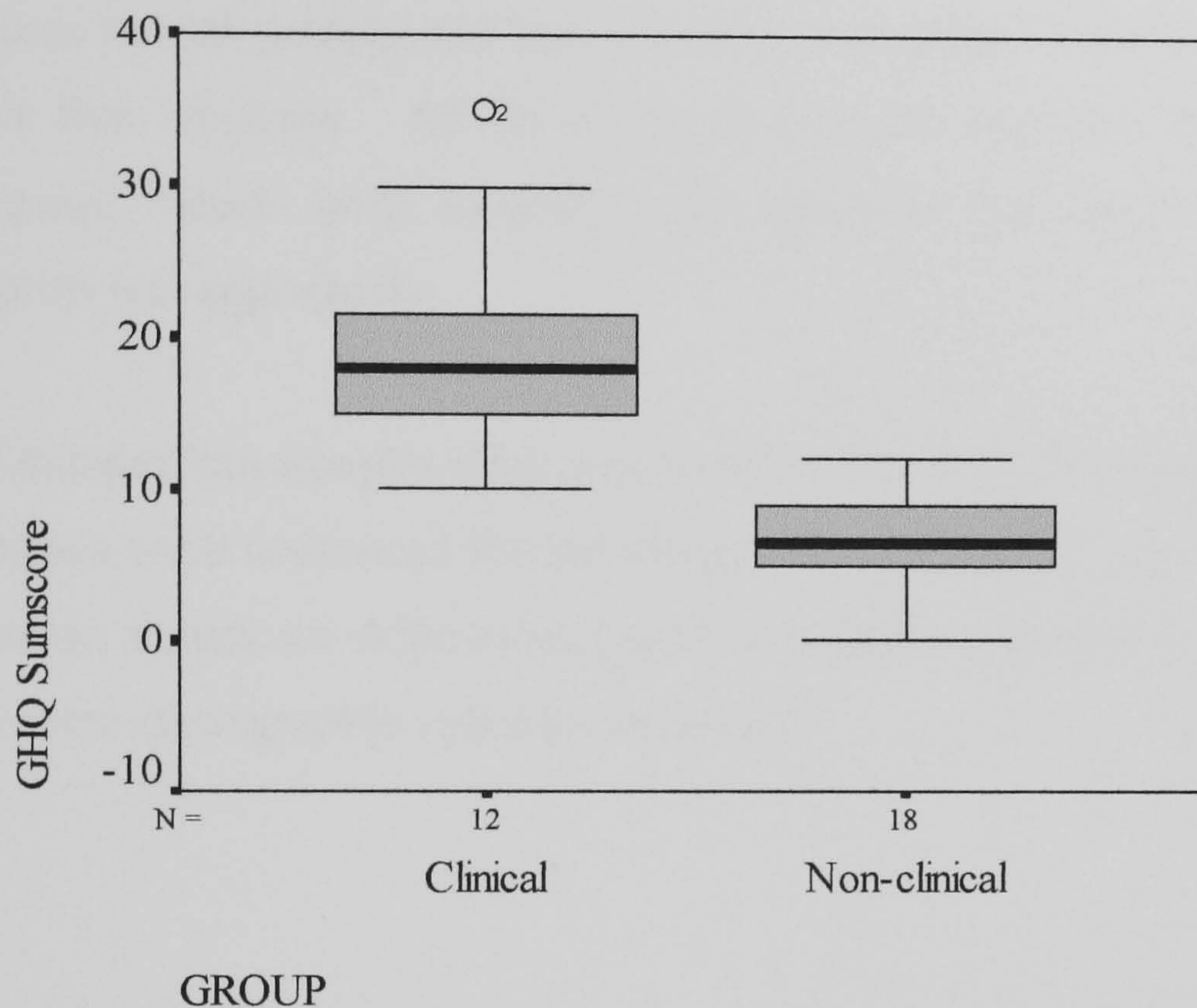


Figure 1. Distribution of GHQ sumscores for clinical and non-clinical groups.

### 3.2 Sample description

The socio-demographic characteristics of participants are summarised in Table 4. below. The age in the clinical group ranged from 20.4 years to 35.9 years, and for the non-clinical group the range was from 17.9 years to 34.9 years. The mean ages of the two groups (23.9 and 24.5 years respectively) were very similar. The majority of participants in both groups were born in the UK, and the remainder were born abroad and moved to the UK before the age of 5 years. Within both the clinical and non-clinical groups the majority of participants were single. However, the non-clinical group contained a higher proportion of married women than the clinical group, 22.2% and 8.3% respectively. The majority of women in both groups had achieved a standard of education equivalent to degree level, indicating a highly educated sample.

Participant-defined ethnicity resulted in the generation of several categories. For the clinical group the two most commonly used categories to define ethnicity were Indian (33.3%) and British Asian (33.3%). Within the non-clinical group the two most frequently endorsed ethnic categories were Indian (33.3%) and Asian (27.8%). On examination of the variable religion, the majority of participants within both groups were Hindu. Due to the small numbers within the remaining three categories of religion it is not possible to examine difference according to religion further. The data indicate that English was the first language for the majority of women in both groups, and that a smaller percentage of participants considered Gujarati to be their first language. All 30 of the participants reported that English was their preferred language, which lends support to the argument that administering all of the measures in English was appropriate.

An independent samples t-test was conducted to investigate differences in age, and chi-square analyses were conducted for the categorical variables to check for equal proportions. There were no significant differences found between the clinical and non-clinical groups on any of the socio-demographic variables examined.

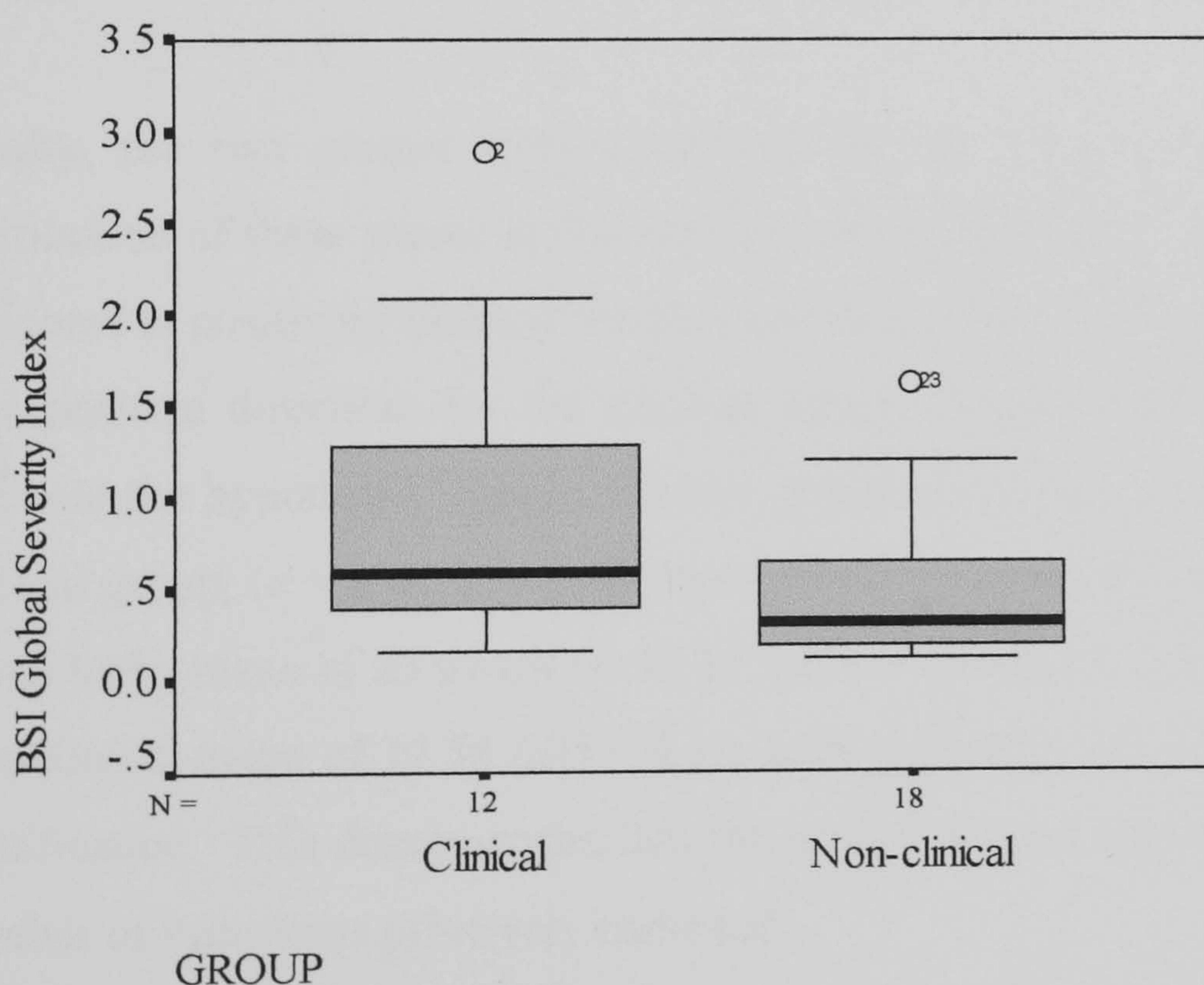
**Table 4.** Summary of the socio-demographic characteristics of clinical and non-clinical groups

<i>Variable</i>		<i>Clinical (n = 12)</i>	<i>Non-Clinical (n = 18)</i>	<i>p-value (two-tailed)</i>
<b>Mean age</b>		23.9 years (SD 5.20)	24.5 years (SD 6.02)	p = 0.79
<b>Place of birth</b>	UK	10 (83.3%)	14 (78.8%)	p = 0.71
	Abroad	2 (16.7%)	4 (22.2%)	
<b>Self defined ethnicity</b>	Asian	1 (8.3%)	5 (27.8%)	p = 0.35
	Indian	4 (33.3%)	6 (33.3%)	
	Hindu		1 (5.6%)	
	Asian Indian		1 (5.6%)	
	Gujarati	1 (8.3%)		
	East African Indian	1 (8.3%)		
	Indian British		1 (5.6%)	
	British Asian-Indian		1 (5.6%)	
	British Asian	4 (33.3%)	1 (5.6%)	
	British Indian	1 (8.3%)	1 (5.6%)	
	British		1 (5.6%)	
<b>Religion</b>	Hindu	10 (83.3%)	14 (77.8%)	p = 0.68
	Muslim	1 (8.3%)	1 (5.6%)	
	Sikh		2 (11.1%)	
	N/A	1 (8.3%)	1 (5.6%)	
<b>Marital status</b>	Single	10 (83.3%)	14 (77.8%)	p = 0.31
	Married	1 (8.3%)	4 (22.2%)	
	Divorced	1 (8.3%)		
<b>Education</b>	School	1 (8.3%)		p = 0.30
	College/ Higher	3 (25.0%)	8 (44.4%)	
	Degree	8 (66.7%)	10 (55.6%)	
<b>First language</b>	English	8 (66.7%)	15 (83.3%)	p = 0.29
	Gujarati	4 (33.3%)	3 (16.7%)	
<b>Preferred language</b>	English	12 (100%)	18 (100%)	

### **3.3 Brief Symptom Inventory (BSI)**

The BSI was administered to provide a more detailed profile of symptoms of psychological distress for the two groups. Figures 2-4 illustrate the distribution of scores on the three global

indices of distress, namely Global Severity Index (GSI), Positive Symptom Distress Index (PSDI) and Positive Symptom Total (PST). When conducting research in the community using a clinical measure such as the BSI, a positively skewed score distribution would be expected as the majority of participants are likely to obtain low scores on symptoms of psychological distress. The boxplot in Figure 2. illustrates that the distribution of Global Severity Index scores for both groups is positively skewed, and the clinical group has a greater spread of scores indicating that the scores are not normally distributed. A Mann-Whitney U test was conducted to evaluate the hypothesis that the clinical group would have higher GSI scores than the non-clinical group. The clinical group had a mean GSI score of 0.95 ( $SD = 0.83$ ,  $Mdn = 0.59$ ), and for the non-clinical group the mean GSI was 0.48 ( $SD = 0.40$ ,  $Mdn = 0.31$ ), and the results confirmed that despite the considerable overlap between the two distributions there was a significant difference ( $z = 1.69$ ,  $p < .05$ , one-tailed). This indicates that the clinical group have a higher overall level of global psychological distress as measured by the BSI. Spearman's rho correlation analysis revealed a significant correlation between overall distress as measured by the GHQ sumscores and the GSI, (Spearman's  $r_s = 0.46$ ,  $p = .01$ , two-tailed).



**Figure 2.** Distribution of GSI scores for clinical and non-clinical groups

The distribution of scores on the Positive Symptom Distress Index is illustrated using a boxplot and can be seen in Figure 3. Similarly to the GSI scores, both distributions are positively skewed, and a Mann-Whitney U test confirmed that the groups differed significantly on this index, ( $z = 2.27$ ,  $p < .01$ , one-tailed). The clinical group had a mean PSDI

score of 1.84 ( $SD = 0.83$ ,  $Mdn = 1.60$ ), and for the non-clinical group the mean PSDI was 1.28 ( $SD = 0.51$ ,  $Mdn = 1.17$ ). This result indicates that the distress experienced by the clinical group is of a higher intensity than that of the non-clinical group.

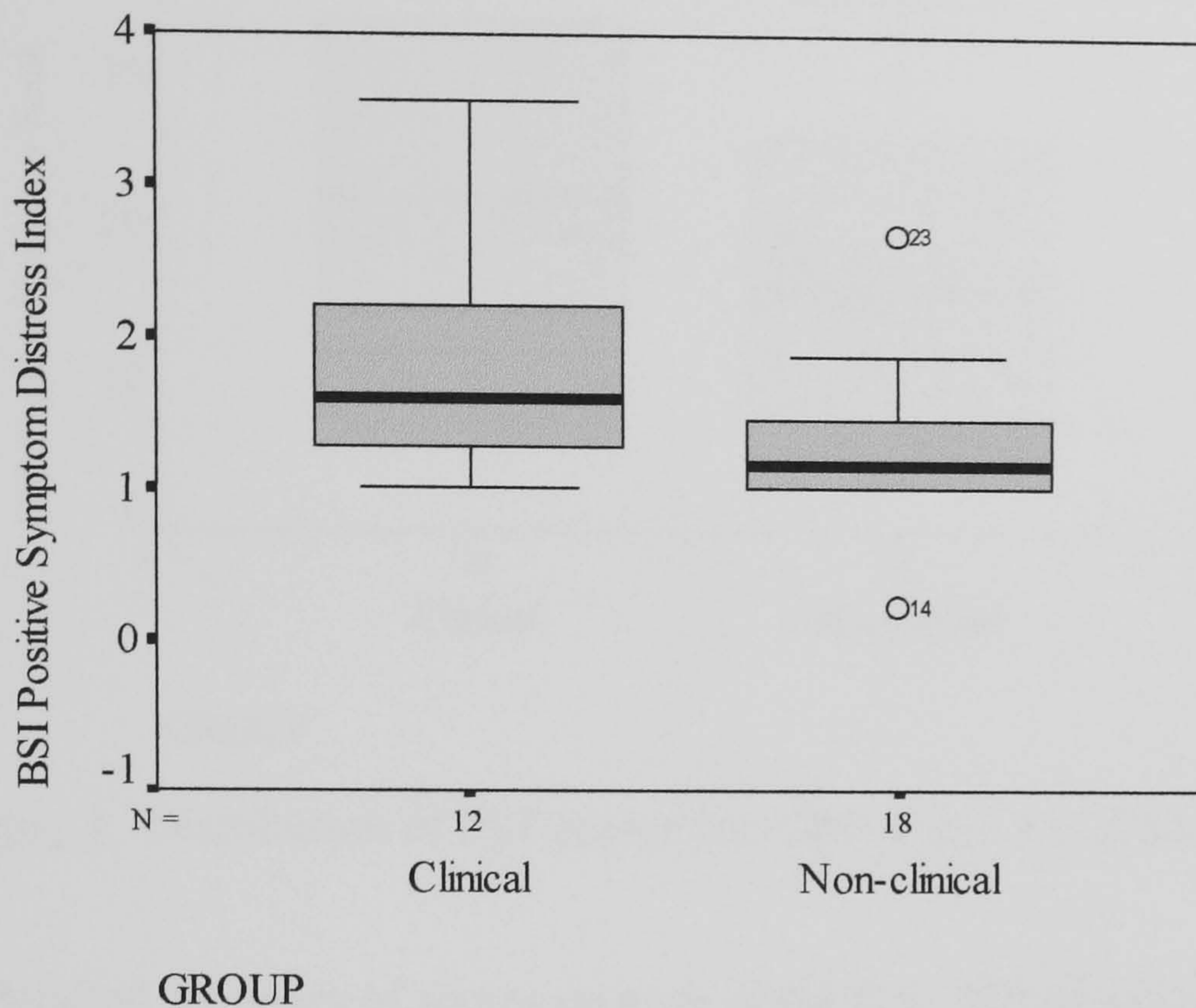


Figure 3. Distribution of PSDI scores for clinical and non-clinical groups

Finally, the two groups were compared on the Positive Symptom Total index, and the distribution of these scores is illustrated in the boxplot presented in Figure 4. The distribution of scores is positively skewed for the non-clinical sample, and is only slightly skewed, again in a positive direction, for the clinical group. A Mann-Whitney  $U$  test was conducted to evaluate the hypothesis that the clinical group would have a higher PST score than the non-clinical group, ( $z = 1.42$ ,  $p = 0.08$ , one-tailed). This result indicates that although the clinical group had a mean of 23.67 ( $SD = 12.12$ ,  $Mdn = 22.00$ ), on the PST, which was higher than the non-clinical mean of 17.56 ( $SD = 9.19$ ,  $Mdn = 16.00$ ), this difference did not reach statistical significance. This demonstrates that the groups did not significantly differ with regard to the number of symptoms positively endorsed.

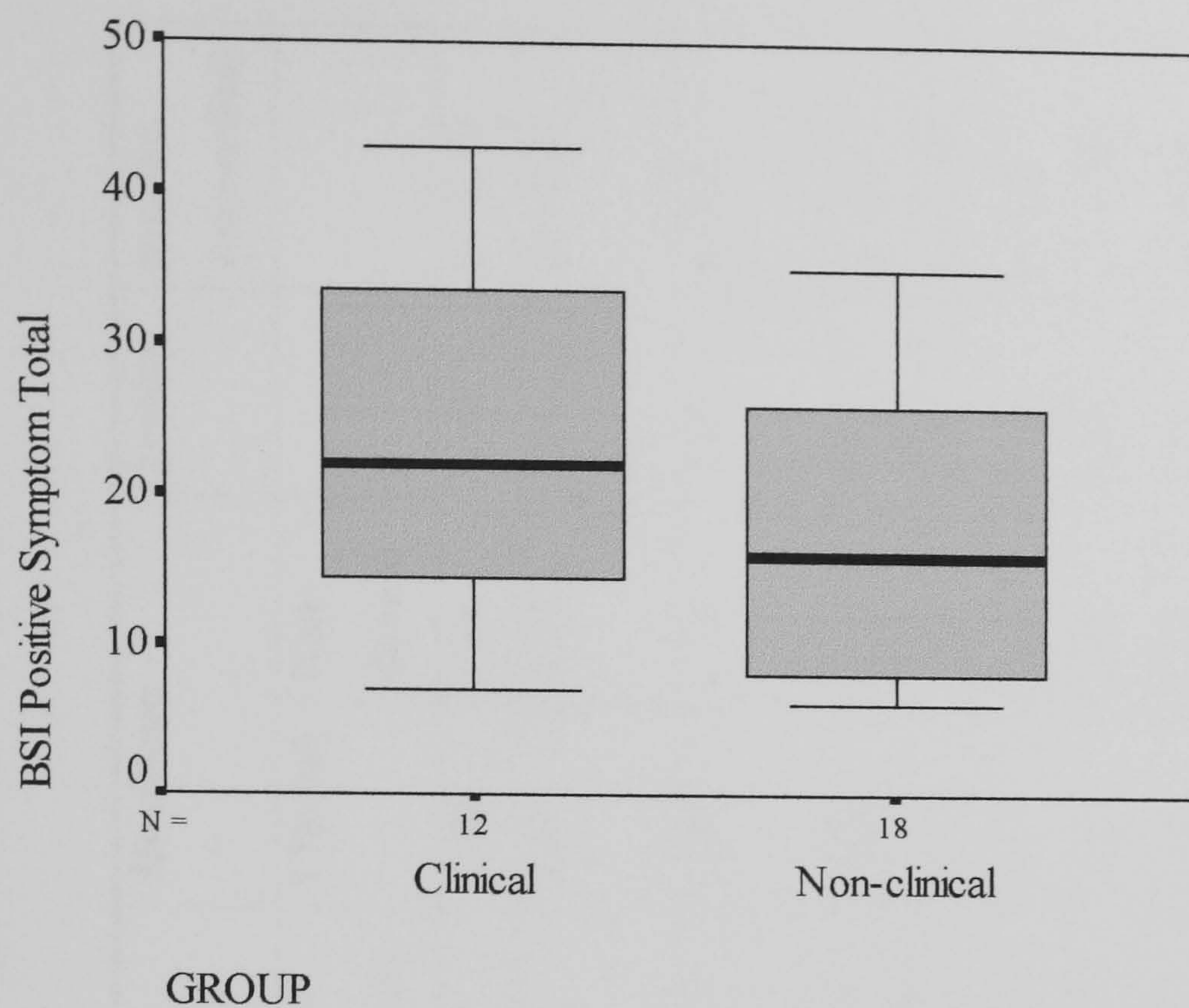


Figure 4. Distribution of PST scores for clinical and non-clinical groups

A detailed summary of scores on each of the nine BSI symptom dimensions for both groups is provided in Table 5. It can be seen that the clinical group obtained higher mean and median scores than the non-clinical group on nearly all of the symptom dimensions, with the exception of the sub-scale for somatisation. On this scale, the mean values were very similar for both groups, and the non-clinical group obtained a higher median score than the clinical group. Mann-Whitney U tests were conducted to evaluate the assumption that the clinical group would obtain higher scores on each of the symptom dimensions than the non-clinical group. The results of these analyses revealed that the clinical group obtained significantly higher scores on the sub-scales for Interpersonal Sensitivity, Depression, Hostility and Psychoticism. However, on the remaining sub-scales the differences between the two groups failed to reach statistical significance.



**Table 5.** Descriptive statistics for each of the nine BSI symptom dimension scores for clinical and non-clinical groups

<b>BSI Dimension</b>	<b>Mean</b>		<b>Median</b>		<b>Standard Deviation</b>		<b>Minimum</b>		<b>Maximum</b>		<b>z-value</b>	<b>p-value (one-tailed)</b>
	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>		
<b>Somatisation</b>	0.42	0.38	0.00	0.29	0.87	0.47	0.00	0.00	3.00	1.86	1.00	p = 0.16
<b>Obsessive-Compulsive</b>	1.10	0.81	0.83	0.59	0.80	0.71	0.33	0.00	3.17	3.00	1.34	p = 0.09
<b>Interpersonal Sensitivity</b>	1.23	0.58	0.88	0.38	1.28	0.71	0.00	0.00	4.00	2.50	1.67	p < .05
<b>Depression</b>	1.26	0.40	0.67	0.19	1.28	0.50	0.00	0.00	3.83	1.83	2.11	p < .05
<b>Anxiety</b>	0.97	0.49	0.67	0.33	0.95	0.41	0.00	0.00	3.17	1.17	1.39	p = 0.08
<b>Hostility</b>	1.10	0.38	1.00	0.20	0.88	0.50	0.20	0.00	3.40	1.60	2.81	p < .05
<b>Phobia</b>	0.47	0.16	0.00	0.00	0.74	0.24	0.00	0.00	1.80	0.80	0.57	p = 0.28
<b>Paranoia</b>	1.28	0.80	1.20	0.60	1.04	0.76	0.00	0.00	3.40	2.60	1.32	p = 0.09
<b>Psychoticism</b>	0.87	0.30	0.50	0.20	0.97	0.40	0.00	0.00	3.20	1.60	1.91	p < .05

### 3.4 Life Events Inventory (LEI)

The Life Events Inventory (LEI) was administered in order to control for the potential confounding effect of life events on level of psychological distress. The descriptive statistics for both groups are presented in Table 6. The non-clinical group had slightly higher mean and median values than the clinical group. The distribution of LEI scores for the clinical group is slightly negatively skewed, and for the non-clinical group is positively skewed, and is illustrated by the boxplot in Figure 5. A Mann-Whitney U test was conducted to investigate difference in mean scores between the groups and the result was found to be non-significant ( $z = 0.45, p = 0.66$ , two-tailed). This indicates that the level of life disruption experienced due to stressful events did not significantly differ between the two groups.

Table 6. Descriptive statistics for LEI scores for the clinical and non-clinical groups

<i>Group</i>	<i>Mean</i>	<i>Median</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Skewness</i>
<b>Clinical</b> (n = 12)	210.17	228.00	85.53	40	363	-0.29
<b>Non-clinical</b> (n = 18)	230.39	256.50	164.35	0	539	0.16

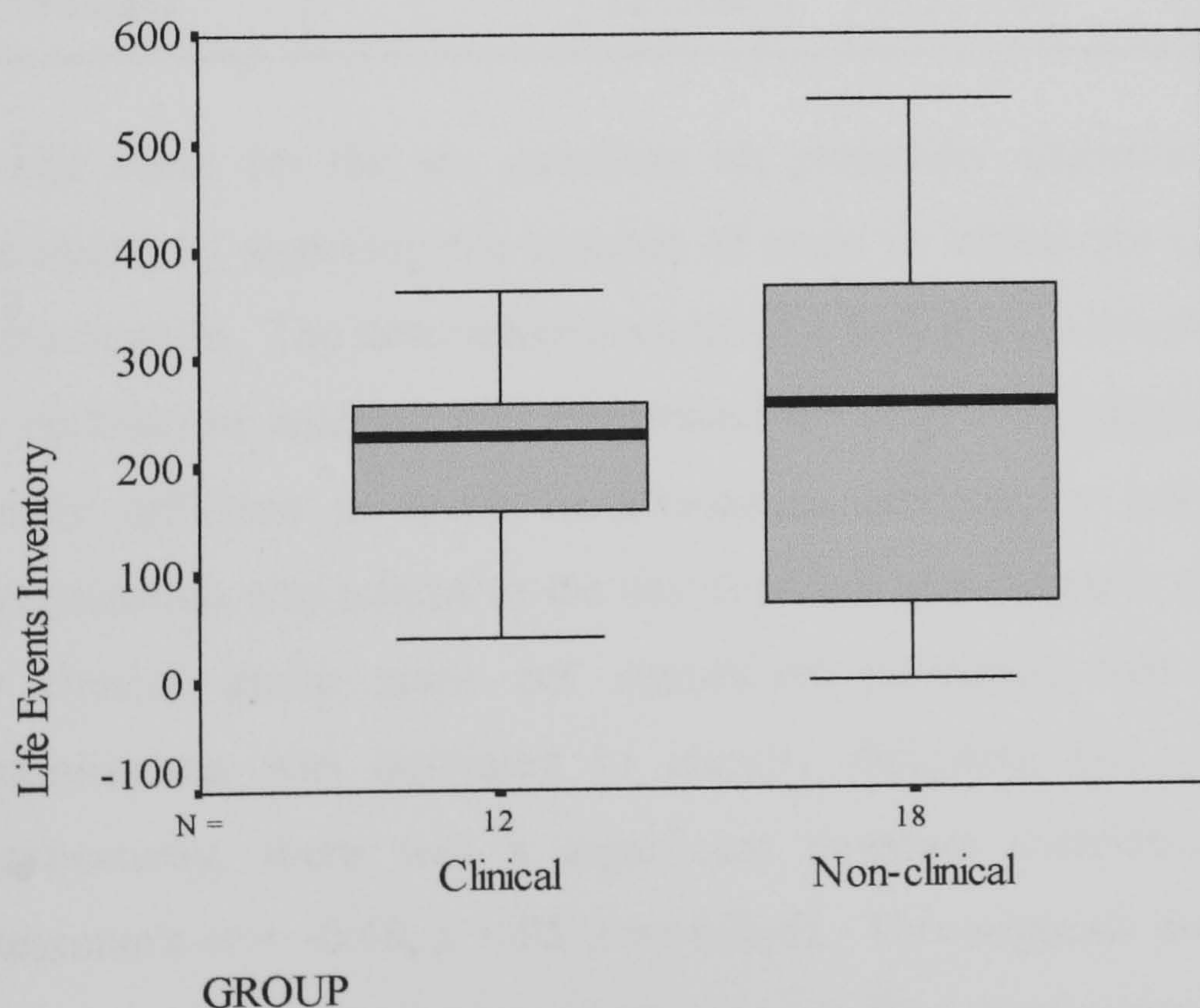


Figure 5. Boxplot of LEI scores for clinical and non-clinical groups

Participants' responses to the additional questions pertaining to whether or not they had experienced prejudice/ discrimination in six main areas can be seen in Table 7. The results indicate that the non-clinical group appears to have experienced a slightly higher level of prejudice/ discrimination than the clinical group in all of the areas except housing. Chi-square analyses, using Yates correction, of the data revealed that these differences were not statistically significant across any of the areas. The results for the LEI and experience of prejudice/ discrimination combined suggest that the higher scores of the clinical group on measures of psychological distress may not be attributed solely to a greater number of life disrupting events or experience of prejudice.

**Table 7.** Percentages of prejudice/ discrimination for the clinical and non-clinical groups

<i>Area of prejudice</i>	<i>Clinical</i>		<i>Non-clinical</i>		<i>p-value</i>
	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>	
<b>Employment</b>	1 (8.3%)	11 (91.7%)	5 (27.8%)	13 (72.2%)	0.36
<b>Housing</b>	1 (8.3%)	11 (91.7%)	1 (5.6%)	17 (94.4%)	1.00
<b>Education</b>	1 (8.3%)	11 (91.7%)	5 (27.8%)	13 (72.2%)	0.36
<b>Social</b>	1 (8.3%)	11 (91.7%)	5 (27.8%)	13 (72.2%)	0.36
<b>Police</b>		12 (100%)	2 (11.1%)	16 (88.9%)	0.50
<b>Government</b>		12 (100%)	2 (11.1%)	16 (88.9%)	0.50

A total score for the six questions on prejudice/ discrimination was calculated for each participant by summing the number of areas in which she reported experiencing prejudice/ discrimination. The descriptive statistics for both groups are presented in Table 8. Spearman's rho correlation analysis was performed between total prejudice/ discrimination scores and identity diffusion in order to investigate whether or not the experience of prejudice/ discrimination was related to the development of a cohesive cultural identity. The results for the clinical group were not significant indicating that the experience of prejudice/ discrimination was unrelated to identity diffusion, ( $r_s = 0.23$ ,  $p = 0.47$ , two-tailed). Unexpectedly, there was a significant negative correlation for the non-clinical group, (Spearman's  $r_s = -0.48$ ,  $p < .05$ , two-tailed). This suggests that the level of identity diffusion decreased with increasing experience of prejudice/ discrimination.

**Table 8.** Descriptive statistics for prejudice/ discrimination total scores for the clinical and non-clinical groups

<i>Group</i>	<i>Mean</i>	<i>Median</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Skewness</i>
<b>Clinical</b> (n = 12)	0.33	0.00	0.49	0	1	0.81
<b>Non-clinical</b> (n = 18)	1.11	1.00	1.13	0	4	0.85

### **3.5 Identity Structure Analysis (ISA)**

*Hypothesis 1.* There will be no differences in the extent to which women with high (clinical) and low (non-clinical) levels of psychological distress empathetically identify with Asian and British culture

The data presented in Table 9. detail the identity parameter of empathetic identification, that is, the extent to which a person views him/ herself as having characteristics in common with another person. Examination of the descriptive statistics presented in Table 9. indicates that within the clinical group, values for mean empathetic identification ranged from 0.47 for Father's age Asian ( $SD = 0.15$ ) and native British males ( $SD = 0.09$ ), to 0.68 ( $SD = 0.13$ ) for second-generation Asian females. For the non-clinical group, the mean values ranged from 0.52 for first generation Asian males ( $SD = 0.16$ ) and females ( $SD = 0.21$ ) to 0.76 ( $SD = 0.16$ ) for second-generation Asian females.

A number of Mann Whitney U tests were conducted in order to investigate the hypothesis that the extent of empathetic identification across Asian and native British entities will not differ between the clinical and non-clinical group. The results indicated that the non-clinical group empathetically identified more closely with native British females of their parents' age ( $z = 1.96, p = .05$ , two-tailed) than the clinical group. This indicates that the non-clinical group viewed themselves as sharing more attributes with native British females of their parents' age than the clinical group. The remaining analyses were non-significant, indicating that there were no differences between the groups. Therefore, the hypothesis that there will be no differences in the extent to which both groups empathetically identify with Asian and British culture was supported in the main.

Additional exploratory analyses of this data was performed using a number of Wilcoxon tests in order to investigate whether both the clinical and non-clinical group would empathetically identify more closely with male and female representatives of both cultures within their peer group than with entities of their parents' age. The results for all of these analyses were significant at an alpha level of 0.05 (two-tailed) for both groups. The only exception was that the clinical group empathetically identified equally closely with both first and second generation Asian males.

Table 9. Descriptive statistics for empathetic identification data for clinical and non-clinical groups (Scale 0.00 to 1.00)

<b>Entity</b>	<b>Mean</b>		<b>Median</b>		<b>Standard Deviation</b>		<b>Minimum</b>		<b>Maximum</b>		<b>Skewness</b>	
	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>
<b>Mother</b>	0.63	0.71	0.57	0.78	0.20	0.25	0.38	0.22	0.94	1.00	0.32	-0.65
<b>Father</b>	0.64	0.67	0.64	0.72	0.19	0.22	0.38	0.17	0.94	1.00	0.13	-0.58
<b>2<sup>nd</sup> generation Asian female</b>	0.68	0.76	0.68	0.80	0.13	0.16	0.44	0.44	0.89	1.00	0.06	-0.80
<b>2<sup>nd</sup> generation Asian male</b>	0.55	0.68	0.47	0.67	0.22	0.21	0.28	0.28	0.88	1.00	0.40	-0.22
<b>1<sup>st</sup> generation Asian female</b>	0.51	0.52	0.56	0.50	0.13	0.21	0.28	0.17	0.67	0.89	-0.82	0.12
<b>1<sup>st</sup> generation Asian male</b>	0.47	0.52	0.43	0.50	0.15	0.16	0.28	0.28	0.72	0.83	0.67	0.32
<b>Own age native British female</b>	0.63	0.69	0.64	0.75	0.18	0.18	0.33	0.33	0.94	0.94	0.07	-0.73
<b>Own age native British male</b>	0.59	0.68	0.55	0.73	0.19	0.20	0.28	0.24	0.89	0.94	0.10	-0.84
<b>Parent's age native British female</b>	0.51	0.63	0.52	0.64	0.12	0.18	0.33	0.22	0.72	0.94	0.13	-0.43
<b>Parent's age native British male</b>	0.47	0.55	0.44	0.56	0.09	0.19	0.33	0.17	0.61	0.83	0.38	-0.71

*Hypothesis 2.* The clinical group will have a higher level of contra-identification with parents and representatives of Asian culture than the non-clinical group

The identity parameter, contra-identification is detailed in Table 10. This refers to the extent to which significant others have attributes which are similar to those one wishes to dissociate from. It can be seen from the descriptive statistics presented in Table 10. that within the clinical group the extent of contra-identification ranged from 0.30 ( $SD = 0.15$ ) with second-generation Asian females to 0.50 ( $SD = 0.15$ ) with first generation Asian females. The pattern of results was similar within the non-clinical group as the mean values for contra-identification ranged from 0.25 ( $SD = 0.19$ ) with second-generation Asian females to 0.45 ( $SD = 0.22$ ) with first generation Asian females.

**Table 10.** Descriptive statistics for contra-identification data for clinical and non-clinical groups (Scale 0.00 to 1.00)

<b>Entity</b>	<b>Mean</b>		<b>Median</b>		<b>Standard Deviation</b>		<b>Minimum</b>		<b>Maximum</b>		<b>Skewness</b>	
	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>
<b>Mother</b>	0.35	0.29	0.31	0.21	0.23	0.25	0.06	0.06	0.72	0.83	0.51	1.00
<b>Father</b>	0.36	0.30	0.33	0.27	0.19	0.19	0.06	0.06	0.67	0.83	0.33	1.42
<b>2<sup>nd</sup> generation Asian female</b>	0.30	0.25	0.33	0.21	0.15	0.19	0.06	0.06	0.56	0.72	0.08	1.24
<b>2<sup>nd</sup> generation Asian male</b>	0.38	0.30	0.44	0.33	0.24	0.19	0.00	0.06	0.67	0.72	-0.50	0.43
<b>1<sup>st</sup> generation Asian female</b>	0.50	0.45	0.47	0.42	0.15	0.22	0.29	0.11	0.78	0.83	0.65	0.32
<b>1<sup>st</sup> generation Asian male</b>	0.48	0.39	0.50	0.39	0.19	0.16	0.11	0.17	0.83	0.78	-0.41	0.85



In order to investigate the hypothesis that the clinical group will have a higher level of contra-identification with parents and representatives of Asian culture than the non-clinical group, a number of Mann Whitney U tests were conducted. The results of these analyses are presented in Table 11. The findings indicate that the clinical group had a significantly higher level of contra-identification with first generation Asian males ( $z = 1.75$ ,  $p < .05$ , one-tailed) than the non-clinical group. It can be seen from Table 11. that the extent of contra-identification with parents, second generation Asian males and females and first generation Asian females were all slightly higher for the clinical group than the non-clinical group, which was in the direction hypothesised. However, these differences failed to reach statistical significance; therefore, this hypothesis was only partially supported.

**Table 11.** Inferential statistics for contra-identification data for clinical and non-clinical groups

Entity	Mean		Mean difference	z-value	p-value (one-tailed)	Cohen's d
	Clinical	Non-clinical				
<b>1<sup>st</sup> generation Asian male</b>	0.48	0.39	0.09	1.75	$p < .05$	0.47
<b>2<sup>nd</sup> generation Asian male</b>	0.38	0.30	0.08	1.08	0.14	0.36
<b>Mother</b>	0.35	0.29	0.06	0.89	0.19	0.26
<b>Father</b>	0.36	0.30	0.06	1.02	0.15	0.32
<b>2<sup>nd</sup> generation Asian female</b>	0.30	0.25	0.05	1.05	0.15	0.29
<b>1<sup>st</sup> generation Asian female</b>	0.50	0.45	0.05	0.68	0.25	0.26

*Hypothesis 3.* The clinical group will have higher levels of conflicted identifications with parents and first generation Asian individuals than the non-clinical group

Identification conflict occurs when a person views a significant other as having some qualities which he/ she identifies with and some which he/ she wishes to dissociate from. Data

summarizing level of conflicted identification for entities across cultures is presented in Table 12. It can be seen from the descriptive statistics in Table 12. that within the clinical group the extent of conflicted identification ranged from 0.41 ( $SD = 0.10$ ) with Mother to 0.48 ( $SD = 0.05$ ) with first generation Asian females. Similarly within the non-clinical group, the values for identification conflict ranged from 0.38 ( $SD = 0.10$ ) for Mother to 0.44 ( $SD = 0.05$ ) for first generation Asian females.

In order to investigate the hypothesis that the clinical group will have higher levels of conflicted identifications with parents and first generation Asian individuals than the non-clinical group a number of Mann Whitney U tests were performed. The results indicated that the clinical group had a significantly higher level of conflicted identification with Father ( $z = 1.62, p = .05$ , one-tailed) and first generation Asian females ( $z = 2.06, p < .05$ , one-tailed). Calculation of mean difference using Cohen's  $d$  indicated that there was a moderate effect size for Father ( $d = 0.50$ ) and a large effect size for first generation Asian females ( $d = 0.80$ ). The extent of conflicted identification with the remaining two entities was greater for the clinical group than the non-clinical group, which was in the direction hypothesised. However, these differences failed to reach statistical significance for Mother ( $z = 0.93, p = 0.18$ , one-tailed) or first generation Asian males, ( $z = 1.15, p = 0.13$ , one-tailed). Therefore, the hypothesis was partially supported as the clinical group had a higher level of conflicted identification with one parent and female Asian first generation individuals. Calculation of mean difference using Cohen's  $d$  indicated that there was a small effect size for Mother ( $d = 0.30$ ) and first generation Asian male ( $d = 0.17$ ).

**Table 12.** Summary of conflicted identification data for clinical and non-clinical groups (Scale 0.00 to 1.00)

<b>Entity</b>	<b>Mean</b>		<b>Median</b>		<b>Standard Deviation</b>		<b>Minimum</b>		<b>Maximum</b>		<b>Skewness</b>	
	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>	<b>Clinical</b>	<b>Non-clinical</b>
<b>Mother</b>	0.41	0.38	0.41	0.39	0.10	0.10	0.21	0.23	0.56	0.53	-0.38	-0.16
<b>Father</b>	0.44	0.40	0.44	0.42	0.09	0.07	0.24	0.24	0.55	0.52	-0.88	-0.52
<b>1<sup>st</sup> generation Asian female</b>	0.48	0.44	0.48	0.46	0.05	0.05	0.39	0.29	0.56	0.51	-0.30	-1.23
<b>1<sup>st</sup> generation Asian male</b>	0.44	0.43	0.46	0.45	0.07	0.05	0.28	0.33	0.53	0.50	-1.14	-0.74

*Hypothesis 4.* The clinical group will have a higher level of identity diffusion than the non-clinical group

Identity diffusion may be defined as the overall extent of identification conflicts across a range of significant others and data for this identity parameter are presented in Table 13. It can be seen that both groups have a moderately high mean identity diffusion score. A Mann-Whitney U test was conducted to evaluate the hypothesis that the clinical group would have higher identity diffusion than the non-clinical group, ( $z = 1.02$ ,  $p = 0.15$ , one-tailed). Although the mean differences fell in the direction hypothesised, with the clinical group obtaining a higher mean identity diffusion value than the non-clinical group, the result was non-significant. Therefore, the hypothesis was not supported. Calculation of mean difference using Cohen's  $d$  indicated that there was a moderate effect size ( $d = 0.49$ ).

**Table 13.** Descriptive statistics for identity diffusion data for clinical and non-clinical groups (Scale 0.00 - 1.00)

<i>Group</i>	<i>Mean</i>	<i>Median</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Skewness</i>
<b>Clinical (n = 12)</b>	0.39	0.41	0.05	0.29	0.46	-0.71
<b>Non-clinical (n = 18)</b>	0.36	0.36	0.07	0.24	0.74	-0.49

*Hypothesis 5.* Identity diffusion will be positively correlated with BSI scores

As the BSI provides an indication of psychological distress across a variety of symptom dimensions, a number of Spearman's rho correlational tests were run to explore the hypothesis that the extent of identity diffusion would positively correlate with BSI scores. The results partially supported this hypothesis as the global index, Positive Symptom Total, was moderately positively related to identity diffusion for the clinical group ( $r = 0.53$ ,  $p < .05$ , one-tailed). This indicates that for the clinical group, the greater the number of symptoms positively endorsed, the higher the level of identity diffusion. An unexpected finding is that Positive Symptom Total was negatively correlated with identity diffusion for the non-clinical group, although this result was not significant at an alpha level of 0.05 ( $r = -0.42$ ,  $p = 0.10$ , two-tailed). There were no significant relationships between identity diffusion and Global Severity Index for the clinical group ( $r = 0.38$ ,  $p = 0.11$ , one-tailed) or the non-clinical group

( $r = -0.40$ ,  $p = 0.10$ , two-tailed), although for the non-clinical group the result was close to statistical significance, but again in the direction contrary to prediction. There were also no significant correlations between the Positive Symptom Distress Index and identity diffusion for either the clinical ( $r = 0.27$ ,  $p = 0.20$ , one-tailed) or non-clinical ( $r = -0.07$ ,  $p = 0.78$ , two-tailed) group.

This correlational analysis was repeated for each of the nine symptom dimensions and the results are summarised in Table 14. As can be seen from Table 14, identity diffusion is significantly positively correlated with the BSI sub-scales Somatisation, Anxiety and Paranoia and the correlation with Depression is close to reaching statistical significance for the clinical group. These results indicate that increasing scores on each of these sub-scales is related to a higher extent of identity diffusion for the clinical group. Examination of the results for the non-clinical group were again unexpected as they indicated identity diffusion is significantly negatively related to Interpersonal Sensitivity and the correlation with Somatisation was close to reaching statistical significance. This suggests that increased scores on these BSI scales are related to decreased identity diffusion values in the non-clinical group.

**Table 14.** Summary of correlational data for the ISA parameter of identity diffusion and each of the nine BSI dimensions

<i><b>BSI Dimensions</b></i>	<i><b>Clinical</b></i>		<i><b>Non-clinical</b></i>	
	<b>r</b>	<b>p - value one-tailed</b>	<b>r</b>	<b>p - value two-tailed</b>
<b>Somatisation</b>	0.54	<.05	-0.42	0.08
<b>Obsessive- Compulsive</b>	0.23	0.24	-0.27	0.27
<b>Interpersonal Sensitivity</b>	0.37	0.12	-0.67	<.01
<b>Depression</b>	0.48	0.06	-0.01	0.97
<b>Anxiety</b>	0.57	<.05	-0.30	0.23
<b>Hostility</b>	0.39	0.11	-0.21	0.40
<b>Phobia</b>	0.10	0.38	0.29	0.24
<b>Paranoia</b>	0.51	<.05	0.03	0.91
<b>Psychoticism</b>	0.26	0.20	-0.16	0.52

### *3.6 Exploratory Analysis*

It was thought that an analysis of the constructs used to evaluate self and others would provide an interesting insight into which aspects of identity were valued by each of the two groups. This was done by examining the structural pressure of constructs, that is, the degree of stability and consistency with which constructs are used to make a judgment. High structural pressures, that is, values close to +100 indicate that a construct is being used in a consistent way when evaluating self and others. This suggests that this construct is a core or important value when making judgements. Low or negative structural pressure values indicate that a construct is being used in an inconsistent way (values closer to -100), which implies that this construct represents an area of conflict or uncertainty when evaluating self and others. Mean structural pressure values for constructs are presented in Table 15. The pole of each bipolar construct favoured by the largest number of participants in each group is highlighted in bold type, that is, participants in the column labelled "majority" favoured the highlighted pole, and those in the column labelled "minority" endorsed the contrast pole. The sum of participants does not always equal 18 for the non-clinical group in Table 15. as some of the participants were unable to use a few of the constructs presented when evaluating entities, that is, the constructs were not meaningful to them.

It can be seen that for the clinical group the two highest structural pressure values are for the constructs, "Confused vs. Has a sense of self" (56.48) and "Mixes with all cultures vs. Just mixes with own culture" (54.05). This suggests that for the clinical group constructs relating to the areas of cultural difference and prejudice/ discrimination are a core evaluative dimension when making judgements about significant others. Core constructs for the non-clinical group were "Is picked on vs. Sticks up for self" (67.01) and "A person who copes vs. A person who does not cope" (66.67). Similarly to the clinical group, the core values of the non-clinical group relate to the idea of prejudice/ discrimination and also coping.

The lowest structural pressure values for the clinical group were obtained for the constructs "Religious vs. Not religious" (20.16) and "Traditional vs. Not traditional" (19.66), which indicates that these constructs were used inconsistently when making judgements, indicating areas of cognitive-affective dissonance or uncertainty. For the non-clinical group, all of the values were moderately high and therefore none of the constructs were conflictual or inconsistently applied.

In order to assess for differences in construing between the two groups, Mann Whitney U tests were run on selected constructs. Constructs were chosen for this analysis on the basis that the majority of participants favoured one pole. It can be seen that the only construct on which the two groups differed significantly was "Is picked on vs. Sticks up for self", with the non-clinical scoring higher than the clinical group. This indicates that the non-clinical group is more likely to value this construct than the clinical group when making judgements. Another construct on which the groups differed at a level which was close to reaching statistical significance, was "A person who copes vs. A person who does not cope", with the non-clinical group again scoring higher than the clinical group.

**Table 15.** Structural pressure values for constructs for both clinical and non-clinical groups (Scale -100 to +100)

<i>Construct</i>	<i>Clinical</i>		<i>Non-clinical</i>		<i>z-value</i>	<i>p-value</i>
	<b>Majority</b>	<b>Minority</b>	<b>Majority</b>	<b>Minority</b>		
<b>Friendly</b> vs. Doesn't have time	59.17 n = 12		66.25 n = 18		0.72	p = 0.47
<b>Rebellious</b> vs. Conformist	30.05 n = 8	9.24 n = 4	29.87 n = 12	66.33 n = 4		
<b>A person who copes</b> vs. A person who does not cope	50.98 n = 12		66.67 n = 18		1.91	p = 0.06
Is picked on vs. <b>Sticks up for self</b>	48.10 n = 12		67.01 n = 17	71.65 n = 1	2.17	p = <.05
<b>Being who he/ she wants to be</b> vs. Being what people want him/ her to be	52.46 n = 12		58.31 n = 18		0.93	p = 0.35
<b>Mixes with all cultures</b> vs. Just mixes with own culture	54.05 n = 12		49.09 n = 18		0.13	p = 0.90
<b>Family orientated</b> vs. Not family orientated	47.03 n = 12		58.04 n = 18		1.10	p = 0.27
<b>Open-minded</b> vs. Prejudiced	52.81 n = 12		61.22 n = 18		1.10	p = 0.27
<b>Religious</b> vs. Not religious	20.16 n = 9	28.29 n = 3	38.88 n = 11	39.45 n = 7		
Not cultural vs. <b>Cultural</b>	37.69 n = 12		33.70 n = 17	85.59 n = 1	0.13	p = 0.89
Strict vs. <b>Lenient</b>	42.70 n = 8	16.53 n = 4	31.75 n = 16	-3.42 n = 2		
Confused vs. <b>Has a sense of self</b>	56.48 n = 12		59.24 n = 18		0.51	p = 0.61
Closed thinker vs. <b>Accepting</b>	51.86 n = 12		53.40 n = 16	55.23 n = 2	0.28	p = 0.78
<b>Academic</b> vs. Creative.	34.87 n = 7	37.23 n = 4	32.50 n = 10	5.59 n = 7		
<b>Free</b> vs. Boundaried	35.70 n = 12		54.36 n = 17	5.21 n = 1	1.64	p = 0.10
Doesn't turn to anybody vs. <b>Needs to talk to somebody</b>	48.57 n = 8	21.81 n = 4	50.83 n = 16	37.49 n = 2		
Has different beliefs to me vs. <b>has same beliefs to me</b>	32.92 n = 11	3.55 n = 1	31.50 n = 17	48.27 n = 1	0.21	p = 0.83
<b>Traditional</b> vs. Not traditional	19.66 n = 9	41.66 n = 3	38.62 n = 11	50.19 n = 7		



### *Self-evaluation*

Self-evaluation indicates whether one's attitudes towards oneself are positive or negative.

A Mann Whitney U test was run to examine the difference in self-evaluation between the groups, and was close to reaching statistical significance ( $z = 2.61, p = 0.09$ , two-tailed). The results indicated that the non-clinical group ( $M = 0.76, Mdn, = 0.77, SD = 0.13$ ) had more positive attitudes towards the self than the clinical group, ( $M = 0.58, Mdn, = 0.63, SD = 0.21$ ). Spearman's rho correlational tests were run to explore whether or not self-evaluation was positively correlated with identity diffusion. There was a negative correlation between self-evaluation and identity diffusion for the non-clinical group and this was close to statistical significance ( $r = -0.44, p = 0.07$ , two-tailed). This indicates that as identity diffusion increases, self-evaluation decreases. Identity diffusion was unrelated to self-evaluation for the clinical group, ( $r = 0.004, p = 0.99$ , two-tailed).

## 4. Discussion

This final section will start by summarising the main findings of the study, and some of the additional results, in relation to the research hypotheses and relevant theoretical models. Following this, the methodological limitations of the study, directions for future research and ethical issues will be discussed. (See Patel (2003b) for detailed review of clinical implications). It is worth reiterating at this stage that no adjustments were made for multiple testing given the small sample size, therefore it is important that all of the findings are interpreted with caution.

### 4.1 Main findings

#### *Identification with Asian and native British cultures*

The results relating to the extent of empathetic identification across cultures indicated that both the clinical and non-clinical groups identified closely with both Asian and native British entities. This suggests that both groups viewed themselves as being bicultural as they perceived themselves as sharing many characteristics with representatives of both cultures. This supports studies which argue that second generation Asians favour a form of biculturalism (Ghuman, 1999; Srinivasan, 2001). The results of the present research contradict literature which portrays identification with a cultural group as an either/ or situation, whereby individuals are portrayed as identifying with one culture and hence being in "conflict" with the other (Ballard, 1979; Bhugra et al., 1999c).

The findings of the present study also contrast to some extent with research which suggests that the most adaptive acculturation strategy is integration (Farver et al., 2002a). According to Berry (1986), integration implies the development of positive relationships with the dominant group whilst still valuing and retaining one's own cultural identity. High levels of empathetic identification with both cultures imply that both the clinical and non-clinical group have formed relationships with dominant society and their culture of origin, and may therefore be considered "integrated". These results lend support to the notion that second generation Asian women born and brought up in the UK will identify with both Asian and British cultures, and psychological distress is related to how well these two types of identification are synthesised. Therefore, simply identifying with, or relating to, both Asian and British culture as suggested by Berry (1986) is not adequate: these identifications or relationships need to be synthesised in order to form a coherent identity.

The hypothesis that there would be no difference between the groups with regard to the level of empathetic identification with representatives of Asian and British culture was partially supported as there were no significant between group differences across the majority of entities. However, the non-clinical group empathetically identified more closely with female native British entities of their parents' age than the clinical group. This indicates that the non-clinical group viewed themselves as having more characteristics in common with native British females of their parents' age than the clinical group. As would be expected, on the whole, both groups identified more closely with male and female representatives of both cultures within their peer group than with entities of their parents' age. Therefore, a possible explanation for the higher level of empathetic identification with parents' age native British females is that the non-clinical group may have more acculturated views than the clinical group with regard to specific issues relating to family structure and parental authority. This is interesting as it is in direct contrast to the study by Bhugra et al (1999c). They found that although both groups of women studied had more acculturated attitudes than their parents, unique to the women who attempted suicide were less traditional attitudes towards work and marriage.

#### *Dissociation from Asian values*

The clinical group were found to contra-identify significantly more with first generation Asian males than the non-clinical group. Therefore, the hypothesis that the clinical group were more likely to view Asian entities (including their parents) as having characteristics that they wished to dissociate from than the non-clinical group, was only partially supported. Research relating to the experiences of second generation Asians growing up in the UK indicates that there are many aspects of Asian culture that are valued such as family relationships and collectivism. This supports the idea that UK born Asians will identify with both cultures, however there is some suggestion that second generation women in particular may favour British or western values in some domains such as gender roles and romantic relationships (Dasgupta, 1998). These values would go against more traditional Asian values relating to the role of women as carriers of cultural heritage and pre-marital relationships, thus increasing the extent of contra-identification with first generation Asian males who may be perceived to hold particularly traditional views.

The finding that there were no differences in contra-identification between the groups on any of the other entities is interesting. The mean values for the extent of contra-identification for both groups are in the moderate range, which indicates both groups contra-identify with members of their own ethnic group to some extent. This implies that wanting to dissociate from the values of representatives of Asian culture and one's parents is not necessarily stress inducing. A possible explanation relates to the idea of compartmentalisation, that is, second generation Asian women identify with native British values outside of the home, and Asian values within (Ghuman, 1999), which may reduce the feelings of stress associated with contra-identifying with members of one's own ethnic group. An alternative view is that contra-identification is not stressful in itself, rather it is only associated with psychological distress when combined with simultaneous empathetic identification. The results for the parameter of conflicted identification lend some support to this argument.

#### *Conflicted identification with representatives of Asian culture*

The clinical group were found to have significantly higher levels of conflicted identification with Father and first generation Asian females than the non-clinical group. Therefore, although the clinical group view themselves as sharing qualities with these entities they also view them as having many qualities they wish to dissociate from, which creates a conflictual state. Taken together with the results for the extent of empathetic and contra-identification, these results lend support to theories which argue that there are two cultures involved in the process of socialisation. The culture of origin is regarded as the primary socialisation influence but has a subordinate relationship to the influence of dominant society (Weinreich, 1979). Therefore, later identifications conflict with earlier identifications with parents and representatives of one's own ethnic group (Ghuman, 1999; Weinreich, 1983a). It is proposed that high levels of identification conflict with significant others are associated with psychological distress, which is supported by the results of the present study.

The finding that the clinical group experience greater identification conflict with Father supports research which suggests that the Asian patriarchal family structure may be a source of stress for second generation Asian women (Ahmed and Lemkau, 2000; Durvasula and Mylvaganam, 1994). Paternal authority may conflict with positively regarded personal values relating to equal opportunities and gender equality that are promoted within native British society. This argument is in line with theories which argue that aspects of wider society are in contrast with home values, creating conflicting social and emotional expectations (Ghuman,

1999). Similarly, the significantly higher level of conflicted identification of the clinical group with first generation Asian women may be associated with gender related issues, since a typical first generation Asian woman may be perceived to hold more traditional attitudes on gender roles.

Although the extent of conflicted identifications with Mother and first generation Asian males was greater for the clinical group than the non-clinical group, these differences failed to reach statistical significance. Therefore, the hypothesis that the clinical group will have higher levels of conflicted identification with parents and first generation Asian individuals than the non-clinical group was only partially supported. One possible explanation for these non-significant findings is that the number of participants in each group was small and consequently the analyses lacked statistical power. However, only a small effect size was detected using Cohen's *d*, for conflicted identification with Mother and first generation Asian males, which suggests that there was not much of a difference between the two groups.

Both groups empathetically identified closely with Mother, but had only low to moderate levels of contra-identification with her, resulting in a similarly low level of conflicted identification with Mother for both groups. It may be that within a patriarchal family structure, fathers hold more authority and consequently this relationship is more stressful and creates greater conflict than the relationship with mothers. Similarly, it may be that there is no significant difference between the groups with regard to identification conflict with first generation Asian males, as holding values which are simultaneously in agreement and contrast with them is not necessarily stress inducing. A possible reason for this is that despite the collectivist nature of Asian culture, the influence of extended family or community figures on participants may be limited, particularly as the sample consisted of adult women.

#### *Identity diffusion*

The level of identity diffusion did not significantly differ between the two groups, and therefore the hypothesis that the clinical group would have higher levels of identity diffusion than the non-clinical group was not supported. However, the mean levels of identity diffusion were greater for the clinical group than the non-clinical group, and a moderate effect size, as calculated using Cohen's *d*, was found, which raises the possibility that the lack of significance may be attributable to the small sample size. Identity diffusion occurs when identification conflicts are reasonably large and are spread across many significant others (Weinreich, 1980),

that is, the failure to successfully integrate earlier and later identifications with significant others results in a confused state of self. In this study, the intensity of the majority of conflicts in identification ranged from moderate to high, with none in the very high range. This may have been a contributory factor to the lower than expected level of identity diffusion found for the clinical group. This finding contrasts with other ISA studies conducted with clinical populations that have found higher levels of identity diffusion within clinical samples compared to non-clinical samples (Weinreich, et al., 1985).

Identity diffusion represents conflicted identifications across all significant others. Therefore, another potential explanation for these results is that the differences in the level of psychological distress found between the groups may be due to conflicted identifications with specific significant others. The results indicate that the clinical group is more likely to have identification conflicts with Father and first generation Asian females; hence, the distress may be attributable to difficulties with specific interpersonal relationships. In conjunction with the findings for empathetic and contra-identification, this would imply that distress may be unrelated to general difficulties in negotiating two contrasting cultures. That is, distress may be attributable to specific family relationships, as opposed to later identifications with British culture generally conflicting with earlier identifications with Asian culture, which would be likely to result in high identity diffusion.

Previous clinical research that has been conducted using ISA has focused on particular client populations, for example, women diagnosed with anorexia nervosa (Saunderson and O'Kane, 1999, 2003). The present study is based on women that are assigned to groups on the basis of their overall level of psychological distress. This raises the possibility that identity diffusion may be more likely to manifest itself in relation to specific psychological problems, which may explain the lack of difference found between the groups in the present study.

The hypothesis that Brief Symptom Inventory (BSI) scores would positively correlate with the extent of identity diffusion only received some support. There were no significant correlations between the global symptom index Positive Symptom Distress Index (PSDI) of the BSI and identity diffusion for either group. This indicates that identity diffusion was unrelated to the intensity of distress experienced. The Global Severity Index (GSI) was also not significantly correlated to identity diffusion for the clinical group, but the correlation was close to significance for the non-clinical group. Interestingly, identity diffusion was negatively

correlated to GSI for the non-clinical group, which would suggest that as identity diffusion for this group increased their overall level of distress decreased. A similar pattern was revealed for Positive Symptom Total (PST). PST was positively related to identity diffusion for the clinical group as predicted. For the non-clinical group there was a negative correlation that was close to reaching statistical significance. This would indicate that for the clinical group as identity diffusion increased so did the number of symptoms endorsed, whereas for the non-clinical group the number of symptoms endorsed decreased with increasing identity diffusion.

When the nine symptom dimensions of the BSI were examined for the clinical group, identity diffusion was positively related to Somatisation, Anxiety and Paranoia, and the relationship was close to reaching significance for Depression. These findings supported the hypothesis that increasing identity diffusion would be accompanied by increasing levels of psychological distress. This is because a higher level of identity diffusion suggests that a person has a vulnerable identity state, which may lead to psychological distress if this uncomfortable state is difficult to sustain. However, for the non-clinical group identity diffusion was negatively related to Interpersonal Sensitivity and the relationship was close to significance for Somatisation. These findings are surprising as they indicate that for the non-clinical group, increasing identity diffusion is associated with a lower level of psychological distress.

A tentative explanation for this unexpected finding is that identity diffusion may have a negative effect on one's sense of well-being or it may also provide an impetus for change and redefinition of one's identity (Weinreich, et al., 1996). All people would be expected to have a degree of identity diffusion as we form only partial identifications (empathetic identifications) with significant others in our social world. Consequently, we will also contra-identify with them to some extent, resulting in a degree of conflicted identification and thus identity diffusion. It may be that when the level of identity diffusion is substantial, it is difficult to bear and results in psychological distress, which may explain the correlations for the clinical group. However, if moderate, identity diffusion may provide the stimulation to reappraise oneself and others (Weinreich, et al., 1996). Therefore, identity diffusion may be negatively related to psychological distress for the non-clinical group as it is promoting the process of identity development and resolution of conflicted identifications.

## ***4.2 Additional findings***

### *Experience of prejudice/ discrimination and identity diffusion*

Participants were asked questions pertaining to the experience of prejudice/ discrimination in six main areas. The results of Chi square analyses indicated that there were no differences between the groups in the amount of prejudice/ discrimination experienced. Correlational analyses revealed that the experience of prejudice/ discrimination was unrelated to identity diffusion for the clinical group. This suggests that the extent of identity diffusion demonstrated by the clinical group is not significantly influenced by the experience of prejudice/ discrimination. The results for the non-clinical group indicate that there was a significant negative correlation. This suggests that the level of identity diffusion decreased with increasing experience of prejudice/ discrimination. This is an unexpected finding as it implies that the experience of prejudice/ discrimination served to strengthen the overall identity state of participants, as opposed to creating a more vulnerable identity state. Alternatively, it may be that individuals with a more secure identity state, that is, low identity diffusion, are more likely to experience prejudice/ discrimination. It is important that these results are interpreted with caution as they are based on a small number of questions. In addition, a limitation of the questions is that each group of participants may have interpreted the meaning of prejudice/ discrimination slightly differently.

### *Structural pressure*

The constructs "Traditional vs. Not-traditional" and "Religious vs. Not religious" were both conflicted, or inconsistently applied, dimensions of identity for the clinical group, but not the non-clinical group. This is an interesting finding in light of the literature which stresses the importance of religion when defining ethnicity (Bhugra and Cochrane, 2001). When considered together with the finding that a small number of participants did not follow any religion, it implies that religion may not be as important when conducting research with second generation Asian individuals as with first generation. The finding that traditionalism is also an area in which there is inconsistency, combined with the high levels of empathetic identification with Asian and native British culture, lends support to the theory proposed by Srinivasan (2001) which states that the second generation have different definitions of what it means to be Asian. This is a view that is backed up by the finding that "Cultural vs. Not cultural" was only a moderately important evaluative dimension for both groups. Alternatively, it may be that there is inconsistency as some aspects of tradition are valued, whereas others are contested, which would support the results relating to contra and conflicted



identification. It also raises the possibility that religion and tradition are areas in which the clinical group experience the most conflict with their families, which results in an increased level of distress. However, it is not possible to draw firm conclusions on this based on the results of the present study as areas that create family conflict were not assessed.

For the clinical group the two highest structural pressure values were for the constructs, "Confused vs. Has a sense of self" and "Mixes with all cultures vs. Just mixes with own culture". This indicates that these constructs play a core role when evaluating and making judgements about one's self and others. These constructs relate to issues of ethnic identity and prejudice/ discrimination, which suggests that having a bicultural identity and forming cross-cultural relationships are valued and also play an important role in defining the identity of these women. In contrast to this, the core values for the non-clinical group relate to coping generally and to prejudice/ discrimination, that is, "A person who copes vs. A person who does not cope" and "Is picked on vs. Sticks up for self". This may be interpreted as indicating that the non-clinical group were significantly more likely to define their identity in terms of their personal/ coping resources than the clinical group.

#### *Self-evaluation and identity diffusion*

It is well established in the literature that psychological distress is often accompanied by poor self-evaluation. The two groups were found to significantly differ with regard to self-evaluation, and as expected the clinical group had a less positive view of the self than the non-clinical group. Identity diffusion was unrelated to self-evaluation for the clinical group. A significant moderate negative correlation between self-evaluation and identity diffusion was found for the non-clinical group, which indicates that as identity diffusion increases, one's self-evaluation decreases. This result may be interpreted as indicating that increased identity diffusion would imply a lack of coherent identity or some confusion about one's sense of self, and consequently less favourable attitudes towards oneself would follow from this. This is again an unexpected finding in light of the above results which indicate that identity diffusion is negatively correlated to psychological distress for this group. It is also not clear why there is no relationship for the clinical group.

### ***4.3 Methodological limitations and recommendations for future research***

#### *Identity Structure Analysis*

The present study followed the recommended procedure for developing an identity instrument, which involves devising a set of bipolar constructs based on semi-structured interviews with representatives of the group of interest. The main advantages of this are that a standardised identity instrument is produced which is useful when conducting research; and areas of interest, for example, cultural identity, can be specifically explored. An alternative technique would be to elicit constructs directly from each individual participant using the triadic sort technique. This would involve presenting each participant with three entities and asking her in what way two of the entities are similar but different from the third, and in what way the third entity contrasts with the other two (Winter, 1992). This technique may have produced different results as research on repertory grids (Kelly, 1955), which share some commonalities with ISA, suggests that elicited constructs are rated more extremely than supplied constructs (Stringer, 1972). This is because elicited constructs would be more meaningful to participants than supplied constructs. If constructs had been elicited as opposed to supplied, content analysis could have been used to look for themes relating to cultural identity as this may have provided an interesting way of exploring the importance of cultural factors for second generation women without making any prior assumptions. This is of relevance as in a qualitative study by Chantler, Burman, Batsleer et al (2001) with Asian women who attempted suicide, none of the participants mentioned culture at all.

The results for the structural pressures on constructs indicate that the constructs "Rebellious vs. Conformist" and "Academic vs. Creative" could not be used by a small number of participants; that is, these constructs were not meaningful to them. Therefore, if this study was to be repeated it would be useful to review these constructs following discussion with the participants of interest and either replace or reword them. Similarly, the entity assessing past self, termed "me as I was 5 years ago" in this study, may have been easier to construe if it was related to a specific event or experience, for example, "me as I was before I got depressed". However, this was not possible in the present study as participants were assigned to a group based on a screening of psychological distress.

Other research conducted using ISA has found that identity diffusion varies according to the "situated self", for example, "me as I am when I am with my own ethnic group" and "me as I am when I am with members of another ethnic group" (Kelly, 1989). This would have been

useful to consider as it may have provided more information on the specific context in which participants experience the most identification conflicts. It was not possible to include additional entities to investigate the situated self in the present study, as the identity instrument was already quite long and increasing the size further may have resulted in respondent fatigue (Weinreich, 1992). A related limitation is that the study only considers Asian and native British entities, which is not representative of the multi-cultural population in the UK. It would have been useful to include entities from other prevalent ethnic groups, for example "A typical Afro-Caribbean woman of my age". This may have given a clearer indication as to the significance of other cultures, in addition to native British culture, in the identity development of second generation Asian women.

There are few published studies available which examine the reliability and validity of ISA, which is a limitation of this tool. There is some justification for this as each study uses a unique identity instrument created to incorporate the cultural and socio-historical context of the participants of interest; therefore it would not make sense to make general comments on the reliability and validity of ISA. However, it may have been useful within this study to have assessed test-retest reliability data if the existing time demands were not present.

ISA produces identity indices for one's past self in addition to one's current self, which serves as a proxy for a more objective longitudinal perspective. Examination of the data produced could have been used to give an indication of identity development/ dynamics in relation to participants' difficulties. For example, the results would indicate if patterns of identification have changed over time and if participants were experiencing or resolving conflict with significant others. It would also give information on whether or not participants are moving towards or away from their aspired self. This is important as an inability to progress in terms of identity development may result in psychological distress (Saunderson and O'Kane, 2003). Unfortunately, such analyses were beyond the scope of the present study.

#### *Brief Symptom Inventory*

The main limitation of the BSI was that it has not been validated with Asian populations living in the UK, and consequently may be an inaccurate indicator of distress among this population. As the data presented in the Results section illustrates, there is a considerable overlap between the BSI score distributions of the two groups (as defined using GHQ cut-off scores). The GHQ and BSI are not parallel measures, and they differ with regard to the level of sensitivity

and specificity with this population. Therefore, it would be predicted that there would be some relation between scores on both measures for each group. However, another possibility is that the BSI is not a sensitive measure of psychological distress among Asian women in the UK. Indirect support for this is provided by informal feedback received during the research process as a few participants commented that items such as "Feeling that you are watched or talked about by others" were difficult to answer. This was because the collectivist nature of Asian culture and value placed on extended networks meant that feeling talked about were not uncommon experiences. However, in the BSI this item relates to symptoms of paranoid ideation. Although the GHQ-28 contains fewer symptom dimensions it may be worth exploring as alternative measure to the BSI in future research. This is because it has been used extensively in research with South Asian populations, and the item wording has been found to be acceptable.

A more general methodological limitation is that the study uses self-report measures. This is because the information generated is subjective and based on the issues participants are aware of or are willing to report. Both the BSI and GHQ have high face validity and are clearly assessing mood. Consequently, there is the danger that information may be under-reported due to anxieties associated with how this information may be interpreted (i.e. social desirability). These disadvantages of self-report measures are difficult to overcome.

### *Sample*

One of the main limitations of this study is the sample size. Due to difficulties in recruiting participants the final sample was relatively small, and consequently there is a lack of statistical power. Therefore, the likelihood of correctly detecting more subtle differences between the groups was reduced. No data were collected on women who refused to participate, and so it was not possible to examine any differences between women who did and did not take part. This would be useful to consider in future research in light of the recruitment difficulties experienced in the present study as it may provide an insight into the reasons why so many women were reluctant to participate. A related issue is that exploratory analyses of interest were precluded by the small numbers within each group. For example, based on the theory that an essential starting point when assessing ethnic identity is ethnic self-identification (Phinney, 1990), a comparison of the ISA identity parameters by self-defined ethnicity would have been informative.

This study uses a convenience sample and therefore the results may not be assumed to be representative of all second generation Asian women. This is particularly evident in relation to the finding that a large proportion of the sample was highly educated suggesting a possible sample selection bias. This may have influenced the results with regard to the extent of empathetic and/ or contra-identification, as a greater level of education suggests significant involvement with native British culture over a prolonged period of time. Also, the research was conducted in an area with a small Asian population relative to other geographical areas. The difference in the pattern of interactions between members of Asian and native British cultures and the consequent impact on identity parameters is unknown, compared to an area with a higher concentration of Asians.

The sample is heterogeneous with regard to religion and cultural group, which has been criticised by many authors in relation to cross-cultural research due to the huge diversity between the cultural sub-groups encompassed by the term "Asian" (Bhui, 1999; Senior and Bhopal, 1994). Although the variations within Asian culture are acknowledged, not distinguishing between sub-groups and religions was felt to be acceptable, although not ideal, in this study. This is because the focus of the research was on the differences between Asian and British culture and how these contribute to identity development, and it is believed that these differences outweigh sub-cultural differences in this instance. Also, the results of the present study justify this decision to some extent as they suggest that religion may not be a core evaluative construct when researching the cultural identity of second generation women; however it would be premature to dismiss the importance of religion in the identity development of UK born Asians until more research is conducted in this area.

It is thought that this exploratory study has taken a useful first step in increasing our understanding of the relationship between general psychological distress and identity issues for second generation Asian women. It may be of value for future research to build on this further by focusing on a particular Asian cultural group, for example, Gujaratis or Punjabis. One reason for this is that in the current study the majority of participants stated that their first language was English and the only other first language reported was Gujarati. This raises the possibility that there may be differences in the extent of traditionalism between different Asian cultural groups as one way of maintaining the traditions and customs of the culture of heritage is to teach the next generation the familial language (Northover, 2000). Alternatively, it may just reflect that the sample contained a higher proportion of Gujarati participants, however it

was not possible to explore this further as information on sub-cultural group was not collected. Focusing on a specific cultural group would also increase the generalisability of the results.

Similarly, other ISA research suggests that focusing on specific psychological difficulties, for example eating disorders, as opposed to general psychological distress, may provide a different perspective on identity issues. Although in light of the fact that mental health services are underused by minority ethnic groups and the problems encountered with recruitment in the present study, this is likely to be a difficult process. (See Patel (2003b) for a more detailed discussion on recruitment). A potential argument against this is that the difficulties associated with researching a non-specific clinical population are partially overcome by the use of the BSI. This is because the BSI provides more detailed information about psychological distress along nine symptom dimensions than is generated by the General Health Questionnaire (GHQ-12).

Existing research indicates that the ethnicity of the researcher can impact upon the research process (M. Patel, 1998), and Kelly (1989) found that identity diffusion varies according to situated self. The main researcher for this study is a second generation Asian female; therefore she is both a member of the same ethnic group as the participants and a peer. The results of the current study indicate that both groups empathetically identify most closely with other second generation Asian women. Therefore a limitation of the study is that what (if any) effect the ethnicity of the researcher had on the results was not examined. One way of assessing this would have been for a female researcher of native British origin to re-administer the identity instrument with a small sample of participants.

### *Ethical issues*

This study only assesses the relationship between cultural identity and psychological distress among Asian women and by focusing on a single cultural or ethnic group, there is the danger that this cultural group will become "pathologised". This raises ethical issues due to the stigma associated with mental health, but also because it reinforces the stereotype that culture is a concept that is only of significance for "visible" minority ethnic groups. In reality, there is variation in the cultural experience of mental illness among native British individuals (See Jadhav, Weiss and Littlewood, 2001) but this is rarely examined. When reflecting on how living in a multi-cultural society influences identity development, the impact of cross-cultural interactions on native British society is often neglected. This implies that any difference

between cultures only influences minority ethnic groups. These concerns would be particularly pertinent for second generation populations who perceive themselves to be bicultural. The other risk associated with examining psychological distress in relation to culture is that other important issues may become decontextualised and/ or masked. Therefore, services may become inaccessible as other difficulties, such as domestic violence and abuse, are not adequately assessed (Chantler, et al., 2001). It was not possible to include other ethnic groups in the present study due to limited time and resources; however this is felt to be an essential way in which this study could be extended by future research.

#### ***4.4 Conclusions***

The present study may be considered as exploratory in nature and so care must be taken when interpreting the findings. The results imply that even women who consider themselves to be bicultural experience psychological distress, which is in contrast with much of the literature. Second generation Asians, by virtue of being raised and educated in the UK, will form cross-cultural identifications. Therefore, it may be that simply focusing on acculturation vs. traditionalism is of limited theoretical value with this generation. Similar to other theoretical debates such as nature vs. nurture, it may be far more useful to acknowledge the involvement of, and develop an understanding of, both influences, that is, how differing degrees of biculturalism impact on mental health.

The results indicate that wanting to dissociate from the values of significant others may not be stress inducing when considered in isolation. Therefore, this needs to be considered together with the extent to which a person shares qualities with significant others. Consequently, the pressure associated with integrating or synthesising the conflicting social and emotional demands of home and wider society may increase vulnerability to psychological distress. In some instances a pronounced inability to form a sense of coherent identity was associated with psychological distress. However, when this sense of confusion was experienced to a milder degree it seemed to serve as a trigger for identity development and progress.

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## Appendix A

### *Covering letter*

I would like to invite you to take part in some research that is currently being conducted within our department. The aim of this study is to gain a better understanding of the experiences of Asian women living in the UK compared with women from different ethnic backgrounds. It is hoped that this research may help to develop strategies for improving health services and make them more accessible. In particular, the researcher is interested in studying **Asian women that were either born in the UK or moved to the UK before the age of 5 years.** *If this does not apply to you please ignore this letter.*

Enclosed is an information sheet detailing the study, which includes the name and contact details of the researcher, Ms. Kajal Patel, whom you are free to contact if you have any further questions. It is up to you whether or not you want to take part. If you would like to participate in this study, please complete the attached slip giving permission for the researcher to contact you directly, and return it in the enclosed stamped addressed envelope. If you decide not to participate in this study, the standard of care you receive will not be affected in any way.

Thank you for taking the time to read this.

## *Information Sheet*

### **Title**

How do the experiences of living in the UK impact on the well being of women?

You are being invited to take part in a research study. It is important for you to understand why the research is being done and what it will involve before you make a decision. Please take the time to read the following information carefully and ask if there is anything that is not clear or you would like more information. Thank you for reading this.

### **Purpose of the study**

The main aim of the study is to gain a better understanding of the experiences of Asian women living in the UK compared with women from different ethnic backgrounds. It is hoped that this research may help to develop strategies for improving health services and make them more accessible.

### **Why have I been chosen?**

All of the women asked to participate in this part of the study have been selected randomly whilst attending their GP on the basis that they are of Asian origin. It is hoped that at least 20 women will take part.

### **Do I have to take part?**

It is up to you decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even after giving consent you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

### **What the study involves**

This study will take approximately 1-1<sup>1/2</sup> hours to complete and will consist of a single meeting. It will involve completing a few short questionnaires related to how you have been feeling over the last few weeks, and generally about life events that have occurred over the past year. It will also involve questions about how you view yourself and other people.

In some cases, participants may be contacted at a later date and asked to take part in a short interview. The interview would be audio-taped and the tapes would be wiped at the end of the study. This is entirely voluntary and refusal to participate will not affect your contribution to the first part of the study in any way.

### **What are the potential harmful effects of taking part?**

We do not expect this research to be distressing in any way. However, the researcher is available to answer any questions and direct you to the appropriate person if you have any concerns following taking part in this study.

## **Confidentiality**

All of the information you give during the course of this research will be kept strictly confidential and will not be used for any purpose other than research. Any information that you provide will have your name and address removed so that you cannot be recognised from it. The data will be kept in a lockable storage facility and only the main researchers will have access to it.

Your GP will be informed that you are taking part in this study, however details of your responses will be confidential.

## **Contact for Further Information**

Ms. Kajal Patel  
Clinical Psychologist in Training  
Doctor of Clinical Psychology Course  
University of Hertfordshire  
Hatfield Campus  
College Lane  
Hatfield  
Herts. AL10 9AB

01707 286 322



*Response slip*

I have read the letter inviting me to take part in a research study focusing on the experiences of **Asian women that were either born in the UK or moved to the UK before the age of 5 years**. I confirm that the researcher (Kajal Patel) has my permission to contact me directly to arrange a mutually convenient time to meet.

Signature:.....

Name:.....

Address:.....

.....

Tel No.....

Date:.....

*Thank you for taking the time to complete this slip.*

## Appendix B

### ***Demographic Information***

*Identification number/code:*

#### Inclusion criteria

Where were you born?

(If outside UK, date of arrival in UK)

What is your religion?

How would you define your ethnicity?

What is your date of birth?

Where were your parents born?

What is your marital status? (Single/Married/Divorced/Separated/Widowed)

Who do you live with?

Do you have friends/family that live close by?

Who do you turn to when you are feeling worried or down?

What is your first language?

What is your preferred language?

Are you currently employed/in education?

(If yes, give details)

What educational qualifications do you have?

## Appendix C

### *The Life Events Inventory*

Which of these events, (if any) have you experienced in the past year? (circle as appropriate)

- |   |        |
|---|--------|
| 1. Unemployment (Head of household)                                 | YES/NO |
| 2. Trouble with superiors at work                                   | YES/NO |
| 3. New job in same line of work                                     | YES/NO |
| 4. New job in new line of work                                      | YES/NO |
| 5. Change in hours or conditions in present job                     | YES/NO |
| 6. Promotion or change of responsibilities at work                  | YES/NO |
| 7. Retirement   | YES/NO |
| 8. Moving house   | YES/NO |
| 9. Purchasing own house (taking out mortgage)                       | YES/NO |
| 10. New neighbours  | YES/NO |
| 11. Quarrel with neighbours   | YES/NO |
| 12. Income increased substantially                                  | YES/NO |
| 13. Income decreased substantially                                  | YES/NO |
| 14. Getting into debt beyond means of repayment                     | YES/NO |
| 15. Going on holiday  | YES/NO |
| 16. Conviction for minor violation (e.g. speeding or drunkenness)   | YES/NO |
| 17. Jail sentence   | YES/NO |
| 18. Involvement in a fight  | YES/NO |
| 19. Immediate family members starts drinking heavily                | YES/NO |
| 20. Immediate family member commits suicide                         | YES/NO |
| 21. Immediate family member sent to prison                          | YES/NO |
| 22. Death of immediate family member                                | YES/NO |
| 23. Death of close friend   | YES/NO |
| 24. Immediate family member seriously ill                           | YES/NO |
| 25. Gain of new family member (immediate)                           | YES/NO |
| 26. Problems related to alcohol or drugs                            | YES/NO |
| 27. Serious restriction of social life                              | YES/NO |
| 28. Period of homelessness (hostel or sleeping rough)               | YES/NO |
| 29. Serious physical illness or injury requiring hospital treatment | YES/NO |

- |  |        |
|--|--------|
| 30. Prolonged ill health requiring treatment by own doctor | YES/NO |
| 31. Sudden and serious impairment of vision or hearing     | YES/NO |
| 32. Unwanted pregnancy                                     | YES/NO |
| 33. Miscarriage  | YES/NO |
| 34. Abortion   | YES/NO |
| 35. Sex difficulties                                       | YES/NO |

***Experience of prejudice/ discrimination***

Have you ever experienced prejudice in/with any of the following areas/agencies?

- |                |        |
|----------------|--------|
| 36. Employment | YES/NO |
| 37. Housing    | YES/NO |
| 38. Education  | YES/NO |
| 39. Social     | YES/NO |
| 40. Police     | YES/NO |
| 41. Government | YES/NO |

## Appendix D

### *Semi-structured Interview*

#### *Work Situation*

**Are you currently working?**

(If yes) What do you do?

**How did you get into this field?**

(If no) What things do you do during the day?

#### *Background, family life, significant events and changes in self growing up*

**How long have you lived in this area?**

Where did you move from?

When did you move to London?

Where did your parents come from?

**Who do you live with?**

**Do you have any brothers or sisters?**

Where do they live?

Which of your brothers/sisters do you have the best relationship with?

**Do you have any relations living with you or nearby?**

**Who?**

How well do you know/get on with them?

**What made your parents move to the UK?**

**What kind of school did you go to?**

**What were you like when you were younger?**

How have you changed?

**What is the most important thing that has ever happened to you?**

**What kinds of things make you happy?**

**Can you tell me about the unhappy times in your life, what kinds of things make you unhappy?**

#### *Present-Friends and others*

**Do you have many friends?**

Who are they?

What are they like?

Are they like you (in terms of personality)?

How are they like you?

What things do you have in common?

How are they different from you?

**Are your friends like each other?**

In what way?

How are your friends different from each other?

**What are people at work like?**

Are they like you?

Do you have much in common with them?

How are they different from you?

**Are there many White/native British people where you work (socialise if not at work)?**

How are they like you?

How are they different from you?

**What kind of people are the White/native British?**

**What kind of people are Asians/Indians?**

**How do other people see you?**

How do White/native British see you?

How do Asians/Indians see you?

**How are Indian people different from White/native British people?**

**How are they alike?**

**Do you have any White/native British friends?**

Are they like you? How?

Are they different from you? How?

**Some people feel that Asians/Indian people in this country are a problem**

Do you think it is a problem? (For the Asians. For the White/native British)

What are the difficulties?

How could they be solved?

**Thinking of all the people you know, are there any people you don't like?**

What is it you don't like about them?

What kind of things do you dislike in people?

*Present - Opposite sex*

**Are you currently in a relationship?**

**Would you go out with/marry a White/native British man/woman?**

Why is that?

**What do you think of other people who do?**

*Present – Parents*

**How would you describe your parents?**

**How do you get on with them?**

Your mother?

Your father?

**Do you have many disagreements with them?**

Why is that?

What happens when you disagree with your mother/father?

**How would you describe yourself?**

**Generally do you feel that you are able to do things as well as other people?**

*Future – Self*

**How do you see yourself in the future?**

**How would you like to be?**

**Who are the people you admire?**

What do you admire about them?

*Socialisation*

**If you have a problem who would you turn to?**

Why?

**Is religion important to you?**

**Do you go to the temple (other religious practice) regularly?**

**Quite often people can't do what they want.**

Are there times when you can't do things?

What stops you?

What about your friends?

**Do you think people are free to do what they want?**

Are you?

What sort of people can't do what they want?

Why can't they?

*Views on society*

**What is it like to live in London?**

How do you family and friends feel about it?

**What is it like to live in England?**

How do you family and friends feel about it?

**Where would you like to live?**

**Are there any times when you think its right for people to be treated differently?**

Should immigrants/people born in this country always be treated the same?

**What kind of things do you most enjoy doing?**





**Appendix F**

Identification number:

**CONSENT FORM**

How do the experiences of living in the UK impact on the well being of women?

**Name of Researcher:** Kajal Patel

**Please initial box**

- 1. I confirm that I have read and understood the information sheet dated (.....2003) (version....) for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical or legal rights being affected.
- 3. I understand that sections of any of my medical notes may be looked at by responsible individuals from the NHS where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.
- 4. I agree to take part in the above study

..... Name of participant	..... Date	..... Signature
..... Name of researcher	..... Date	..... Signature

## Appendix G

Kajal Patel  
Doctor of Clinical Psychology Course  
University of Hertfordshire  
Hatfield Campus  
College Lane  
Hatfield, Herts.  
AL10 9AB

Dr. (GP)

23<sup>rd</sup> June 2003

Dear Dr. (GP),

I am a final year Clinical Psychologist in Training currently studying at the University of Hertfordshire. For my doctoral thesis, I plan to research the role cultural identity and psychological distress amongst second generation Asian women. It will involve completing a few short questionnaires related to the person's mood, and generally about life events that have occurred over the past year. It will also involve questions about how the person views themselves in relation to other people.

I am writing to inform you that your patient **Ms. X** has agreed to participate in my study.

Please feel free to contact me if you require more information about the research or have any views or concerns. If I do not hear from you I will assume that you do not have any objections.

Yours sincerely,

Kajal Patel.

Victory House  
170 Tottenham Court Road  
London W1T 7HA  
Tel: 020 7756 2500  
Fax: 020 7756 2502

Chair                      Marcia Saunders  
Chief Executive        Christine Outram

1<sup>st</sup> November 2002

Miss Kajal Patel  
Clinical Psychologist in Training  
Doctor of Clinical Psychology Course  
University of Hertfordshire  
Hatfield Campus, College Lane  
Hatfield, Herts, AL10 9AB

Dear Ms Patel

**119/02 – Does identification conflict increase vulnerability to psychological difficulties**

Acting under delegated authority I write to confirm that the above study was considered at the LREC meeting held on 29<sup>th</sup> October 2002 and was approved. There is now no objection on ethical grounds to the proposed study. I am therefore happy to give you the favourable opinion of the LREC on the understanding that you will follow the conditions set out below:

- You do not undertake this research in a NHS organisation until the relevant NHS management approval has been gained as set out in the Framework for Research Governance in Health and Social Care.
- You do not deviate from, or make changes to, the protocol without prior written approval of the LREC except where this is necessary to eliminate immediate hazards to research participants, or when the change involves only logistical or administrative aspects of the research.
- You send an interim report to this LREC in one year's time or when you have completed your research or if you decide to terminate it prematurely.
- You advise this LREC of any unusual or unexpected results that raise questions about the safety of patients taking part in the research.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please quote LREC number 119/02 on any future correspondence.

With best wishes.

Yours sincerely

---



**Psychology Department Research Project**

**Investigator Name** Kajal Patel

**Title** Identification of vulnerability to psychological difficulties in second generation Indian women

**Registration Protocol Number** PSY 010

The approval for the above research project was granted on 9<sup>th</sup> June 2003 by the Ethics Committee of the Psychology Department under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed

A handwritten signature in black ink, appearing to be 'Kajal Patel', written over a horizontal line.

Date

12/6/03.

Chair  
Psychology Ethics Committee

# **Critical Review**

Identification of vulnerability to psychological difficulties in second generation South Asian women

**Kajal Patel**  
**November 2003**

### *Title*

Identification of vulnerability to psychological difficulties in second generation South Asian women

### *Question*

What is the impact of cultural identity on the mental health of second generation South Asian females?

### *Design*

Non-experimental, cross-sectional study

### *Participants*

30 South Asian women who were born in the UK or moved to the UK before the age of 5 years participated. This study used a convenience sample of participants that were accessed via primary care, clinical psychology services and a student population.

### *Method*

The General Health Questionnaire (GHQ-12; Goldberg, 1972) was used to estimate psychological symptom levels in order to categorise the sample into two groups (clinical vs. non-clinical) according to 'caseness'. These groups were then compared on a range of identity parameters drawn from Identity Structure Analysis (ISA; Weinreich, 1979, 1980), which is a meta-theoretical framework designed to investigate cultural identity and acculturation. A more detailed psychological profile of participants was provided using the Brief Symptom Inventory (BSI; Derogatis and Melisaratos, 1983).

### *Main results*

The results indicated that both the clinical and non-clinical groups identified closely with representatives of both Asian and native British culture, which suggests that both groups viewed themselves as being bicultural. There were no differences between the groups in the extent to which they viewed their parents and representatives of Asian culture as having characteristics they wished to dissociate from; with the exception of first generation Asian males whom the clinical group were significantly more likely to view as having qualities they wished to dissociate from than the non-clinical group. The clinical group were significantly more likely than the non-clinical group to view their fathers and first generation Asian females

as having some qualities which they identified with and some that they simultaneously wished to dissociate from, thereby creating a conflictual state (conflicted identification). When these conflicted identifications were considered across a range of significant others (identity diffusion), there was no difference between the groups. Identity diffusion was positively correlated with some of the BSI symptom dimensions for the clinical group and negatively correlated for the non-clinical group.

### *Conclusions*

The results imply that even women who consider themselves to be bicultural experience psychological distress. This is in contrast with much of the literature which suggests that by identifying with one culture, second generation women are in conflict with the other resulting in psychological distress. Another finding was that wanting to dissociate from the characteristics of representatives of Asian culture was not thought to be associated with psychological distress when considered in isolation. Instead the results suggest that potential psychological stressors include the experience of integrating the conflicting demands of home and wider society, that is, difficulties synthesising identifications when a significant other has some qualities one identifies with, and others which one would wish to dissociate from. When identifications with a range of significant others were highly conflictual in nature this was associated with a negative effect on one's sense of well-being, however when this was experienced to a milder degree it appeared to serve as a trigger for identity development.

### *Clinical implications*

#### *Working therapeutically*

This study may be considered to be exploratory in nature, and therefore it is difficult to draw firm conclusions regarding clinical implications on the basis of these findings. However, the results indicate that considering cultural identity when working therapeutically with second generation Asians may be of great importance. This research provides support for the view that being born and raised in the UK is likely to lead to the development of a bicultural identity, that is, second generation Asians are likely to identify with both Asian and native British culture. There is also some support for the hypothesis that vulnerability to psychological distress may be increased by viewing oneself as both identifying with one's Father and first generation female representatives of Asian culture, and also wanting to dissociate from their values and beliefs (identification conflict). This is in contrast with literature which suggests that second generation Asian women identify more with one culture.



thereby rejecting the other (Ballard, 1979; Bhugra, Bhui, Desai, and Singh, 1999c). The implication of this is that it may be damaging to encourage second generation Asians to reject the views of their families in favour of becoming more autonomous or acculturated, as they clearly identify with and value the influence of both Asian and native British cultures. Instead it may be more beneficial to focus on difficulties in integrating these identifications across cultures.

When working clinically it may be of use to explore the meaning of culture for the individual and how identifications with both cultures may be synthesised or integrated to form a cohesive sense of self. This may involve firstly considering the positive aspects of identifying with two cultures and highlighting that it is not necessary to favour or devalue one culture in favour of another (empathetic identification). Secondly, if there are aspects of Asian culture that a person disagrees with, for example, values relating to community, it may be threatening to reject these totally (contra-identification). Instead it may be of use to examine how elements of these wider cultural beliefs fit with the individual's own values relating to community (reducing contra-identification). In other words, the psychological distress experienced as a result of being unable to synthesise identifications across two contrasting cultures (identification conflicts) may be addressed by increasing awareness of the characteristics that the client shares with representatives of Asian culture and reducing the extent to which they wish to dissociate from Asian culture. Therefore, re-evaluating oneself (Ali and Northover, 1999) and one's values in relation to others may be a way of reducing the conflicted identification which results from identifying with more than one culture.

The results suggest that wanting to dissociate from the values of one's father and extended family (first generation Asian females) may increase vulnerability to psychological distress. When considered in conjunction with literature that highlights the importance of collectivism among Asian culture, this implies that family work may be of value. Including families may also be a way of reducing feelings of distrust towards services. Family sessions could be used to explore how differences in opinion and conflict are managed. Also, the literature suggests that first generation Asians have concerns about losing their culture of origin if their children identify closely with native British culture. Consequently, they may be restrictive towards their children. The anxieties of the family about losing their heritage and how these impact on their parenting are also issues that may be addressed in family sessions. This is essential as part of the problem may stem from the fact that the parents and extended family of the client

do not identify with native British culture to the same extent as their children. However the limitations of this idea are that it may be difficult to engage families in this process due to suspicion towards mental health services and concerns regarding stigma and confidentiality (Bhugra, 1993). This is an area that would be worth exploring further in future research.

It is also important to draw attention to the fact that cultural identity is only one part of a person's overall identity. Therefore, although it is of value to address cultural identity when working therapeutically, care must be taken to ensure that issues relating to culture do not mask or take precedence over other issues of importance. A related point is that the results also indicate that conflicted identifications with a range of significant others (identity diffusion) is not necessarily negative as it may serve as an impetus for change or redefinition of one's identity (Weinreich, Luk and Bond, 1996) when experienced to a mild degree.

### *Training*

The training of professionals working in mental health is based on "western" models of individualism and autonomy (Bains, 2001). Consequently many professionals may feel deskilled and overwhelmed when working with issues concerning cultural identity and acculturation. Therefore further training may be needed to help support professionals when working therapeutically with cultural groups that value community involvement and interdependence to consider how these values may be integrated into their existing models of working. This may be especially important with second generation Asians as the emphasis of therapeutic work relating to culture may well be focusing on an exploration of the meaning of culture and what it encompasses, and how identifications with different cultures can be balanced. Further training may relieve some of the pressure felt by professionals to have an in-depth understanding of all cultural groups.

### *Service provision*

It has been argued that the mental health needs of first and second generation Asians differ, which leads to the question of whether or not there should be separate services for these two populations. Arguments in favour of having separate services include the view that at present professionals may lack the skills and/ or knowledge to be able to adequately manage the distress associated with being unable to integrate identifications across cultures. This is because for first generation Asians the emphasis would be on how to adapt to a new culture and way of life following migration. This has different implications for identity development

than for the second generation who are negotiating an identity that is influenced by two contrasting cultures. Another view is that existing services for Asian women may place an emphasis on cultural values and religious beliefs that are of limited relevance for second generation Asians. The results of this study provide some support for this as they indicated that traditionalism and religion were both inconsistently applied dimensions of identity when evaluating significant others. The participants in this study are predominantly in their late teens and early 20's, and therefore it is difficult to draw any conclusions about adolescents. It may be that for younger clients a specialist service may be more appropriate as this may be better resourced to deal with family work, and the issues faced by first generation Asians. Adolescence is a significant stage of transition and identity development, and this may be a time when some second generation Asian females have an increased vulnerability to developing symptoms of psychological distress. Therefore there may be a greater need for specialist intervention at this time.

An argument against having a separate service for first and second generation Asians is that focusing on the differences between these two populations promotes specific service solutions, as opposed to solutions which promote equal service provision and access (Bhui and Sashidharan, 2003). Similarly, setting up specialist services which focus on the cultural needs of particular ethnic groups implies that culture is not of relevance for the majority population, and suggests that culture is a problematic aspect of identity (Bhui and Sashidharan, 2003). Bearing in mind that the second generation women in this study were found to identify strongly with both Asian and native British culture, the question of whether or not they would prefer to be seen in specialist services for Asian women or mainstream mental health services needs to be addressed. Also, second generation Asians would not face the same language barriers as the first generation, which would reduce the need for ethnic matching between client and therapist.

A limitation of the present study is that information on help-seeking behaviour was not obtained. Some of the participants in the clinical group obtained high scores on the screening measure for psychological distress, and therefore it would have been of value to examine how many of these women were in touch with services. This links in with the fact that little is known about the attitudes of second generation Asians towards mental health services and help-seeking. This is an area that needs to be researched before further recommendations about service provision can be made. Since an important limitation of the above clinical

implications is that many of these ideas can only be implemented once a service has been accessed. The experience of conducting this research project and the literature both indicate that services are underused, and therefore more work in the area of increasing awareness of existing services (mental health promotion) and understanding difficulties relating to access are needed.

### *Recruitment*

The sample size in this study was small due to problems in recruiting participants. In the early stages of the study, many difficulties were experienced when trying to determine a suitable setting from which participants could be recruited. The literature indicates that psychotherapy services are underused by minority ethnic groups (Commander, Sashidharan, Odell et al., 1997b; Wilson and MacCarthy, 1994) and this was supported by the low numbers of referrals received for Asian women within several local psychology departments. It is not clear how these rates of referral compare to services in areas in which there is a higher population of Asian women, which may be useful to explore in future studies.

Numerous GP practices in the local area were therefore also approached and asked if participants could be recruited via their waiting rooms. Interestingly, great variation existed between GP's in terms of a willingness to support psychological research and attitudes towards mental health. Some GP's were of the view that inviting their patients to participate in research relating to mental health may cause offence. Those who were in favour of promoting the research were noticeably more open about mental health related issues, for example they had posters in the waiting area highlighting the symptoms of depression and how to access help.

A widely held view concerning the help-seeking behaviour of people from the Asian community is that they may under use mental health services as they find them inaccessible and unable to meet their needs. Therefore, a number of local community organisations which have been designed specifically to address the needs of Asian women were identified and approached as potential sites for recruiting participants. Of the five main local services approached, none agreed to participate. In some cases this was partly due to suspicion about the process of research and of mental health services, and in others it related to concerns about protecting the confidentiality of women using the service. Two of the organisations expressed some interest in possibly participating at some point in the future, but did not have any clients

who may be classed as second-generation. It was noteworthy that all of these voluntary services were severely under-resourced, which may have been part of the reason why they were reluctant to take part.

When considered all together these recruitment difficulties raise the question if second generation Asian women are under-represented among psychotherapy services and are unlikely to attend voluntary organisations, what is the best way to recruit this population for research? A popular way is to use primary care or student populations as they are the most accessible. However as implied above this is dependent to some degree on the attitudes of primary care services. Although this is clearly a convenient and logical alternative to targeting mental health services and community organisations, the main difficulty with this is that it is harder to conduct research with women suffering from specific disorders. This is partly because it is more time consuming as it may be necessary to use several stages/ measures to identify an appropriate sample, for example, an initial screen for the presence of psychological distress and then more detailed clinical interviews. However, recruiting women in this way does provide the opportunity to elicit attitudes towards help-seeking, and mental health services in particular, which is valuable.

#### *Future research*

This study may be extended by future research in a number of ways. One way would be to focus on a specific clinical population such as women with eating disorders, or women who attempt suicide. However, to do this would involve addressing the issues relating to recruitment outlined above. It has been argued that it is important to understand the views of members of dominant society and their relationships with minority ethnic populations in order to fully understand minority ethnic groups (Berry, 1986). Therefore, it may be useful to include a comparison group of native British women. This would also indicate if the findings pertaining to identity and psychological distress are specific to Asian women or not. Similarly, in order to assess the importance of culture and negotiating two opposing cultures, it would be of value to also include a sample of second generation women from a different cultural background, for example, Afro-Caribbean women. Based on the literature relating to racism and discrimination, including a sample of second generation women of Irish origin would provide a useful way of assessing the impact of racism on mental health. This is because Irish women may experience similar difficulties in relation to negotiating two

cultures, but as "non-visible" minorities would not experience racism and prejudice in the same way.

There has been much research on the mental health of first generation minority ethnic groups and the effects of migration and acculturative stress on mental health. In order to truly illustrate how the experiences of first and second generation women differ, a direct comparison of the identity parameters of these two populations is needed. This was not possible in the present study due to limited time and resources, as it would have been necessary to translate all of the measures in order to make the research equally accessible to all Asian women. Similarly, comparing the identity parameters of men and women may be a way to highlight important gender differences.

The identity instrument itself could be developed further by including meta-perspectives, for example "me as my Mother/ Father sees me". This in conjunction with the existing data would provide useful information about how relationships with significant others are construed. Also, it would be useful to interview selected participants using the results of the identity instrument as a basis for exploring the concept of cultural identity and psychological distress in more detail. This would be in line with Kelly's (1955) theory of personal construct psychology on which Identity Structure Analysis is based, and it would also give an indicator of the accuracy of the identity parameters produced by ISA. Finally, it may be of value to elicit constructs using focus groups including participants from different cultural backgrounds in addition to individual interviews when creating future identity instruments. This may provide a more accurate indicator of constructs relating to the current socio-political context and experiences of living in a multi-cultural society.

### *Measures*

Existing research investigating issues relating to acculturation and cultural or ethnic identity has been conducted mainly using interviews or questionnaires. Examples of questionnaires include the Cultural Values Conflict Scale (CVCS; Inman, Ladany, Constantine et al., 2001) and the Asian Cultural Identity Schedule (ACIS; Bhugra, et al., 1999c). The advantages of using questionnaires are that they are quick and easy to administer and they lend themselves well to a hypothetico-deductive way of working, that is hypothesised relationships can be specified and statistics can be used to examine to what extent the data meet predictions. The disadvantages are that topics such as cultural identity are huge and incredibly complex areas

and therefore questionnaires run the risk of oversimplifying important issues. Also, the topic areas will be predetermined and may not be based directly on the experiences and the values of the women participating in the study. For example, the items included in the Cultural Values Conflict Scale were selected following a review of the relevant literature and their wording was amended according to qualitative feedback from a small group of participants and consultation with experts. As a result the scale becomes slightly decontextualised as it focuses on the two main areas of intimate relations and sex role expectations, but neglects socio-cultural issues such as relationships with wider society and the influence of prejudice.

Advantages of qualitative research methods are that it is possible to study individuals in some depth and avoid the difficulty of complex information being oversimplified. They also impose fewer restrictions on the type of data provided by a participant, and are able to paint a more vivid picture of the experiences of individual participants. However, the limitations of this type of research are that it is harder to generalise the findings and make comparisons between groups of individuals.

Identity Structure Analysis (ISA) incorporates both qualitative and quantitative techniques as the identity instrument used is created based on interviews with the population of interest. The identity instrument includes values pertaining to culture that are meaningful to participants, and requires participants to rate significant others in relation to these values. The advantages of this technique are that it provides rich and detailed information about the extent to which participants identify with significant others and about their identity states. As the results outlined above illustrate it would be simplistic to argue that cultural identity relates to identification with one culture alone. Also, by including significant others it encompasses the social world of the participants of interest. It is not thought to be possible to obtain this type of information from questionnaires or interviews alone. However, the disadvantages are that ISA is a technique which is theoretically extremely complex, and the identity instruments are time consuming to administer and interpret.

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**"Critically evaluate the concept of "dual diagnosis" and argue its degree of relevance to treatment planning".**

**KAJAL PATEL  
OCTOBER 2001  
ESSAY 1  
YEAR 1**

Diagnosis is the process by which clinicians identify a disorder, and use groups of frequently occurring signs and symptoms to allocate it to a category (Gelder, Gath and Mayon, 1989). The most common method of diagnosis involves the use of two main classification systems, the Diagnostic Statistical Manual (DSM-IV; American Psychiatric Association, 1994) and the International Classification of Diseases (ICD-10; World Health Organisation, 1992). The following essay aims to discuss the advantages and disadvantages of diagnosis and dual diagnosis, and argue the importance of the concept of dual diagnosis, using the example of substance abuse and psychiatric disorder, when planning treatment.

Diagnosis provides a framework from within which an understanding of a person's difficulties may be developed. More recent systems of classification such as DSM-IV use a multi-axial system for diagnosis. Each of the five axes represents a different area of functioning that the client may be evaluated on. This reflects the idea of a move away from a traditional medical model approach, towards a model that encompasses the biological, psychological and social (biopsychosocial) aspects of a person's difficulties. Clinicians are required to consider factors such as personality traits or disorders, physical problems and life stressors when making a diagnosis (Ryglewicz and Pepper, 1996). Diagnosis is therefore an important aid to treatment planning as it may be helpful when deciding which clients can access different forms of treatment or intervention, and how effective different forms of therapy are (Reiss, 1994). Or, it may be used to guide the prescribing of medication. Diagnosis can also be used to give an indication of how a disorder is likely to progress; its severity and approximate duration in the absence of any treatment or intervention (Ryglewicz and Pepper, 1996; Blashfield, 1998).

It is convenient to use diagnoses to describe clients when communicating with other health professionals. This is because a diagnosis is a concise way of describing symptom clusters. It enables professionals to liaise and plan treatments without having to describe all of the symptoms of an individual case. The use of different diagnostic labels provides staff working in the area of mental health with a common language or vocabulary to use when discussing clients (Blashfield, 1998).

Diagnostic categories are used when conducting epidemiological research. Epidemiological research plays an important role in health service planning and delivery as it involves the study of incidence and prevalence rates for disorders within a population. These rates are used

to allocate services, for example inpatient beds, within the health system. This type of research is also valuable when assessing unmet treatment needs within a society or community, and can be useful in identifying groups of people that are not accessing services (Ryglewicz and Pepper, 1996). Another area of research in which diagnoses are of use is in developing knowledge of psychiatric symptoms. This is because once clients have been allocated to a diagnostic category it is possible to research aetiology and different treatment options for a group of clients with a specific set of symptoms (Davison and Neale, 1998).

The issue of the reliability and validity of diagnoses is a divided one, and may be considered to be both an advantage and a disadvantage. When making a diagnosis using DSM-IV and ICD-10, explicit rules or criteria are specified to help a clinician decide whether or not a client should be included in a diagnostic category, resulting in high objectivity and reliability. Several studies have found that diagnostic systems such as DSM-IV and ICD-10 have high inter-rater reliability (Davison and Neale, 1998), supporting the view that diagnoses can provide an effective means of communication between professionals. The validity or, ability to differentiate a particular diagnosis from other disorders using diagnostic systems, is also high (Feighner and Herbstein, 1987; Davison and Neale, 1998). Therefore, diagnoses can be used to make reasonably accurate statements and predictions about the prognosis of a disorder (Davison and Neale, 1998).

However, despite all of the effort made to produce high levels of reliability and validity when applying diagnostic categories, a great deal of subjective judgement is still required on behalf of the clinician (Davison and Neale, 1998). This may result in any biases the clinician holds influencing how likely a client is to be given a specific diagnosis. Also, improving reliability by introducing operational criteria does not guarantee high validity, therefore, increasing the reliability of a diagnosis does not ensure that it will provide more useful information for treatment planning (Blashfield, 1998).

The use of a diagnostic system involves classifying clients according to their similarities and does not take into account individual differences (Blashfield, 1998). Often important differences are ignored so clients can be fitted into categories (Gross, 1992). One example would be that by diagnosing clients according to strict criteria, the focus is on common areas of difficulty. Consequently, the individual client's existing coping skills are not considered,

and these may be very useful when planning treatment. The use of diagnosis fails to consider wider factors that may have an influence on a person's mental health such as his/her social support network (Ryglewicz and Pepper, 1996), quality of home life, age, gender, culture and socio-economic status (Swanson, Holzer, Ganju and Jono, 1990). This poses the question of how a holistic care approach can be provided if such significant information is not considered.

Both ICD-10 and DSM-IV have been criticised for being "culturally insensitive" and predominantly aimed at diagnosing western populations (Radden, 1994: cited in Fulford, 1999). One reason is that religious/spiritual experiences have been found to be quite similar in presentation to severe psychiatric symptoms, and to simply look at the duration of the experience is not enough as both may be enduring (Fulford, 1999). For example, a mother was legally denied access to her child who had been paralysed by meningitis, because she had been praying and fasting for his recovery, as she believed that demonic forces had caused his illness. She was given a diagnosis of paranoid schizophrenia (Redlener and Scott, 1979: cited in Loewenthal, 1999). Another reason is that symptoms and behaviours may be culturally related and therefore, differ between ethnic groups leading to misdiagnosis (Jones and Gray, 1986: cited in Juss, 1999). For example, Caribbean men are ten times more likely to be diagnosed as having schizophrenia than native British men.

A diagnosis of mental illness may be very stigmatising for an individual. This may result in him/her being guarded to prevent others finding out about his/her diagnosis, which may have a negative impact on the person's ability to form new relationships. It may also have an impact on existing relationships as the person may be treated differently by friends and family. Finding employment may be difficult for a person labelled as having a mental illness, particularly if the employer has a limited understanding of the illness (Davison and Neale, 1998). Labelling may lead to self-fulfilling prophecies, and so if an individual is labelled as deviating from the norm in some way due to mental illness, this may increase his/her deviant behaviour further (Goffman, 1961: cited in Blashfield, 1998).

Dual diagnosis is not a formal term that can be found in ICD-10 or DSM-IV, it simply refers to any sets of symptoms that meet the criteria for two separate diagnoses (Frances, Widiger and Fyer, 1990: cited in First and Gladis, 1993). When diagnosing a person with multiple difficulties both ICD-10 and DSM-IV recommend that a primary diagnosis be identified. The

primary diagnosis being that which led to the referral or contact with mental health services. Or, it may be a "lifetime diagnosis", for example, a client with schizophrenia. The primary diagnosis is the focus of any treatment intervention.

One definition of dual diagnosis is when, " the patient suffers from two initially unrelated disorders that may interact to exacerbate each other" (p.1022, Lehman, Myers and Corty, 1989). This is not possible to determine using a formal classification system such as DSM-IV or ICD-10, because very often the two disorders are conceptually divided. For example, DSM-IV and ICD-10 can be used to describe symptoms for depression not related to substance abuse, and symptoms of substance abuse not related to depression quite clearly. This lends itself well to organising the disorders into primary and secondary diagnoses, but opposes the idea of an interaction between the two disorders. Therefore, the concept of dual diagnosis occurs as the two disorders are separated.

A useful way of exploring the importance of the concept of dual diagnosis in relation to treatment planning is to use the example of a common dual diagnosis, namely psychiatric disorder and substance abuse. Menezes, Johnson, Thornicroft, Marshall, Prosser, Bebbington and Kuipers (1996) interviewed one hundred and seventy one (171) clients with a psychotic illness within two London community mental health teams (CMHT) and found a one year prevalence rate of 36.3% for substance abuse. They found that clients that abused substances were 1.3 times more likely to use emergency services and spent almost twice as many days in hospital. Glass and Jackson (1988) carried out a study at the Maudsley and found that 10% of psychiatric patients abused alcohol, and 40% of clients who were diagnosed as alcohol dependent also had a psychiatric illness.

In South Westminster, Duke, Pantelis, and Barnes (1994) assessed two hundred and seventy one (271) people with schizophrenia for alcohol-related problems. They found that 22% had a lifetime prevalence of alcohol abuse. Although the duration of their illness was shorter, this group had higher rates of anxiety, depression, hostility and hallucinations. Smith and Hucker (1994) claim that substance abuse in clients with schizophrenia is usual not exceptional. Due to the fact that substance use tends to be under reported, it is possible that dual diagnoses are even more widespread than the results of these studies would lead us to believe.

Clients with a dual diagnosis of psychiatric disorder and substance abuse disorder have been found to have greater levels of social disability, for example, relationship problems and unemployment, than clients of comparable age, gender and socio-economic status (SES). They are also thought to have a poorer prognosis, difficulties with impulsivity and are less likely to comply with treatment (Mirin and Weiss, 1991).

Diagnosis and classification should be guided by how useful the information is when making therapeutic decisions and co-ordinating care provision (Lehman et al. 1989). One of the main difficulties within the area of dual diagnosis is that it is difficult to develop diagnostic categories as not much is known about the development of dual disorders. We have limited information on what is therapeutically useful, service use by clients with dual diagnosis over long periods of time, and how the course of dual disorders is affected by long-term interventions (Brown, Ridgely, Pepper, Levine and Ryglewicz, 1989). Therefore, we are still developing an understanding of how to use assessment and diagnosis in a way that informs decisions on the most appropriate form of treatment (Lehman et al. 1989). Therefore, it is not possible to base important clinical decisions on a dual diagnosis alone if we do not fully grasp the implications and value of it.

The concept, dual diagnosis of psychiatric disorder and substance abuse disorder, provides limited information because it is not able to give any indication of whether or not the two disorders interact, and the effect this has on planning treatment (Lehman et al. 1989). For example, in the case of client RP who was referred for alcohol abuse and depression, as he became abstinent from alcohol, his depression started to lift. The relationship between these two disorders was not evident from the diagnosis alone. A paper by Crome (1999) provides a more detailed account of how two disorders may interact. She looked specifically at the mechanisms of the relationship between substance abuse and psychiatric disorder, and has identified ten relationships that could potentially exist. Her work proposes the view that it is too simplistic to claim that these two disorders can exist independently of each other. It follows the idea that in order for an optimal package of care to be provided, it is important that both disorders are addressed concurrently. This can only be done if we develop an understanding of how to work with one disorder without it being undermined by the other illness. For example, active substance use adversely affects compliance with medication

(Drake, Osher and Wallach, 1989: cited in: Drake, Bartels, Teague, Noordsy and Clarke, 1993).

Clients with a dual diagnosis of psychiatric disorder and substance abuse are more likely to be violent than clients with a single diagnosis. Swanson et al (1990) studied a large community sample and found a significant positive relationship between risk of violent behaviour and the number of diagnoses given to a client. They also found that of clients with a dual diagnosis of schizophrenia and substance abuse, 30.3% reported violent behaviour compared to only 8.36% of clients with schizophrenia alone. Dually diagnosed clients are at much higher risk of committing suicide. Dorpat (1974; cited in: Mirin and Weiss, 1991) found that suicide risk is significantly increased by the presence of major depression and substance abuse. Cohen, Test and Brown (1990; cited in: Mueser, Bellack and Blanchard 1992) claims that there is an increased suicide risk in young male clients with schizophrenia, and that this group is also more likely to exhibit suicidal ideation and attempt suicide. When working with dually diagnosed clients, to plan treatment from diagnosis alone is inadequate, as issues around low motivation to engage with services and risk factors such as violence and self harm need to be directly addressed.

Historically, when assessing for more than one disorder funding of services was decided according to which of the two diagnoses was considered primary (Cutts, 1957: cited in Reiss, 1994). Reiss, Levitan and McNally (1982; cited in: Reiss, 1994) argue that services are not always appropriate when based on the distinction between primary and secondary disorders. For example, if a client's primary diagnosis is a substance abuse disorder, with a secondary psychiatric disorder, then the client is less likely to get funding for a mental health service. Therefore, debating which of the disorders is primary may leave the client without the help that he/she needs (Reiss, 1994).

One reason why the treatment of clients with a dual diagnosis is not well advanced is due to the gaps between mental health and addiction services. There are many differences in ideology; for example mental health services advocate the use of medication as being a useful form of treatment, whereas addiction services are concerned about clients becoming dependent on medication (El Guebaly, 1990). This would create difficulties for a client with schizophrenia whose illness was currently stabilised through the use of medication. Being



abstinent from all substances is a prerequisite for addiction services, as opposed to abstinence being viewed as an aim to work towards as in mental health services. Mental health services actively seek compliance to treatment, whereas addiction services tend to rely on using the client's motivation. Alcoholics Anonymous programs for example, use confrontation to make clients understand that alcohol abuse has consequences and that they are responsible for themselves. This would be extremely stressful for a client with schizophrenia and may result in an increased risk of relapse (Mueser, Bellack and Blanchard 1992). It is due to these ideological differences that treatment given to dually diagnosed clients is often disjointed and inconsistent.

Within existing health care services there are a number of problems associated with treating clients with a dual diagnosis. For example, staff working in mental health services may find it difficult to manage clients with addictions as they lack the experience, confidence and knowledge to do so. As a result they make work in a way that is punitive rather than therapeutic, as they may get angry, or feel threatened in response to a client that is intoxicated. Just as staff working in the area of addiction may feel ill equipped to work with clients with psychoses (Drake, Mueser and Clark, 1996). Staff often feel deskilled and pessimistic about treatment outcome and often do not have the training and/or adequate support from their team or department to overcome these issues (Minkoff, 1987: cited in Brown et al., 1989). This may result in clients with dual diagnoses having difficulty being admitted to either mental health or addiction services.

The concept of dual diagnosis is highlighting deficiencies in existing services as it is demonstrating that staffs feel unable to manage clients with a dual diagnosis, and as a result services may become inaccessible. Therefore, dual diagnoses are currently having a negative impact on treatment planning with respect to staff attitudes and morale. This implies that in order for this concept to be useful when planning treatment, more staff training needs to be introduced. Training needs to provide further information on dual diagnoses and the relationships between diagnoses; and teach practical clinical skills so that staff feel better equipped to manage clients on a day to day level (Zimberg, Soloman, Shollar and O'Neill, 1993).

An advantage of dual diagnoses is that when accurate, it can have a critical role in treatment planning (First and Gladis, 1993). When assessing clients, clinicians need to examine the psychological, biological and social influences on a person, therefore it is important to identify whether both disorders have developed separately, or if one has contributed to the development of the other (Mirin and Weiss, 1991). This is because having an understanding of which of the disorders is primary can help identify risk factors to prevent future relapse. For example, for a client diagnosed as having a primary psychotic illness with secondary alcohol abuse, work rehabilitation would be different from a client with primary alcohol abuse who had intermittent psychotic symptoms due to alcohol intake (Lehman et al, 1989).

It is possible for a client to be given two primary diagnoses. This would occur in situations where it is not possible to distinguish which of the two disorders should be the primary focus of treatment (Othmer and Othmer, 1994). This may be because the relationship between the two disorders is so complex that it is not possible to distinguish between the two. For example, client MV has been given a dual diagnosis of schizophrenia and substance abuse. He uses cannabis to help manage the anxiety associated with his positive symptoms of schizophrenia, which in turn exacerbates his delusional symptoms. Or, a dual primary diagnosis may demonstrate that there does not necessarily have to be any interaction between the two disorders. For example, a client that previously abused alcohol and has been sober for a number of years, suffers from a delusional disorder, but does not relapse in terms of alcohol abuse (Zimberg, 1999). An important advantage of giving a dual primary diagnosis is that it is now thought to be a way of highlighting that a client has multiple needs and as a result requires help from more than one service. In both of these examples, the client would need help from both mental health services and addiction services.

A way of overcoming some of the difficulties outlined above such as staff attitudes, gaps between addiction and mental health services, and accommodating clients with a dual primary diagnosis, is the creation of specialist dual diagnosis services. One such service is the community based Mental Illness Drug and Alcohol Service (MIDAS) in Hertsmere. All members of staff are trained to work with dually diagnosed clients with emphasis on a non-confrontational approach, persuasion and relapse prevention. It is a multi-professional service that liaises with community mental health teams, social services, primary care, probation services and voluntary agencies. MIDAS supports, trains and advises other staff working with

clients with a dual diagnosis, and provides a number of services including an intensive outreach service, therapeutic support, anxiety/stress management and substance detoxification programs.

MIDAS currently has a caseload of fifty-two clients. Of these, 72% have a severe mental illness or personality disorder, and co-morbid drug and/or alcohol problem. Between April 1996 and March 2000, the number of episodes involving the Crisis Intervention Service had only reduced by eight. However, the number of days spent as an inpatient had decreased by 76% (from 1116 to 265). MIDAS monitored the number of outpatient sessions attended by clients and found the rate of engagement to be 79.7%. An interesting finding is that 80% of clients reported that their self-esteem, confidence and optimism had improved (MIDAS, 2001). This finding suggests that a specialist service may not necessarily significantly reduce the number of crises experienced by dually diagnosed clients, but has a stabilising effect that is reducing hospital admissions. It is also having a positive psychological effect on factors such as self-esteem.

Kofoed, Kania, Walsh and Atkinson (1986) created a specialist dual diagnosis program based in a substance dependence treatment unit to encourage an abstinence-oriented approach. This program involved a focus on managing symptoms, medication and abstinence both as outpatients and inpatients depending on the individual needs of the clients. Clients participated in Alcoholic Anonymous meetings, weekly support groups and education on dual diagnoses and its management to encourage compliance. Clients were also able to attend individual and family therapy and skills training groups. Kofoed et al (1986) found that eleven of the thirty-two clients remained in the program for more than three months, and of these a further seven remained for over one year. They found that clients who have had previous outpatient appointments were more likely to remain in treatment, and that staying in treatment was not related to the severity of psychiatric illness. Their results support the finding of MIDAS, which is that staying engaged with specialist services was related to fewer days as an inpatient.

An advantage of specialist services is that clients are provided with a consistent package of care from one service, which overcomes the problem of co-ordinating mental health and addiction services. Another advantage is that the primary problem does not need to be

identified before a thorough assessment by the relevant service takes place. If a client presents in crisis, at the Accident and Emergency department of a hospital, for example, the difficulties associated with substance abuse and psychiatric symptoms may be hard to distinguish between. Therefore, having staff with appropriate training that is equipped to deal with both disorders is valuable (Minkoff, 1997).

Lehman, Herron, Schwartz and Myers (1993) developed and evaluated a dual diagnosis treatment program that combined specialist group work with an intensive case management approach. They found no significant effect on substance use, psychiatric problems, life satisfaction and hospital use between the group in the specialist program and the control group that had only regular case management. One of the main difficulties was engaging clients in the specialist program. This study demonstrates that a specialist service is not always more advantageous than existing packages of care.

Not all types of specialist services are thought to be effective for dually diagnosed clients. Bartels and Drake (1996; cited in: Johnson, 1997) found that intensive residential programs are not beneficial for clients with a dual diagnosis that frequently relapse. They argue that long term work that is based in the area where a client lives, with an emphasis on engaging the client, is more important. If this finding is applied to the UK then this suggests that there is a role in developing more effective working links between mental health and addiction services, and primary care services and community mental health teams.

A disadvantage of specialist services is that if a client does not want a combined service, there may be little else on offer (Minkoff, 1997). This may be particularly problematic if a client is moved to a specialist service having already engaged with, for example, mental health services, as this may result in the continuity of care being disrupted (Johnson, 1997). Another disadvantage is that there may be a great deal of stigma associated with the use of a service for dual difficulties.

In the UK, addiction services are part of the mental health system, unlike in the USA where addiction and mental health services have separate funding and training. Therefore, an alternative to a specialist service may be to adapt existing community mental health teams. Community mental health teams in the UK are both successful and well developed, and so one

possibility is that an addiction specialist could work within a community mental health team on appropriate referrals. This would be a way of improving the co-ordination of the two services, without creating a new specialist service and would avoid the problem of a disjointed package of care. One practical difficulty however is that this may result in a client having two keyworkers which is not ideal (Johnson, 1997). Or, community mental health team staff could be provided with additional training in working with clients with addictions. This again raises a number of practical issues such as it may not be possible to provide training for all staff due to lack of resources. Services are already overworked at present and so there may not be enough time for training, or after training has been completed there may be problems supervising staff (Johnson, 1997).

Another option is that a few members of staff within a community mental health team could be given intensive training in managing clients with a dual diagnosis. Their role would be to take on the majority of the dually diagnosed clients and support the wider team. Problems of "burnout" and professional isolation could be overcome by ensuring low caseloads, and the provision of adequate supervision and training (Johnson, 1997). If the staff is from different disciplines, it is more likely that a holistic package of care can be provided, as each of the professionals would bring their own expertise.

An alternative to specialist services is case management, which is the co-ordination of services involving thorough, often multi-professional assessment, and resources from different services, which are managed by a case manager. It focuses on meeting the needs of the individual client, as opposed to trying to fit the client into an existing service. Case management examines both therapeutic and practical issues, such as finances and housing faced by a client (Huxley, Hagan, Hennesly and Hunt, 1990). It would be useful for dually diagnosed clients because it could potentially address all of their difficulties. For example, for a client given a diagnosis of substance abuse and depression, case management could work with the psychological problems associated with substance abuse such as, relationship problems and difficulties with work (Dorpat, 1974: cited in Mirin and Weiss, 1991). It could also examine the role (if any) played by substances in the exacerbation of depressive symptoms, and the actual depression itself.

The study cited above by Lehman et al (1993) highlights that case management is just as effective as specialist programs in stabilising clients. Case management also overcomes some of the criticisms associated with the use of diagnosis such as it treats clients as individuals, and takes into account culture and the client's unique life situation. It also does not have the added stigma that may be associated with the use of a specialist service for mental health and addiction.

A criticism of case management is that it is very time consuming for a case manager to be co-ordinating all the different services, and with resources becoming increasingly stretched it is becoming increasingly difficult to perform efficiently.

An alternative to diagnosis that overcomes some of the difficulties discussed above is formulation. A formulation is a hypothesis about the causes and maintaining factors of a problem. It is developed through combining information about an individual client with theory, scientific principles and research findings (Wolpe and Turkat, 1985: cited in Butler, 1998). A disadvantage of diagnosis is that not all problems are clearly defined and able to meet precise diagnostic criteria, therefore a diagnosis may not have specific treatment implications (Butler, 1998). Whereas, a formulation links theory to clinical practice and may be tested using selected interventions.

Diagnoses are thought to be mainly descriptive and not based on theory, whereas a formulation is designed specifically for an individual client and may be thought of as explanatory as well as descriptive. For example, one client may be depressed and feel like a failure due to problems forming close relationships, whereas for another client feeling a failure and depressed may be due to an inability to cope with the combined pressure of a work and home life. It would not be possible to ascertain information such as this from a diagnosis alone and so treatment outcome is likely to be influenced. Formulation is particularly valuable for complex cases in which the client may have multiple difficulties, as it overcomes the problem of trying to fit a client into hierarchical diagnostic categories (Butler, 1998). It is also useful for clients that have difficulties that are disrupting their daily functioning, but cannot be fitted into any diagnostic categories.

A criticism of formulation is that the theory on which it is based may be inaccurate, or it may not have been fully understood by the clinician. Also, formulation requires clinical judgement and so, like diagnosis, it is also susceptible to bias (Butler, 1998).

In summary, the main difficulties with dual diagnoses are that we are still developing an understanding of this concept and its long-term effects. We have limited knowledge of what is therapeutically effective and as a result the needs of clients are not always met. Our lack of understanding of this concept is reflected to a degree in the attitudes of staff who feel ill equipped to manage this client group, and in the poor links between services. Advantages of this concept are that it has led to the development of specialist services, and other alternatives such as adapting existing services. It has also led to improved treatment planning.

I think that the concept of dual diagnosis has limited importance when planning treatment for clients with multiple difficulties. Dual diagnoses can be a useful framework to start working from but they need to be considered in conjunction with the client's life situation. It is too simplistic to focus on the primary diagnosis alone, as often other difficulties experienced by the client are equally important. Future research needs to examine the long-term effects of multiple difficulties, for example, how they develop and respond to treatment over time. It also needs to investigate alternatives to diagnosis such as the effect of working with clusters of symptoms (Lehman et al, 1989).

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**There are sharply defined diagnostic criteria in Adult Mental Health. When children act out, however, does this stem from mental health issues ('psychopathology') or environmental factors? Critically discuss the issue of problematic child behaviour and whether it may emanate from "within child" or environmental forces. Use clinical examples to illustrate your argument.**

**KAJAL PATEL  
OCTOBER 2002  
ESSAY 2  
YEAR 2**

According to the NHS Health Advisory Service (1995), up to 25% of children and adolescents have a diagnosable mental health disorder at any one time. Epidemiological research suggests that this prevalence rate is on the increase (HAS, 1995), which highlights the importance of developing a better understanding of the nature of childhood difficulties. The following essay aims to discuss the main theories regarding whether problematic child behaviour is inherent in the child or the environment, using the example of conduct disorder and anti-social behaviour, and will argue that theories which consider the interaction between a child and his/ her environment have advantages over these main schools of thought.

### *Diagnosis*

One way of defining problematic child behaviour is via the use of diagnosis. Diagnosis is the process by which clinicians identify a disorder, and use groups of frequently occurring observable signs and symptoms to allocate it to a category (Gelder, Gath and Mayon, 1989). The most common method of diagnosis involves the use of two main classification systems, the Diagnostic Statistical Manual (DSM-IV-R; American Psychiatric Association, 1994) and the International Classification of Diseases (ICD-10; World Health Organisation, 1992). There are a number of advantages to using classification systems. Diagnoses provide a concise summary of symptom clusters which are convenient to use when communicating with other professionals. This enables the planning of treatment without having to describe all of the symptoms of an individual case (Carr, 1999). Clinical decisions are often based on diagnoses, for example the prescription of Ritalin for ADHD (Cantwell, 1996). Diagnosis also has an important role in research, for example, it can be used to ensure that cross study comparisons have similarly defined participants.

However, there are concerns about the applicability of these classification systems to the disorders found in children. DSM-IV-R and ICD-10 are categorical in nature and are based on cross-sectional phenomenology, without adequate consideration of contextual factors such as psychosocial and biological correlates, and response to treatment (Cantwell and Rutter, 1994). Clients are often assigned a diagnosis on the basis of arbitrary cut off points regarding the number and type of symptoms they exhibit (Cantwell, 1996). Costello (1990; cited in Cantwell, 1996) suggests that sub-threshold disorders in childhood, that is, disorders that do not have the required number of symptoms to meet the criteria for DSM-IV-R or ICD 10 diagnosis, are more common than those which do. When trying to define problematic behaviour, in addition to the number of symptoms present, it is important to consider the

severity of symptoms and the resulting level of difficulties, as children may have functional impairments despite not meeting formal diagnostic criteria. Therefore, classification systems may miss out on a range of clinical problems that do not reach diagnostic level.

Another disadvantage of classification systems is that developmental issues are not fully considered. The diagnostic criteria for many disorders are the same across the lifespan from pre-school to adulthood, for example in the case of schizophrenia, mood and anxiety disorders. It would be more accurate to say that some symptoms are present at particular points but not at others. For example, ideas of guilt as a symptom for depression cannot be experienced until the appropriate developmental stage has been reached (Cantwell, 1996). Also, behaviours have different levels of significance at different developmental stages, for example, enuresis would be acceptable in a 4 year old child, but unusual in a 14 year old (Lerner, Walsh and Howard, 1998). Therefore, in comparison to Adult Mental Health, diagnostic criteria for children lack relevant developmental information which makes them potentially problematic to use.

Furthermore from a psychological perspective it is essential to go beyond diagnosis and take into account the effects of context, social class, ethnicity and culture based on the view that definitions of problem behaviour are socially determined. For example, Weisz, Suwanlert, Chaiyasit.(1987; cited in Grizenko and Fisher, 1992) compared the behavioural and emotional problems in general population samples of Thai and American children and found that Thai children were more likely to exhibit problems relating to shyness, depression and somatisation. However, being overly shy in Thailand may not be considered as much of a difficulty as in America, based on the Thai Buddhist belief that children should be peaceful and inhibit expressions of anger. Alternatives to using categorical diagnostic systems would be to take a dimensional approach and use measures such as rating scales or behaviour checklists.

### *Conduct disorder and anti-social behaviour*

One example of problematic child behaviour, which will be the focus of this essay, is conduct disorder and the associated concept of anti-social behaviour. This will be explored with a view to looking at its contextual rootedness in theory of development. It is estimated that between one third to one half of all referrals to child and adolescent services consist of children with conduct disorder or anti-social behaviour (Wenar and Kerig, 2000). According



to DSM-IV-R conduct disorder may be defined as "a repetitive and persistent pattern of behaviour in which either the basic right of others or major age appropriate societal norms or rules are violated." (pp.93, American Psychiatric Association, 1994). This diagnostic system identifies four main categories of symptoms; aggression towards others, destruction of property, deceitfulness or threat and serious rule violations. The severity of the disorder is determined by the number of symptoms present and the degree of harm to others. Difficulties with this definition include the view that it is biased towards males, as females are less likely to exhibit the type of aggressive behaviours described, as females are more likely to be deceitful, spread rumours etc. (Farrington, 1999). In order to distinguish between childhood and adolescent type conduct disorder, age of onset needs to be specified (Wenar and Kerig, 2000), however it is important to bear in mind that this is not the same as assessing developmental stage. Anti-social behaviour has been defined by Earls (1994) as being aggressive and argumentative, with cruelty, lying, stealing and damage to property.

### *Parenting*

This essay will start by considering a few of the main environmental risk factors which may contribute to the development of conduct disorder or anti-social behaviour. Loeber and Stouthamer-Loeber (1986; cited in Lytton, 1990) carried out a meta-analysis of longitudinal studies examining parental and family effects on conduct disorder and found that the best predictor of later developing conduct disorder was lack of parental supervision, lack of parent-child involvement and parental rejection. A cumulative adverse effect was demonstrated if two or more of these effects were present. Support for this finding is provided by other studies which have found that parents of children with anti-social behaviour were not as warm, affectionate or accepting as parents of children that did not exhibit anti-social behaviour. Also they were not as emotionally supportive and had a lower level of attachment (Kazdin, 1996).

There has been considerable research examining the effects of differential parenting and anti-social behaviour. Reiss, Hetherington, Plomin et al. (1995) investigated the effects of three main aspects of parental behaviour; conflict/negativity, warmth/support and monitoring/control, on the behaviour of same-sex sibling pairs. They found a strong association between parental conflict/negativity towards each child and anti-social behaviour, as greater levels of parental punitive behaviour towards the sibling resulted in lower levels of anti-social behaviour by the other child. A positive correlation was also found between fathers control behaviour towards the sibling and levels of anti-social behaviour in the other child.

Reiss et al (1995) introduced the idea of a "sibling barricade" effect, as the child exhibited less anti-social behaviour if he/she received little parental conflict/negativity, more direct warmth and his/ her sibling was the focus of problematic parenting.

### *Marital conflict*

Research indicates that marital conflict has more impact on difficult behaviour than divorce or separation. Hetherington, Cox and Cox (1982; cited in Rutter, 1985) found that if divorce brought harmony to family relationships then children's behaviour problems improved, whereas difficult behaviour continued if parental conflict remained. Jenkins and Smith (1990) examined the impact of marital disharmony on children's behaviour by comparing families with harmonious and disharmonious marriages. They interviewed each of the parents and the child on various aspects of behaviour, such as lying, stealing, aggression to siblings and peers and disobedience. A significant positive relationship was found between overt parental conflict and both parents and child reports of behaviour problems. That is, the more frequent and severe the conflict, the greater the difficulties reported by mothers, fathers and children. Jenkins and Smith (1990) found that as parental conflict increased, there was an increase in the lack of care given to the child and in the level of parental aggression directed towards the child. One of the strengths of this study is the use of reports from both parents and the child, as if one parent was upset due to marital difficulties his/her perception of problem behaviours may be distorted and not reflect a holistic perspective on the marital problems..

### *School*

Another important environmental influence on conduct disorder and anti-social behaviour is the school setting. Rutter, Maughan, Mortimore and Ouston (1979; cited in Farrington, 1999) carried out a large study comparing the delinquency rates of twelve secondary schools in London, and how characteristics of the school related to child behaviour. They found that in schools where there were high delinquency rates, truancy rates were also high and students tended to have lower levels of ability and were of families from a low SES group. However, the development of antisocial behaviour was also attributed to aspects of the teacher-student relationship such as frequent use of punishment and limited use of praise. This finding is consistent with those of the family studies outlined above as it demonstrates that harsh discipline and lack of warmth from significant adults may lead to problematic behaviour. One of the difficulties with examining school effects is dividing characteristics of the school from those of the children and families they serve. For example, the school may be located in an

area where a large proportion of the families have financial problems and use harsh child rearing practices and do not adequately supervise their children (Kazdin, 1996).

### *Modelling*

According to social learning theory, children may develop conduct disorder or exhibit anti-social behaviour as a result of observational learning or modelling of aggressive behaviour by parents and/ or delinquent peers (Rutter, 1985; Gross, 1992). Children will learn that the use of aggression is an appropriate way to resolve conflict (Olewus, 1993; cited in Carr, 1999), and this behaviour will be maintained by the fact that the child is likely to be in a setting where anti-social behaviour is more likely to be accepted or tolerated (Rutter, 1985). Support for this theory is provided by Stewart, deBlois and Cummings (1980) who found that fathers of sons with anti-social behaviour had a higher frequency of anti-social personality and alcoholism, and were more likely to be physically violent towards their partner than fathers of boys with other disorders including hyperkinetic disorder.

### *Life events/ Family adversity*

A study by Goodyer, Kolvin and Gatzains (1985) investigated the effects of mild versus severe life events, and found that events with a moderate to severe degree of negative impact such as family/marriage related issues, accidents and illness were significantly related to conduct disorder. Another important finding was that children with conduct disorders had experienced significantly more mild life events than the control group, which could be interpreted as being indicative of this group having a lowered threshold to external stress. An alternative view would be that this group may be exposed to a greater number of life events overall due to social adversity.

It has been argued that different aspects of family adversity have a cumulative effect on the behavioural adjustment of young children. Rutter, Cox, Tupling, Berger and Yule (1975a; cited in Shaw, Vondra, Dowdell Hommerding, Keenan and Dunn, 1994) compiled a Family Adversity Index of chronic stressors in an Inner London Borough and on the Isle of Wight. These stressors included overcrowding in the home or having a large family, mother suffering from depression or neurotic disorder, father having an unskilled/semi-skilled job. In both communities, the presence of two or more stressors increased the likelihood of the child having a behaviour problem as these stressors are thought to compromise the quality of parenting. As well as the actual occurrence of events or presence of stressors it is important to

consider a child's perception of stress as what might be distressing for one child may not have the same effect on another child.

### *SES*

Kolvin, Miller, Fleeting and Kolvin (1988) conducted a longitudinal study in which they assessed family environment and parental characteristics in the first five years of life and several times over a thirty year period. From their sample, 31% of males and 6% of females were later involved in criminal behaviour, and of these 31% males, 42% were in lower social classes. A criticism of studies focusing on SES group is that it is not enough to consider this factor in isolation. For example, in a low SES group it is more common for other stressors to be present such as mothers are more likely to be poorly educated and there is an increased likelihood of having an absent parent, which may lead to a disorganised rearing environment Kolvin et al (1988), and consequently have an impact on behavioural outcome (Grizenko and Fisher, 1992; Shaw et al, 1994).

### *Genetics*

So far the essay has been concerned with environmental factors as a source of stress and adversity, and the context in which learning may occur that might lead to the development of anti-social behaviour in children. However, based on the finding that not all children exposed to these environmental factors develop conduct disorder or exhibit anti-social behaviour, it is important to discuss other factors that may increase the vulnerability to environmental risks of certain children. When considering factors intrinsic to the child, a logical starting point would be to consider the effects of genetics. Due to the limited research data available on the contribution of genetic factors to conduct disorder and anti-social behaviour in children, this theory is often considered using indirect support from adult studies. In the large scale Danish adoption study conducted by Mednick, Moffit, Gabrielli and Hutchings (1986; cited in Lytton, 1990), 13.5% of males had a criminal conviction when neither the biological or adopted father had any criminal convictions. When the adopted father did have convictions this figure rose slightly to 14.7%, however, it was 20% when the biological father had convictions. This supports the idea of a genetic influence, based on the view that if the behaviour of adopted children is similar to that of their biological parents this is due to heritability, whereas similarity to their adoptive parents is indicative of a greater environmental influence.

Existing research on adults consistently supports a moderate genetic effect in the development of anti-social behaviour. However, most cases of aggressive behaviour in children do not continue into adulthood. It has therefore been suggested that genetic effects may be stronger in conduct disordered behaviour that continues into adulthood in comparison to those anti-social behaviours of childhood alone; however there is no empirical data to support this hypothesis to date (Rutter, Macdonald, Le Couter, Harrington, Bolton and Bailey, 1990).

### *Temperament*

The basis of temperament is thought to be genetic as this aspect of personality has been found to be consistent across situations and time, and differences can be identified at an early age. Characteristics of temperament include for example, levels of activity, adaptability to new situations, mood quality and emotional responsiveness. A scale ranging from easy-to difficult is often used to describe differences in temperament. A child with an easy temperament would be identified by the way he/she approached new stimuli, how adaptable he/she was to change and the level of intensity in his/her reaction to new stimuli and would have a positive mood. A child with a difficult temperament would be the opposite and research indicates that he/she is likely to exhibit behavioural problems, or is vulnerable to developing them at a later stage (Kazdin, 1996; Lee and Bates, 1985).

Lambert (1988) conducted a longitudinal study examining various factors in a child's early development including peri natal and post natal factors, child's health and social relationships. They found that a difficult early temperament was a better predictor of developing conduct disorder at the age of 17-18 years than family environment. One of the strengths of the study was that the control group were students taken from the same school as the experimental group, thereby controlling for any potential school effects.

### *Autonomic arousal*

Patterson (1976; cited in Lytton, 1990) studied the effect of aversive consequences, for example, physical punishment, shouting, disapproval by parents, on children's behaviour. In children without problematic behaviour, hostile behaviour and social aggression were found to decrease slightly, whereas in children with conduct disorder these behaviours increased. Patterson (1976; cited in Lytton, 1990) suggested that reinforcement and punishment worked differently in children with conduct disorder. It has been hypothesised that the lack of response to social reinforcement exhibited by this group may be due to low levels of

autonomic arousal. This idea was investigated by Schmidt, Solant and Bridger (1985) who measured skin conductance levels, which indicate arousal, in children with conduct disorder in neutral and more stressful conditions. The children with conduct disorder did not differ in their level of arousal to each condition, which implies that in situations that may be aversive, or arouse fear in others, children with conduct disorder might be less inhibited due to this lower level of arousal, thereby facilitating anti-social behaviour.

### *Biochemical influences*

Rubin (1987; cited in Lytton, 1990) summarised the findings of several studies looking at biochemical influences, such as testosterone. They concluded that no consistent relationship has been found between levels of testosterone and measures of hostility and aggression in children without identified behavioural problems. However, they did find increased levels of testosterone in children with an objective history of particularly violent behaviour. These findings may not be entirely due to a direct relationship between testosterone and anti-social behaviour as other biochemical substances may play a role in behaviour. Also, animal studies indicate that levels of testosterone may be high as a consequence of the aggressive behaviour or due to social situations (Maccoby and Jacklin, 1974; cited in Lytton, 1990).

### *Cognitive processes*

According to the social information processing model aggressive or anti-social behaviour is due to the result of faulty cognitive processes. When in an ambiguous situation, aggressive children misattribute aggressive intent to others and fail to pick up on relevant social cues that could help them interpret the intentions of others correctly. These inaccurate assumptions lead to an impulsive aggressive reaction. Aggressive children therefore demonstrate a limited ability to generate alternative ways to solve interpersonal problems and expect the outcome of aggressive acts to be positive (Dodge, 1980; cited in Dodge, Bates and Pettit, 1990). Support for this model is provided by Dodge et al (1990) who used a prospective study examining the effects of physical abuse on children's aggressive behaviour using mothers and teachers' reports, peer nominations and direct observation. They found that children who had been harmed in early life were more aggressive towards their peers than those who had not. Dodge et al (1990) argue that social information processing patterns will be influenced by abusive socialising experiences due to the development of internal working models of the world as a threatening place resulting in a hypervigilance to hostile cues.

### *Goodness of fit*

It may be argued that considering "within child" or environmental factors as being independent of each other is too simplistic based on the observation that it is often difficult to separate out the specific contributions of each. It is therefore plausible to take the stance that problematic child behaviour results from an interaction of these two influences as a way of reconciling this debate. According to the "Goodness of Fit" model (Chess and Thomas, 1999), properties of the environment for example, the social and physical setting, will place demands on the child, for example, the attitudes and stereotypes of others in the environment towards the physical or behavioural characteristics of the child. In order for interaction between the child and the environment to be adaptive, the child must co-ordinate or "fit" his/her characteristics with others in the surrounding context.

Difficulties develop when a child's characteristics and capacities are unable to meet environmental demand resulting in distorted development or maladaptive functioning, that is, "poorness of fit". It is not the case that the emergence of symptoms is due to abnormal capacities or pathology of the child. Rather that the child is "normal" but has a specific vulnerability, and the development of pathology occurs through the process of interaction. For example, client DV who was an 8 year old boy whose vulnerability was a low attention span and difficulty in expressing his thoughts and feelings. He managed reasonably well at school with only minor problems. However, following the death of his mother with whom he had a very close relationship he started to become extremely "clingy" toward his father who could be both loving and rejecting towards him. This resulted in DV's existing vulnerability becoming more serious and he began to demonstrate extremely aggressive behaviour at school when faced with difficult situations.

The New York Longitudinal Study (Chess and Thomas, 1995; cited in Carr, 1999) aimed to systematically study how variation in parent-child relationships is influenced by child temperament. They obtained details on the child's temperament, parental styles and attitudes and important life events such as moving house, starting school. They divided the children into three groups, easy, difficult and slow to warm up temperament. They found that the group with a difficult temperament had problematic patterns of feeding, sleeping and toileting, avoided new situations and responded to change with intense negative emotion. This group was found to be most at risk for developing conduct and adjustment problems and had high levels of conflict with parents, peers and teachers. They adjusted better when there was

greater compatibility between parental expectations and temperament, and needed parents who were tolerant and responsive to achieve "goodness of fit".

This model moves away from a unidimensional perspective of development as it does not view the child in terms of a stimulus-response relationship or from a genetic perspective. Instead it considers that there are multiple influences including individual biological factors, social relationships with family and peers, societal and cultural factors all of which dynamically interact with the child to create behavioural and emotional problems or healthy development (Lerner et al, 1998).

### *Genotype-environment effects*

The theory of genotype-environment effects argues that the type of environments people experience and the effects these may have, are prompted by genetic differences, and that a person's responsiveness to environmental opportunities are determined by genotypes. Genotypes are the genetic characteristics of a person. Scarr and McCartney (1983) claim that the difficulty with "pure" genetic or environmental theories is that they are unable to account for the fact that individuals select their own environment to an extent. They claim there are three main types of genotype-environment effect, passive, evocative and active. The passive genotype-environment effect is that genes and environment cannot be differentiated, as parents provide both the genes and the environment. For example, parents who can read and like reading will give their children books; therefore, these children will be likely to enjoy reading and books. Evocative genotype-environment effects represent development that is shaped by responses from the social and physical environment to the person's genotype characteristics, and this persists throughout life. For example, smiley babies are more likely to receive greater social stimulation. The active genotype-environment effect is that an individual will seek out stimulating and compatible environments, and will choose some aspects to respond to, learn from and ignore, based on aspects of his/ her genotype such as motivation and personality.

This model outlines a developmental process as the three kinds of genotype-environment effects change over time from infancy to adolescence. In infancy much of the environment is provided by adults, whereas older children are able to extend their experiences outside of the family environment. Therefore, the importance of passive effects decrease and that of active effects increase as opportunities outside of the family increase, for example starting school or getting a part-time job. The main advantage of this interaction model is that it addresses the



idea of development being a process. It also highlights how children may actively influence their own development which overcomes the implicit assumption of the "within child" theories that development is predetermined.

### *Coercive interaction*

A third interaction model is proposed by Patterson (1982; cited in Patterson, DeBaryshe and Ramsey, 1989). This theory claims that anti-social behaviour is taught via coercive parent-child interactions. When a child behaves aggressively, if the parent is ineffective in managing or controlling this behaviour and "gives in", this reinforces the child's behaviour and the child is likely to introduce another aversive behaviour of escalating intensity. As a result pro-social behaviours are less likely to be acknowledged, or are ignored, which contributes further to the coercive cycle. Support for this model is provided by O'Connor, McGuire, Reiss, Hetherington and Plomin (1998) who conducted a longitudinal study in which they carried out assessment of behavioural problems at the ages of 7, 9, 10, 11 and 12 years. They found significant correlations between negative control and parent related behaviour problems, and on the basis of the pattern of correlations across the years claimed that there appeared to be a bi-directional effect between parents and children.

A potential criticism of aetiological theories proposing that conduct disorders are the result of factors such as negative parenting or child temperament is that anti-social behaviours may be either a cause or consequence of these influences. An important advantage of the interaction model by Patterson (1982; cited in Patterson, et al, 1989) is that by describing parent-child relationships as a two way process it goes some way toward addressing this issue. It also emphasises the idea that both parents and children are developing. Parents are developing in terms of family relationships, career roles etc. and these experiences of multiple roles will affect their relationships with their children, just as children will provide different stimulation to their parents based on their own individual experiences (Lerner et al, 1998).

### *Clinical implications*

These theories have a number of important clinical implications. Based on the interaction perspective, the process of development is multidimensional; therefore this should be reflected in assessment and intervention. This means that assessment of functioning should be carried out across a variety of contexts and take into consideration the social and cultural background of the child. This would help develop a clearer formulation of a child's difficulties and

anticipate contextual influences which could potentially hinder the progress of any intervention (Wachs, 2000). Various researchers have noted that information on a child's behaviour can vary according to the source (Rutter, 1999); this may be as parents, teachers and others are also developing and responding to their own contexts. This may have a significant impact on a clinician's understanding of the child's difficulties which highlights the importance of using multiple sources of data during the assessment stage.

With regard to intervention, interaction models would argue that it is not effective to focus on a single aspect of a problematic behaviour and that intervention should target co-varying risk factors, based on the belief that difficulties are the result of a dynamic interaction between the child and his/ her environment. Therefore, any intervention would need to be multi-dimensional in order to improve the relationship between a child and his/ her context, that is, it should enhance "fit" (Lerner, et al 1998; Wachs, 2000). One way of achieving this would be to use a multidisciplinary approach so that the skills of different professionals could be used to target different dimensions of the problem. Following from this, if development is viewed as a process, then it is essential that clinicians are also dynamic in their work in that they are continuously assessing and monitoring progress and adapting the intervention to meet the individual needs of the child and his/ her context.

In conclusion, theories regarding whether problematic child behaviour emanates from "within child" or environmental forces has contributed a great deal to our understanding of childhood disorders. However, they are unable to fully incorporate the processes involved in development as usefully as interaction theories, and as a result are not as clinically valuable.

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**Small Scale Service Related Project**

**An audit of multi-disciplinary team working  
within a child and family clinic**

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May 2003**

## **Abstract**

This audit examined the level of multi-disciplinary teamwork within a child and adolescent mental health service in order to assess the extent to which the clinic met the key Health Advisory Service (HAS; 1995) criteria for a Tier Three service, which is the provision a multi-disciplinary service within a larger network of service components. The results indicated that just under half of all the clients seen within the clinic received multi-disciplinary input in the form of at least one of the following; direct joint work, discussion in multi-disciplinary setting or discussion in a clinical setting, and there was liaison with external agencies in just over one third of cases. There was no association between multi-disciplinary input and re-referred cases, or with cases classed as urgent. This audit discusses the importance of multi-disciplinary teamwork and makes recommendations for increasing the level of multi-disciplinary and multi-agency work within the service.

## **Introduction**

According to the NHS Health Advisory Service (1995), up to 25% of children and adolescents have a diagnosable mental health disorder at any one time. Epidemiological research suggests that this prevalence rate is on the increase (HAS, 1995), which highlights the importance of maximising limited resources to provide a child-centred and integrated service. One of the main criticisms of mental health services throughout England and Wales for children and young people was that they lacked cohesion and were inconsistently organised across agencies and disciplines, as often the operational policies along which they were developed were experimental in nature. Services were thought to lack co-ordination and planning resulting in health, social and education agencies providing a disjointed service with gaps and overlaps (Harrington, Kerfoot and Verduyn, 1999). The HAS Report proposed a four tier model to overcome this by bringing about closer integration between all agencies involved in the care of young people (HAS, 1995; Day and Davis, 1999).

The four tier model for child and adolescent mental health services (CAMHS) aimed to integrate different aspects of services to provide a coherent whole, and to try and develop service networks so that professionals working with young people and their families felt able to develop their skills and manage their workloads. Each of the tiers may be defined as follows: Tier One is the point of primary contact with a service, or a direct service, and includes GP's, social workers and school nurses. These professionals are not necessarily employed in work relating directly to mental health, but impact upon it through their work with young people and their families (HAS, 1995).

Tier Two refers to a service in which individual specialist mental health professionals work with clients, often through a multi-disciplinary team. The role of these staff is to offer specialist support, liaison, training and consultations to community based staff, and also direct clinical services to young people from various primary care and community settings (HAS, 1995; Day, Davis and Hind, 1998).

Tier Three services carry out the tasks of Tier Two services. In addition, a Tier Three service may be regarded as a more specialised service often due to the severity and complexity of problems clients present with. A key feature of a Tier Three service is the provision a multi-disciplinary service within a larger network of service components, which enables different

aspects of a problem to be addressed by various professionals in a co-ordinated way (HAS, 1995; Day et al, 1998).

Tier Four services provide the most specialised care and are offered to clients with extremely complex and persistent difficulties, in addition to providing the services outlined for Tiers One to Three. Examples of Tier Four services include inpatient psychiatric units, secure accommodation and eating disorder units (HAS, 1995).

The XXX Child and Family Clinic is a Tier Three CAMHS service, and the aim of this audit is to assess the extent to which it meets the key HAS (1995) criteria of multi-disciplinary service provision. Before examining the advantages and disadvantages of multi-disciplinary team work it may be useful to consider how this mode of working was originally brought about.

#### *Origins of multi-disciplinary teamwork*

A new form of interdisciplinary practice formed alongside the growth of the Child Guidance Movement in the 1920's. This consisted of psychiatrists, psychologists and social workers (Parry-Jones, 1986; Ryan, 1996). Over the years, this core team shaped service organisation and other professions gradually joined this collaborative way of working. The concept of the "therapeutic community" started in the 1950s and 1960s in "mental hospitals" and resulted in a shift from profession-centred working to more blurred staff roles. Around this time the separate professional identities of non-medical professionals working with people with mental health problems started to develop which had huge implications for the notion of professional autonomy and the hierarchy of organisations. This led to rivalry, conflict and power struggles, and so the notion of a multidisciplinary team was introduced in the 1960's to try and overcome and/ or disguise these inter-professional tensions (Parry-Jones, 1986).

#### *Advantages of multi-disciplinary teamwork*

Multi-disciplinary teamwork is particularly useful within CAMHS services based on the view that, "A satisfactory child and adolescent mental health service requires a wide range of assessment and treatment provision and this is only possible when contributions are available from the full range of relevant professionals" (Cox and Wolkind, 1990; cited in HAS, 1995). That is, the understanding and management of cases is improved by organising services so that skills and knowledge of different professionals can be contributed (HAS, 1995). This mode of

working is also a way of acknowledging that problems are interconnected and clients need to be treated holistically within their community or family context. By providing different perspectives based on the expertise of individual team members it is possible to offer service that is flexible and client centred (McGrath, 1991). When a client is seen by a single professional, there is the risk that therapeutic techniques will be overemphasised, whereas, if the client is being seen by a team, there will be more of a focus on goals by the very nature of trying to co-ordinate the input of several disciplines.

Another advantage of multi-disciplinary teamwork is that it improves collaboration between different disciplines. There is considerable evidence that professionals develop a better understanding of each others roles when they work as a team. This is important as a common source of team conflict is limited understanding and stereotyping of the roles of other professionals (Norman and Peck, 1998; Kane, 1975 cited in McGrath, 1991). Improving the collaboration between disciplines minimises fragmented service provision and overlap between roles resulting in clients being provided with a more co-ordinated service (McGrath, 1991). It also results in more appropriate referrals being made to other disciplines.

In areas where there are a limited number of specialists relative to demand, an advantage of multi-disciplinary teams is that tasks may be divided according to the specialist skills of a professional. This is of benefit to clients as they are more likely to receive a service from the most relevant worker to address their needs, as opposed to being allocated to a single worker. The danger of working in this way is that it creates debate about the role of a specialist and may cause anxiety about professional roles becoming blurred. However, it also encourages staff to develop their skills, and facilitates the development of specialist skills and expertise which are not necessarily related to formal qualifications, for example, group work (McGrath, 1991).

Multi-disciplinary teamwork with clients may result in certain problems being identified at an earlier stage and result in a more accurate assessment of need (Wheeler, Bone and Smith, 1998). It may also encourage preventative work due to the provision of a broader service. Also, as most CAMHS teams are based in the same clinic, professionals may work more informally and refer clients earlier (Pfeiffer, 1980; cited in McGrath, 1991).

### *Disadvantages of multi-disciplinary teamwork*

In order to provide a service that is organised and coordinated, professionals spend a great deal of time in meetings. This may be considered a disadvantage as staff may start to lose enthusiasm as this reduces clinical time with clients (McGrath, 1991). Even though it may be argued that the quality of time spent directly with clients is improved significantly by discussions held in professional meetings.

If the objectives and boundaries of a team are not clearly defined, professional roles may become inadvertently blurred. This would lead to professionals holding ambiguous and confused expectations about each others roles and may result in personal and professional conflict (McGrath, 1991). This may interfere in client work as the issues raised may be time consuming to resolve.

The concept of working as a team implicitly implies that responsibility for clients and other decisions is equally distributed. This may be a disadvantage as some professionals may be uncomfortable with the idea of being accountable to their peers (McGrath, 1991; Norman et al 1998). However, a more common scenario is that the team is predominantly influenced by one discipline, usually, psychiatry, which may create difficulties for team members who would prefer a more democratic and less hierarchical structure.

Within some teams, there is often a single representative of a particular discipline. This may result in that member of staff feeling professionally isolated despite being part of a supportive team. This in turn would have implications for the staff member's sense of professional identity and may make him/her more resistant to teamwork in order to avoid the risk of role blurring (Stark, Skidmore, Warne and Stronach, 2002). Alternatively, if the staff member has a line manager outside the service he/she may struggle with feelings of loyalty towards his/her discipline and the rest of the team (McGrath, 1991).

The process of teamwork, that is, how teams work together, is also important as if a piece of work is poorly co-ordinated and none of the professionals involved take responsibility, a client may be given mixed messages and conflicting advice (Roberts and Partridge, 1998; McGrath, 1991). To go to the opposite extreme, if all team members start to think alike to avoid conflict, there is the danger that they will have a limited capacity to explore things from different angles.

### *Multi-agency work*

The HAS guidelines state that the mental health problems should not be dealt with only by health services. It is argued that multi-disciplinary work should extend to multi-agency work as young people and their families live within a context and emotional and behavioural disorders are often correlated with risk factors such as financial deprivation and school non-attendance. Therefore, mental health professionals must liaise with social services, education and the voluntary sector (DoH, 1996; Harrington et al, 1998).

### *Aims and objectives of present audit*

The XXX Child and Family Clinic staff is made up of a multi-disciplinary team consisting of one part time Consultant Psychiatrist, two part time Senior House Officers in Child Psychiatry, one half time Clinical Psychologist, three part time Child Psychotherapists, one part time Child Psychotherapy trainee, one half time Child and Adolescent Mental Health Social Work Manager, three part time Child and Adolescent Mental Health Social Workers, one half time Nurse Therapist. The HAS guidelines emphasise the importance of an integrated and client-centred service, and state that one of the primary ways in which a Tier Three service can do this is to provide clients and their families with multi-disciplinary service. Therefore, the main purpose of this audit is to assess whether the St Albans Child and Family team are working collaboratively, and to generate recommendations for improving multi-disciplinary and multi-agency work.

The audit will generate a database of information relating specifically to team working out of existing clinical files, and will attempt to answer the following questions:

1. To what extent is the team providing a multi-disciplinary service to clients and their families? The criteria for multi-disciplinary input would be one or more of the following:
  - Direct joint work, that is, with more than one discipline working directly with the client and his/her family
  - Discussion of the case in a multi-disciplinary clinical meeting
  - Discussion of the case in a multi-disciplinary setting
2. To what extent is the team liaising with external agencies, for example, education and voluntary agencies?
3. Are cases classed as priority cases more likely to receive multi-disciplinary input?
4. Are re-referred cases more likely to receive multi-disciplinary input?

5. Are clients with high scores on the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) rating scales more likely to receive multi-disciplinary input than clients with low scores? (These scales provide an indication of the severity and complexity of the client's needs and are completed following assessment).



## **Method**

### *Data source*

This audit performed a retrospective review of cases using case note analysis and self-reports by professionals. Within the clinic each client has an individual case file which contains information on reasons for the referral and detailed notes on each contact with the client and/or their family. It also contains information on liaison work with other agencies involved with the care of the client, and copies of all correspondence both with and regarding the client. Most of the information required for this audit was readily available within the files; however information pertaining to multidisciplinary discussions was not routinely recorded by the team and was based on staff reports.

The inclusion criteria were all cases allocated between 01/03/2001 and 01/03/2002 regardless of whether the case was now open or closed. This included clients referred to the service for the first time and also clients that had been re-referred. Each client must have attended a minimum of one session at the clinic in order for there to be sufficient information about the nature of the service provided. Cases which involved consultation work with external agencies were excluded, as were cases seen in the multi-disciplinary Looked After Children (LAC) workshop.

### *Data generation*

In order to obtain the necessary data, each member of the multi-disciplinary team was asked to complete an audit form (See Appendix A) for all cases allocated during the specified time period. Staff members were given written instructions on how to complete the forms (See Appendix B) and were provided with the opportunity to discuss any difficulties with members of the audit team in order to ensure that forms were completed uniformly.

The form included basic case information such as age and sex of the client, allocation date and whether or not the case was prioritised. That is, whether or not the case was viewed as fairly urgent and therefore seen within 4-6 weeks of referral. Information on whether each case received uni-disciplinary or multi-disciplinary and /or multi-agency input was also accessed. As was data on whether the case received multi-disciplinary team input via discussion in a clinical meeting or a multi-disciplinary setting. Finally, staff were asked to report HoNOSCA scores for each of the clients seen.

During the time frame specified for this audit, out of twenty team members, seven left the service. Therefore, the forms for these professionals were completed by the main auditor (KP) using client's case files.

#### *Data analysis*

Data was generated by providing each of the responses with a numerical code. It was then analysed using descriptive statistics. This included contingency table analyses to examine the frequency distribution of two categorical variables.

Some of the analyses were based on a sub-set of data. This is because information regarding discussions in a clinical meeting or multi-disciplinary setting was unavailable as the members of staff who were worked with the clients had left the service and no other records were available. Similarly, the HoNOSCA rating scales are relatively new within the service and so were not completed for all clients. Therefore, some analyses were conducted only where complete data existed.

## **Results**

*To what extent is the team providing a multi-disciplinary service to clients and their families?*

During the specified time period (i.e. between 01/03/2001 and 01/03/2002) 176 clients were allocated and seen at least once. In order to be classified as multi-disciplinary work, professionals must have engaged in at least one of the following direct joint work, discussion in a clinical meeting or multi-disciplinary setting. Of the 176 clients seen, 65 (36.9%) received direct joint work. Both social workers and psychiatrists had the highest levels of overall direct joint work, and worked with at least one other discipline in 19 (29.2%) cases. The discipline with the lowest level of joint work overall was psychology which worked directly with another discipline on 3 (4.6%) cases.

Data on whether or not a case had been discussed in a clinical meeting was available for 138 clients and is presented in Figure 1. The bar chart illustrates the finding that overall 46 (33.3%) of cases had been discussed in a clinical meeting. Nursing was the discipline which presented the most cases for consultation with the team in a clinical meeting, and raised just over a third the total cases presented 16 (34.8%). When individual disciplines were considered, nursing was still the discipline which discussed the most cases and raised 16 (43.2%) of the cases on the nursing caseload. The fewest cases were presented for discussion by family therapists (2.2%). Although it should be noted that of the seven members of staff that have left the team two were family therapists, and there are currently no family therapists in the team.

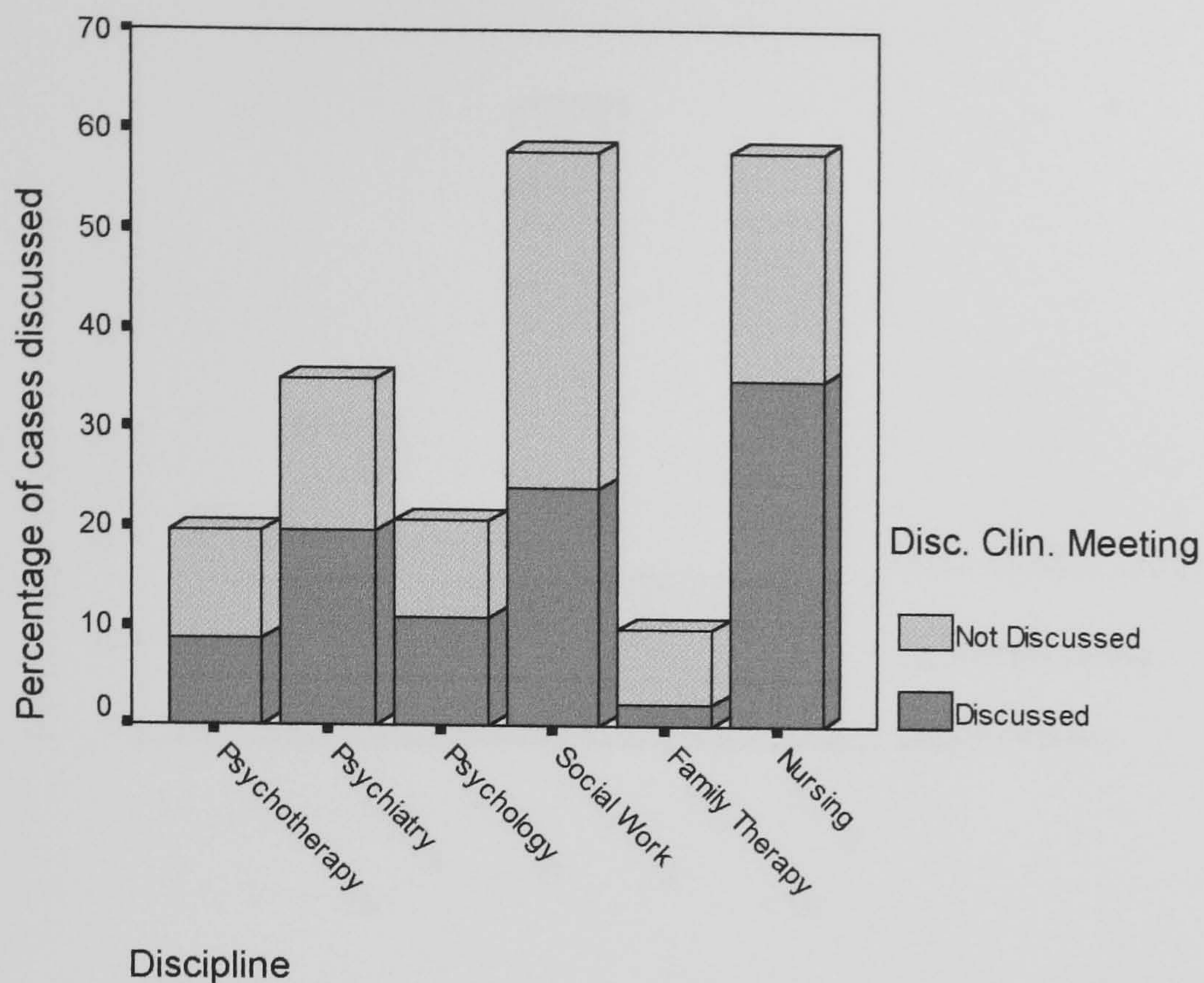


Figure 1. Number of cases discussed in a clinical meeting

Of the 139 cases for which data on whether or not a case had been discussed in a multi-disciplinary setting was available, it was found that 78 (56.9%) cases in total had been discussed. It can be seen from Figure 2. that nursing (34.6%) was the discipline which discussed the most cases overall in a multi-disciplinary setting and the fewest cases were discussed by family therapists (1.3%). When individual disciplines were considered it can be seen that psychology was the discipline which raised the highest number of cases relative to caseload and discussed 12 (85.7%) of the cases on its caseload in a multi-disciplinary setting.

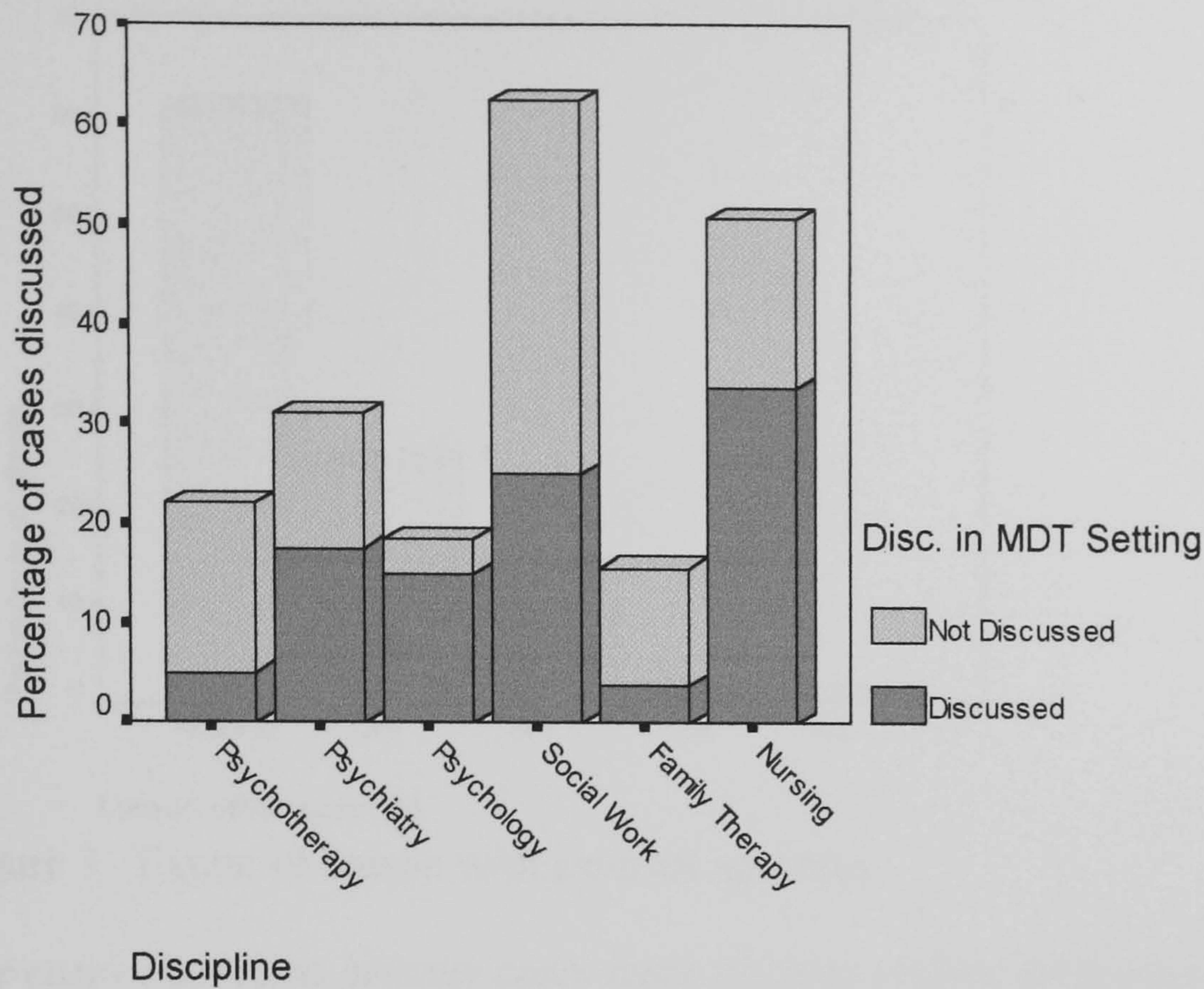


Figure 2. Number of cases discussed in a multi-disciplinary setting

Overall, based on the criteria for multi-disciplinary input, 64 (46.7%) of cases did not receive input from more than one discipline.

*To what extent is the team liaising with external agencies, for example, education and voluntary agencies?*

Figure 3. illustrates that there was no liaison with external agencies in over half of the cases seen 106 (60.2%). There was liaison with at least one agency in approximately one quarter of cases 43 (24.4%), and there was liaison with three or more external agencies in less than 2% of cases.

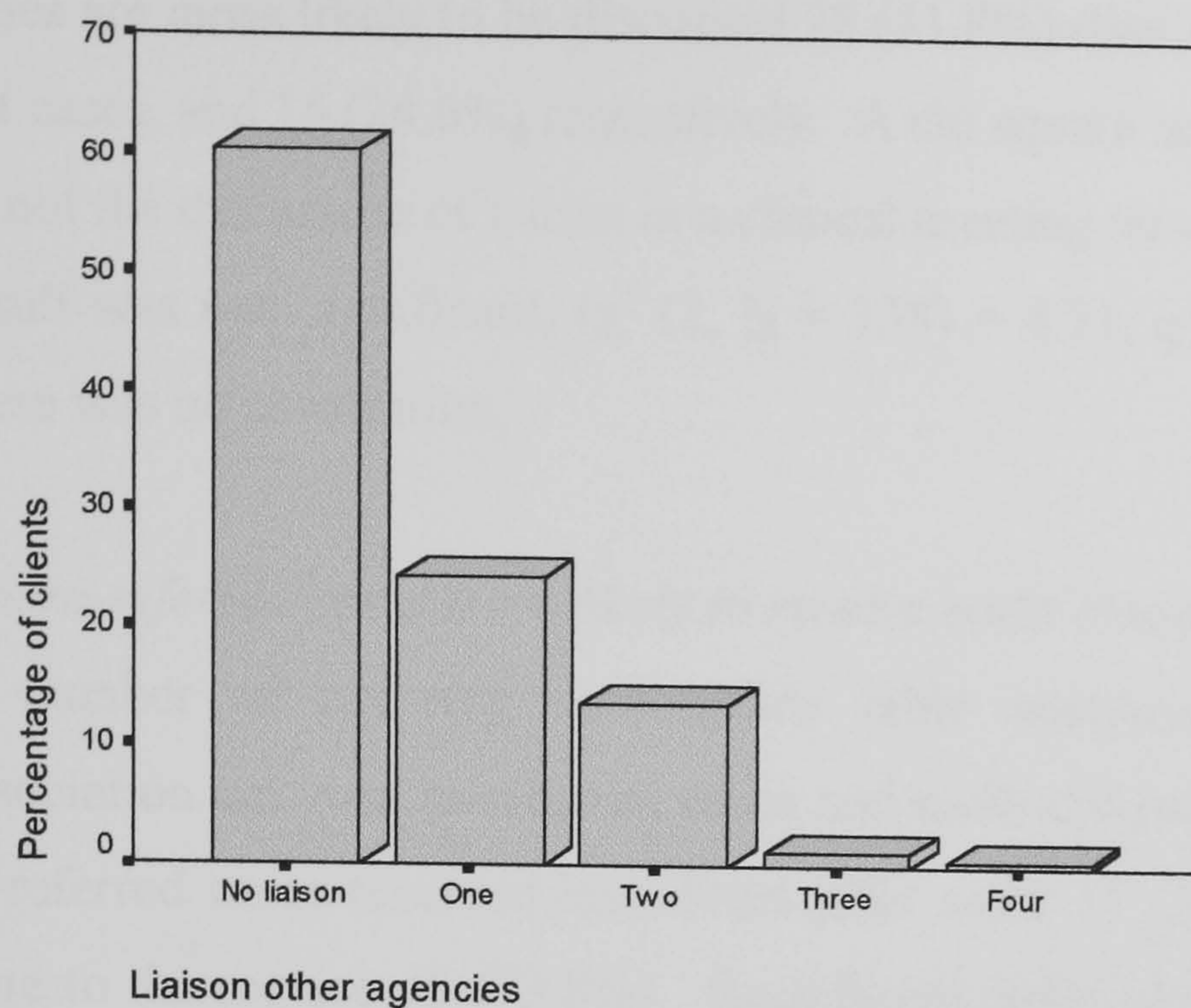


Figure 3. Extent of liaison with external agencies

*Are cases classed as priority cases more likely to receive multi-disciplinary input?*

Whether or not a case is prioritised may be viewed as an indicator of the urgency of the case. The results are reported in Table 1, from these it can be seen that cases taken from the waiting list were just as likely to receive direct joint work as cases that were immediately prioritised, 29 (44.6%) and 31 (47.7%) respectively. However, across all three levels of prioritisation, the extent of direct joint work was approximately equal which suggests that there is no relationship between level of direct joint work and level of prioritisation. A similar pattern of results was evident for level of prioritisation and discussion in a multi-disciplinary setting, where 37 (46.3%) cases taken from the waiting list were discussed, compared to 38 (47.5%) cases that were immediately prioritised.

Table 1. Illustrating number of cases which received direct joint work relative to level of priority.

Joint work		prioritisation			Total
		Waiting list	Prioritised later	Immediately Prioritised	
<b>Yes</b>	Count	29	5	31	65
	% of Total	16.5%	2.8%	17.6%	36.9%
<b>No</b>	Count	56	7	48	111
	% of Total	31.8%	4.0%	27.3%	63.1%
<b>Total</b>	Count	85	12	79	176
	% of Total	48.3%	6.8%	44.9%	100.0%

The results for a contingency table analysis of level of prioritisation and whether or not a case was discussed in a clinical meeting indicate that cases that were classed as immediate priority

cases are more likely to be discussed 28 (41.8%) than later priority cases 3 (30%) and waiting list cases, and 15 (24.6%) respectively. A chi square analysis was conducted to assess whether or not the discussion of a case in a clinical meeting was related to the urgency of the case. The result was non-significant, ( $\chi^2 (2, N = 138) = 4.31, p = 0.12, \text{Cramér's } \underline{V} = 0.12$ ) indicating there was no association.

*Are re-referred cases more likely to receive multi-disciplinary input?*

A number of two-way contingency table analyses were conducted to investigate the association between re-referred cases and multi-disciplinary input. The results indicated that re-referred cases received less direct joint work 17 (26.2%) than cases referred for the first time to the service 48 (73.8%). Re-referred cases were also less likely to be discussed in a multi-disciplinary setting 23 (28.8%) than new referrals 57 (71.3%). Similarly, re-referred cases were also less likely to be discussed in a clinical meeting 12 (26.1%) than new referrals 34 (73.9%). However, chi square analyses of these findings was non-significant indicating that there was no association between direct joint work, ( $\chi^2 (1, N = 176) = 1.63, p = 0.20, \text{Cramér's } \underline{V} = 0.20$ ), presentation in a clinical meeting ( $\chi^2 (1, N = 138) = 1.79, p = 0.67, \text{Cramér's } \underline{V} = 0.67$ ) and discussion in a multi-disciplinary meeting ( $\chi^2 (1, N = 139) = 3.49, p = 0.06, \text{Cramér's } \underline{V} = 0.06$ ), and whether or not a case had been previously referred to the service.

*Are clients with high scores on the (HoNOSCA) rating scales more likely to receive multi-disciplinary input than clients with low scores?*

The data presented in Table 2 is based on clients for whom complete data was available, and indicates mean HoNOSCA scores according to type of multi-disciplinary input. Independent samples t-tests were conducted to investigate whether or not clients who had higher HoNOSCA scores were more likely to receive multi-disciplinary input. It was found that clients who received direct joint work ( $t (114) = -2.92, p = 0.004$ ) and/or were discussed in a clinical meeting ( $t (99) = 3.48, p = 0.001$ ) had significantly higher HoNOSCA scores than those who did not. Clients who were discussed in a multi-disciplinary setting did not have significantly higher HoNOSCA scores than clients who were not discussed, ( $t (100) = 1.51, p = 0.135$ ). These results suggest that clients with more severe problems were more likely to receive multi-disciplinary input in the form of direct work and discussion in a clinical meeting, than clients with less severe problems.

Table 2. Illustrating the HoNOSCA scores for clients according to type of multi-disciplinary input

		<b>Presented in clinical meeting</b>	<b>Discussed in multi-disciplinary setting</b>	<b>Direct joint work</b>
<b>Yes</b>	Mean	19.53	17.0	18.39
	N	32	59	38
	SD	6.12	6.78	6.9
<b>No</b>	Mean	14.71	14.93	14.5
	N	69	43	78
	SD	6.65	6.94	6.68
<b>Total</b>	Mean	16.24	16.13	15.78
	N	101	102	116
	SD	6.84	6.89	6.97



## Discussion

*To what extent is the team providing a multi-disciplinary service to clients and their families?*

A multi-disciplinary service, defined as at least one of the following, direct joint work, discussion in a clinical meeting and/or multi-disciplinary setting, was provided in 64 (46.7%) cases. This was a surprisingly low figure which indicates that almost half of the clients seen at the clinic received input from only one discipline. It may be argued that this figure is not entirely accurate and underestimates the multi-disciplinary input provided as these figures do not include cases which are discussed informally within the clinic.

It may be useful to examine the cases that did not receive any multi-disciplinary input in more detail. It may be that these clients did not receive a multi-disciplinary service due to overwhelming demands on the service. If this is the case then ways of maximising limited specialist resources need to be explored. For example, during the time of this audit one of the existing meetings was restructured to enable the discussion of all new assessments carried out in the clinic. This is a way of providing every case with the perspectives of several disciplines. Alternatively, the high number of cases that did not receive any multi-disciplinary input may mean that some of the clients that were seen at the clinic (Tier Three) could have been seen in Tier Two. This view would have implications for existing primary and community child mental health care services, and for professionals working in Tier Three services with regards to training, supervision and consultation.

It is important to bear in mind that the concept of teamwork is a model for working and that its presence alone does not guarantee that service delivery is being improved (McGrath, 1991). The information generated by this audit reflects the quantity of multi-disciplinary input and does not indicate the quality or intensity of the service provided. For example, the data does not reflect the length or frequency of professionals contact with clients and their families. In light of all the literature about differences between disciplines working as a team, and the lack of literature on the effectiveness of teamwork, it may be useful to carry out an audit on case outcomes. That is, investigate whether or not outcome was improved by multi-disciplinary input.

*To what extent is the team liaising with external agencies, for example, education and voluntary agencies?*

The results indicate that in over half of all the cases seen (60.2 %) there was no liaison with external agencies. This figure is lower than would be expected as children live within a context and also because guidelines devised by the Health Advisory Service (HAS, 1995) and the Department of Health have specified the importance of providing a comprehensive and “seamless” service to young people and their families. It would therefore be useful to review the clinic's policies regarding working with external agencies, and develop ways of increasing the level of liaison with them. For example, inviting professionals from external agencies to attend case discussion meetings.

*Are cases classified as priority cases more likely to receive multi-disciplinary input?*

Cases that were viewed as urgent or high priority cases were just as likely to receive direct joint work and be discussed in a multi-disciplinary setting as cases that were taken from the waiting list. However, as would be expected, urgent cases were more likely to be discussed within a clinical meeting, than less urgent waiting list cases. This finding implies that the urgency of a case does not necessarily reflect its complexity and consequently does not influence the level of multi-disciplinary input.

*Are re-referred cases more likely to receive multi-disciplinary input?*

The results indicated that re-referred cases received less direct joint work and were also less likely to be discussed in a multi-disciplinary setting or clinical meeting than new referrals. This is an interesting finding as the fact that a client has been re-referred to the service implies that his/her difficulties are chronic. This suggests that multi-disciplinary input may not be determined by the severity of a client's needs alone and that other factors play a part. In order to examine the association between multi-disciplinary input and re-referred cases more accurately, it would be useful to look at the type of cases which are re-referred (for example, nature of difficulties, severity), and how long after discharge they were re-referred.

*Are clients with high scores on the HoNOSCA rating scales more likely to receive multi-disciplinary input than clients with low scores?*

The results indicate that cases with higher HoNOSCA scores were slightly more likely to be discussed in a clinical meeting and receive joint work than those with lower scores. Although it must be noted that HoNOSCA scores are an inaccurate measure of the severity of a client's

difficulties. This is because closer inspection of the scales reveals that the scores may be influenced by age, as not all of the sub-scales (For example, non-accidental self-injury and alcohol/substance/solvent misuse) are equally applicable across age groups. Therefore, younger children may have severe and complex problems but receive a low HoNOSCA score. Another limitation of HoNOSCA scores is that they do not reflect the urgency of a case as it is possible to be given a low score and still be prioritised.

In order to examine the relationship between multi-disciplinary input and severity it may be useful to adapt some of the rating scales used in other services. For example the caseload management tool used in Learning Disabilities services. This scale provides a way of rating the severity and complexity of cases according to various domains, and also allows professionals to weight cases according to the time demands they create.

### *Limitations*

One of the main limitations of this audit is that it focuses on a very narrow range of data, as it only looks at cases that were allocated during a specified time period. It may have been more useful to audit all cases on each professional's workload as this would give a clearer indication of the extent of multi-disciplinary work that is being carried out. Another limitation is that the audit does not take into consideration multi-disciplinary workshops such as the Looked After Children workshop which consists of professionals from psychiatry, social work, psychology and psychotherapy.

The data generated from this study was reliant on all staff completing the audit table in the same way, and it is inevitable that there will be some discrepancies and inaccuracies, particularly since some of the information was dependant on professional's memory skills. One way to overcome this in future is for the data to be collected by a small audit team. However, this would only be possible if new records are generated detailing which cases are discussed in clinical meetings and in multi-disciplinary settings.

Finally, the HAS guidelines specify that the core role of a Tier Three clinic is to provide a multi-disciplinary service. However, the degree or extent to which this should occur is not specified. Therefore, it may be useful to compare the results of this audit to those of another local CAMHS team to give a comparative indication of level of teamwork.

### *Clinical and service related implications*

A study by Wheeler et al. (1998) found that multi-disciplinary assessments of complex cases over one half day were more useful in developing an understanding of a client's difficulties than each discipline carrying out single assessments and discussing the results. This is because it provided the opportunity for an ongoing dialogue between professionals and encouraged multi-disciplinary discussions. This is something which could be incorporated into this clinic's referral system at a later stage and would be a way of facilitating more direct joint work and discussions. Alternatively, clients could be jointly assessed by two disciplines following a referral before a decision is made about the most appropriate worker for the case (Roberts et al, 1998). However, this would be very time consuming and may be practically impossible.

One way of improving the level of teamwork is to revisit the shared aims and objectives of the team so that the service offered can be altered in response to changing need (Yerbury, 1997). For example, epidemiological studies indicate that the number of cases of young people with substance-use related difficulties is on the increase (Street, 2000). This is a relatively new phenomenon amongst children and therefore the team could jointly devise new strategies to address this.

Other ways of increasing the level of multi-disciplinary teamwork is through the use of both multi and uni-disciplinary training. This would encourage professionals to continue developing skills both individually and as a team. It would also allow each discipline to maintain a sense of professional identity whilst fostering good working relationships with other professionals. Another way in which these aims could be achieved is via the use of "skill share" sessions. This would involve different team members introducing other disciplines to alternative ideas and models of working which would help with professional development and would also increase professionals understanding of each others work. This could be done in the form of presentations and discussions (Lynggaard, Donati, Pearce and Sklavounos, 2001).

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