POSITIONING SHAME IN THE RELATIONSHIP BETWEEN ACCULTURATION/CULTURAL IDENTITY AND PSYCHOLOGICAL DI SPECIFICALLY DEPRESSION, AMONG BRITISH SOUTH ASIAN WO

By

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Thesis submitted to the University of Leicester, School of Psychology: Clinica Faculty of Medicine, in partial fulfillment of the degree of Doctorate in Clinical

July 2003

29,978 words

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Positioning shame in the relationship between acculturation/cultural identity and psychological distress (specifically depression) among British South Asian women.

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ABSTRACT

Recent findings indicating higher than expected levels of psychopathology amongst British South Asian women over the last decade provided a rationale to investigate the links between acculturation/cultural identity and psychological distress (specifically depression) and the experience of shame. Ninety British South Asian women were drawn from the general population of five culturally diverse cities in the UK and completed measures of acculturation/cultural identity (AIRS-B), psychological distress (GHQ-28) and shame (ESS). Hypotheses and explanations generated in the previous literature to account for the high incidence of mental health problems among British South Asian women were critically examined to assess their usefulness in understanding the cultural factors implicated in the causation of psychological distress. Theoretical and empirical links between the constructs were discussed in relation to evolutionary models of shame (Gilbert, 1997, Lewis, 1987) and Berry's (1980, 1997) bi-dimensional model was applied to the two-way interaction process between minority and majority cultures to determine the psychological adaptation of individuals living in a bi-cultural context. Results indicated that acculturation strategy and level of cultural identity were related to psychological distress and depression but these relationships were *mediated* by the intervening mechanism of shame. Full or partial identification with South Asian culture was related to higher levels of shame and the vulnerability to experience shame (shame prone-ness) was associated with psychological distress, specifically depression. A preliminary model of *possible* relations between the different psychological constructs was developed from the findings of the study. The relations between acculturation/cultural identity and shame illuminated the complex processes involved in shaping an individual's sense of self and provided a tentative understanding of the dynamics involved in the development of psychological distress for British South Asian women.

ACKNOWLEDGEMENTS

All my gratitude and appreciation to Professor Ray Cochrane; for his invaluable supervision and guidance, support and patience, and for taking on this study at such a late stage. Thank you to my academic supervisor, Dr. Aftab Laher, for his much valued advice and support. My thanks also to Professor Harriette Marshall, for making the time to read my work, give constructive feed back and for continuing to be an inspiration to me.

I would also like to acknowledge Dr. Dinesh Bhugra and Professor Paul Gilbert for discussing my research ideas with me during the development of this study, for sending me useful papers and whose research contributions in the area of my research were an invaluable learning resource and inspiration. Thank you to the administrative staff at the University of Leicester, to all the participants who took part in the study and to my peer, Shelley McKeown, to whom I am indebted for help with statistics and just being there (to share the pain)!

Special thanks to my family- Mama, Pankaj, Dimple, Jeju, Krishna - for *everything*- their love, strength, patience and faith, which guided me when I lost my own, and to my beautiful nephew- Tarun Amol- for bringing so much sunshine in to my life. My warm thanks also to my best friends, Gillian, Radiya, Isabel, Gavin and Adam, for all their love, understanding, emotional and practical support, and for giving me regular doses of laughter and retail therapy throughout this course.

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PROLOGUE

"I am Indian. To be more accurate, I was raised in England,

but my parents came from India- land, people, government, self – 'Indian' –

What does that mean? At this time, the government of India is testing nuclear weapons-

Am I less Indian if I don't defend their actions?

Less Indian for being born and raised in Britain?

For not speaking Hindi? Am I not English because of my cultural heritage?

Or the colour of my skin? Who decides? –

'History' tells me my heritage came from the 'Sub'-continent – a 'third world' country, a

'developing' nation, a 'colonised' land – so what is history?

My identity and my history are defined only by myself- beyond politics, beyond nationality,

beyond religion, and Beyond Skin".[1]

[1] Taken from the album 'Beyond Skin' by Nitin Sawhney, 1999.

CHAPTER ONE

1. PREFACE

The focus of this chapter is to review the research conducted on the psychology of British South Asian women which informs the research questions addressed in the following pages and Chapter two. The review will begin by highlighting the importance of issues of identity before setting the context for the present study and describing its relevance to current clinical practice. In order to understand the role of cultural factors in the mental health of British South Asian women, it is necessary to review the literature on acculturation and cultural identity in relation to the varying trends in psychopathology. In reviewing the prevalence literature, hypotheses and explanations generated to account for the high incidence of mental health problems will be critically examined to assess their usefulness in aiding an understanding of the cultural factors that have been implicated in the causation of psychopathology. At a theoretical level, an aim is to draw together key concepts and findings from various research bases in order to delineate relationships between phenomena. A review of the literature on shame constitutes the second half of the chapter where an attempt is made to contextualise shame within South Asian cultures. The discussion of shame will focus on an outline of the theoretical approaches, the relevant domains, measurement and role of shame in identity, culture and psychopathology. Finally, empirical links between the three constructs (shame, acculturation/cultural identity and psychological distress) will close the chapter.

1.1 Introduction

Over the past few decades, there has been a growing interest in the role of cultural factors in the mental health of ethnic minority individuals living in Britain. Some of this interest has focussed on the interface between acculturation, cultural identity and psychological adjustment (Bhugra *et al.* 1999a, 1999b; Cochrane & Stopes-Roe, 1981; Guglani, *et al.* 2000; Sonuga-Barke & Mistry, 2000). What appears to be emerging from the literature is the recognition that all ethnic minority individuals, on some level, are affected by issues of acculturation and cultural identity in white mainstream society. Researchers generally agree that ethnic minority individuals must address issues of (1) their relationship with the mainstream white majority culture, (2) retention of characteristics from their original culture of heritage, and (3) the accompanying mental health concerns that arise from these processes. These issues of *participation and contact* within a larger cultural context and *maintenance of*

contact within one's own ethnic group have been conceptualised and empirically examined in the measurement domains of acculturation and cultural identity (Sodowsky, 2002).

1.2 Setting the Context

The migration of diverse cultural groups to Britain since the 1960's has gone some way towards bringing about subtle 'changes' at different levels among the various groups of second generation (British-born) ethnic minority individuals. These changes have been observed in relation to each other and to British society at large (Ali & Northover, 1999). Over the last decade, artistic mediums such as music and dance have helped to bring issues of identity and expression amongst Britain's ethnic minority individuals into the mainstream. For example, South Asians and African Caribbeans have contributed to and influenced each other's musical traditions, which have embraced for example, African Caribbean reggae, hip hop and soul with classical Indian music, Punjabi bhangra and bollywood music in a fusion of musical styles (e.g. Apache Indian, Nitin Sawhney, Stereo Nation and Missy Elliot). The fusion of culture in artistic realms has also been explored in dance, where choreographers such as Akram Khan and Shobana Jaya Singh have blended contemporary western dance styles with classical Indian dance, bringing new vitality to the cross-cultural expression of identity in Britain's multicultural society. These cultural 'fusions' have also extended to and influenced the general youth culture in Britain (Ali & Northover, 1999). They are a general testimony to the processes of re-definition of identity, which have been taking place amongst Britain's second generation immigrants and the cohort of native white youngsters who have grown up along side them.

Many of these issues are expressed in the opening prologue and are particularly pertinent in the current political, religious and social climate where tensions in cultural groups in recent years have manifested in assertive expressions of identity (e.g. young Pakistani men in Bradford during the summer of 2000), and on occasion, race attacks across the country (e.g. Stephen Lawrence, Damilola Taylor). To set the context further, the recent war in Iraq (perceived by some as West versus East or Christianity versus Islam) has brought issues of identity and cultural allegiance to the surface of peoples' awareness. Issues of identity and, indeed, other related issues such as the experience of racism and discrimination are thus rooted within the socio-cultural mileau and the political zeitgeist of the receiving country. The relationship of the majority culture with the minority culture is therefore very important when considering the interactive process (Bhugra *et al.* 1999c).

1.3 Clinical Relevance

Most of the empirical work on cultural identity has tended to concentrate on children and adolescents (Ghuman, 1998, 2000) with a focus on 'racial' identity development (Maximé, 1986; Robinson, 2000). Much less research has addressed the psychological role of cultural identity *beyond* adolescence. This is surprising given that recent research suggests that young South Asian women are one of the most vulnerable populations in terms of the prevalence of psychopathology in Britain. Prevalence studies addressing such issues will be reviewed in section 1.7 of this chapter. Also, there is a substantial body of research conducted in the field of psychotherapy, which has mainly tended to address the clinician's 'racial'/cultural identity and the client's preference for a clinician of a similar 'race' or culture (e.g. Carter, 1995). However, Helms (1984) has recognised the importance of assessing cultural identity and explained the reason why many clients (who have a different cultural background to their therapist) failed to return to clinical services to be related to the clinician's 'inability to assess and incorporate the cultural identity of the client and how this factor has an impact on their construction of the problem' (cited in Patel, *et al.,* 2000, pp. 46).

The clinical relevance of studying acculturation and cultural identity has been further highlighted in the British Psychological Society's Briefing Paper (No. 16), which states that black and minority ethnic group people can develop psychological problems which fall into the following main areas:

- Psychological problems as experienced by other clients such as anxiety, depression, child abuse, dementia, learning disabilities, obsessional compulsive disorders, phobias and so on.
- Psychological consequences directly related to being a member of black and minority ethnic group such as the psychological trauma of experiencing racism, of being a refugee, conflicts of racial identity and the effects on child development, and ongoing complex grief as a result of loss of role, identity, homeland and culture.
- People may present with complex problems arising from a combination of the above (Division of Clinical Psychology, BPS, 1998, p.7).

Further, National Service Frameworks have targeted anxiety and depression as priorities in the National Health Strategy (Department of Health, 1999). Within this context, there is some evidence to suggest that certain groups of South Asian people are particularly vulnerable to experiencing anxiety and depressive states (e.g. Guglani *et al.,* 2000; Shah & Sonuga-Barke,

1994), which have recently been implicated as giving rise to psychopathology such as eating disorders (Littlewood, 1995; Bhugra & Bhui, 2003). Given that acculturation has been found to be related to a number of psychological variables (e.g. Bhugra *et al.*, 1999c, Cochrane & Stopes-Roe, 1981; Thompson & Bhugra, 2000), understanding and being able to assess these constructs is an important task for clinical psychologists who serve a growing and diverse population of ethnic minority individuals.

1.4 Notes on Terminology

The literature on culture and ethnicity in clinical psychology is replete with inconsistencies in the usage of terms, which are often used synonymously and has produced much overlap and ambiguity in the current discourse as a result. A review of the literature indicates that there is a general lack of consistency in the ways in which ethnicity, culture, acculturation and cultural identity are incorporated into empirical studies, which has led to a poor understanding of these concepts and casts considerable doubt on their operationalisation (Sheldon & Parker, 1992). It is therefore appropriate to make a conceptual distinction between the terms for the purpose of clarifying discussion in the present context, before proceeding with the review of relevant literature, which constitutes the focus of the chapter.

1.4.1 South Asian

The broad category 'South Asian' refers to a heterogeneous population diversified in terms of religion, class, migration patterns, language, traditions and identifications. Following Marshall and Yazdani (2000), the category of 'South Asian' will be used in the present context to refer to those peoples whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka. It will also be used to include people from East Africa, most commonly people from Kenya and Uganda and South Africa whose ancestors originated (and later emigrated) from South Asia.

1.4.2 Generational Status

The term 'first generation' will be used to refer to foreign-born, post Second World War migrants and their offspring born in the UK will be referred to as 'second generation'. The children of second-generation migrants will be referred to as 'third generation'.

1.4.3 Ethnicity

The concept of 'ethnicity' has two definitional dimensions; the first is in the way in which it allows individuals to self identify themselves as belonging to an ethnic group and the second is in the way in which it allows researchers to distinguish groups of people by their ancestry, customs, religion, culture, geography or nationality (i.e. self-versus-other ascription). Many researchers have argued that ethnicity is situational and not fixed; it is 'transactional, shifting and essentially impermanent' (Patel, *et al.* 2000, pp.31). This definition implies that there is no single criterion by which the term ethnicity can be defined. The implication inherent in such an interpretation is that people belong to multiple 'ethnicities' in terms of geographical region, religion, culture, and so forth (Bempah, 2000). For the purpose of this study 'ethnicity' will be used to refer to a group identification which signifies allegiance to the culture of origin, and is applicable to both minority and majority groups (Patel *et al.,* 2000).

1.4.4 Culture

Culture has also been defined in diverse ways in the literature. D'Ardenne and Mahtani (1999) viewed culture as a dynamic concept that permeated the way in which people lived their lives. Sodowsky *et al.* (1991) conceptualised culture in more detail as referring to "common and shared values, customs, habits and rituals; systems of labeling, explanation and evaluation, social rules of behaviour; perceptions regarding human nature, natural phenomena, interpersonal relationships, time and activity; symbols, art and artifacts and historical developments" (Sodowsky *et al.*, 1991, pp.194). This working definition will be used in the present study as it includes the psychologically relevant elements, such as roles and values that constitute culture, which are considered to be important in relation to mental health issues. Further, Betancourt and Lopez (1993) contended that when culture is defined in terms of psychologically relevant elements, it becomes amenable to measurement.

1.4.5 Acculturation

The concept of *acculturation* was first used by cultural anthropologists and sociologists to refer to the cultural changes that resulted from two cultural groups coming in to continuous and direct contact. The form that change took in relation to the new culture was referred to as acculturation. Redfield *et al.* (1936) presented a classical definition of acculturation as "acculturation comprehends those phenomena which result when groups of individuals having different cultures come in to continuous first hand contact with subsequent changes in the original culture patterns of either or both groups" (Redfield *et al.*, 1936, pp. 149). Since the

process of acculturation involves the transmission of cultural phenomena of one cultural group to members of another distinct cultural group, according to Berry (1997), it is likely that one group will dominate the exchange of group characteristics.

Acculturation has been described in the literature at the collective or group level (which involves changes in the culture of the group), and also at the individual level (which involves changes in the psychology of the individual) (Graves, 1967). Psychologists contend (e.g. Ryder *et al.*, 2000) that when an individual from one cultural group moves to live in a different cultural context, many aspects of their self-identity may be modified in order to accommodate information about and experiences within the new culture. Berry (1997) developed the concept of ' psychological acculturation' to refer to the changes observed in the individual on a number of different domains such as language usage, cognitive style, cultural attitudes towards the dominant group, values, behaviour, personality and sense of cultural identity. These factors interact to create a multidimensional conceptualisation of acculturation. The final outcome of the acculturation process is adaptation.

1.4.6 Cultural Identity

There is no widely agreed definition of cultural identity and the term has been used synonymously with ethnic identity (e.g. see Phinney, 1990, Weinreich, 1999). Many researchers' subscribe to Tajfel's (1981) definition of cultural identity, which refers to the "ethnic component of social identity (that part of an individual's self-concept which derives from knowledge of membership of a social group or groups) together with the value and emotional significance attached to that membership" (Tajfel, 1981, pp.255). Cultural identity is thus a social or collective self-identity based on the culture of one's ancestral group, and modified by the demands of the majority host culture (Sodowsky & Lai, 1997). Cultural identity may therefore be seen as an *aspect* of acculturation in which changes are observed in relation to how an individual relates to their culture of origin as a subgroup of the larger culture (Phinney, 1990).

Cultural identity is fluid, contextual, multidimensional in nature and has internal and external characteristics (Suthakaran & Sodowsky, in press; Woollett *et al.*, 1994). External characteristics include observable behaviours such as mother tongue language usage, friendships and participation in ethnic group functions. Other observable behaviours include practising cultural traditions and the eating of ethnic foods. Internal cultural identity

characteristics have been specified as cognitive, moral and affective (Suthakaran & Sodowsky, in press). The cognitive aspects include self-image in relation to one's culture of origin and image of one's ethnic group. The moral dimension includes cultural values and sense of moral obligation to one's ethnic group (e.g. marrying within the same cultural group). The affective part refers to a sense of belonging, preference to associate with in-group members and comfort with the cultural patterns of one's ethnic group (Suthakaran & Sodowsky, in press).

1.4.7 Relationship between Acculturation and Cultural Identity

A review of the literature suggests that issues of *acculturation* are most meaningful for first generation immigrant groups (who go through the continuous process of adapting to a larger white society) and issues of *cultural identity* seem to be related to a reverse acculturation process and may be more relevant for second generations. Sodowsky and Lai (1997) made a distinction between the two processes: "acculturation adaptation is a response to the dominant group and ethnic [cultural] identity is a response to one's ethnic group" (Sodowsky & Lai, 1997, pp.213). Sodowsky's (2002) conceptualisation of acculturation and cultural identity will be used in the present study to distinguish the two constructs. Sodowsky (2002) proposed that first generation immigrants arriving in white society as adults might have struggled with their acculturation to the white society, having already undergone socialisation in their culture of origin. Alternatively, second and subsequent generations, are in a position whereby they must determine what aspects of their culture of origin are most salient to them and thus to be retained (Sodowsky & Frey, 2003). Second generations develop a cultural identity by negotiating their relationship with their culture of origin (often through their parents) and the dominant white culture (through education and employment in the labour market). In this process, new formulations and fusions of cultural identity are often created.

The preceding conceptualisations of acculturation and cultural identity suggest that the two constructs are separate but related processes and both are experienced by individuals from ethnic minority groups. Several studies support this proposition. For example, Hutnik (1986) studied the self-identification (as 'Indian' or 'British') and cultural behaviours of adolescent girls from East Indian backgrounds and found the two constructs to be independent. Sodowsky (2002) described the relationship between acculturation and cultural identity as a 'push-pull phenomenon', whereby an individual feels both the *push* to acculturate to the larger white culture and the *pull* toward their own cultural group. The tension between 'push

and pull' may give rise to psychological stress. Some researchers have commented that the nature of contact and change between two the diverse cultures may be 'difficult, reactive or conflictual' and it has been suggested that the nature, purpose, duration and permanence of the contact will determine the response (Berry, 1997; Bhugra *et al.*, 1999c, pp.212).

1.5 Models of Acculturation

Researchers have proposed a number of models to describe the changes that occur within, among and between cultures when they come into close contact. The theoretical conceptualisation of acculturation has evolved from a simple unidimensional model (which conceptualises changes in cultural identity of the minority along a continuum, from strong adherence to culture of origin at one extreme, to strong mainstream adherence at the other) to the recognition that acculturation is a multidimensional process that occurs when individuals and groups come into continuous contact with different cultural groups. Each model has a different emphasis and set of assumptions and identifies different outcomes for the individual.

1.5.1 Uni-dimensional Model

Acculturating individuals are in a process of relinquishing the attitudes, values and behaviours of their culture of origin whilst adopting those of a mainstream society. This process is called assimilation and is uni-directional. The underlying assumption of all assimilation models is that individuals lose their original cultural identity as they acquire a new identity in a second culture. Assimilation is therefore the process by which an individual relinquishes their original cultural identity and develops a new cultural identity. However, the weakness of the unidimensional conceptualisation of acculturation is it's inability to account for contextual factors in the acculturation process (Sodowsky, 2002). Ethnic minority individuals may adopt different acculturative attitudes depending on the particular context in which they function.

1.5.2 Bi-dimensional Model

An alternative way of understanding the process of change is offered by bi-dimensional models which describe acculturation as a two way process, where the relationship with the individual's culture of heritage and the relationship with the wider mainstream culture is considered to be somewhat or even entirely independent of one another. Individuals may adopt many of the values, attitudes and behaviours of the mainstream culture *without* relinquishing facets of self identity related to their culture of origin. In short, a strong cultural identity does not necessarily imply a weak relationship (low involvement) with the

mainstream culture. According to this formulation, psychological acculturation begins with an individual's subjective experience of the contact between the two distinct cultures and the need to participate to varying degrees in both.

The most widely researched bi-dimensional approach is Berry's (1980, 1997) conceptual framework, which is based on two important issues that are in opposition and may create conflict: cultural maintenance and cultural participation. These two issues represent the dimensions of individual acculturation and can be assessed by two fundamental questions: (1) 'Is it considered to be of value to maintain cultural identity and characteristics and (2) Is it considered to be of value to maintain relationships with other groups?' (Berry, 1990, p.216). The model assumes dichotomous decisions (yes or no) and the individual's response determines the acculturation strategy adopted when living in a culturally diverse society. Berry *et al.* (1980, 1987, 1990) conceptualised this process by defining four possible strategies. These are assimilation, rejection, integration & marginalisation (Berry, 1980, 1990). *Assimilation* is synonymous with high acculturation and refers to an exclusive identification with the dominant culture. *Rejection* is synonymous with low acculturation and refers to an exclusive identification with the cultural values and practices of the individual's culture of origin and little or no involvement with the larger society. Conceptually, *Integration* represents the balance between *Rejection* and *Assimilation* and has been referred to as bi-culturalism (identification with both groups). *Integration* is characterised by an allegiance to the culture of origin and an allegiance to the majority culture. Identification with neither culture suggests *Marginality*.

1.5.3 Interactional Model

Padilla (1980) presented a model of acculturation that addressed the effects of the extent and rate of acculturation on psychological functioning. Padilla's (1980) model was developed specifically for Mexican Americans but the author claimed that the constructs inherent in the model were applicable to many different cultural groups. Padilla (1980) contended that two components of the acculturation process, cultural awareness and ethnic loyalty, determined the acculturation status of individuals. Cultural awareness refers to the knowledge an individual possesses of cultural material regarding both the culture of origin and the majority culture. Ethnic loyalty refers to an individual's propensity to chose one cultural orientation over the other. Padilla (1980) introduced the notion of *cultural preferences*, which vary from

minor relevance to high significance. This model suggests that an individual's preference for the minority versus the majority culture provides a measure of acculturation.

Padilla's (1980) conceptualisation is based on five key dimensions. The first is language familiarity and usage, which was conceptualised in terms of preferences. Language usage has been exclusively studied in previous research (based on linear models of acculturation) to indicate that an increase in the use of the majority culture's language reduces the use of the culture of origin's language, resulting in greater acculturation (assimilation). However, in Padilla's (1980) conceptualisation *preference* for either language is more important than studying language familiarity and usage. The second dimension in Padilla's (1980) model is cultural heritage, which refers to a "knowledge of a wide variety of cultural artifacts and materials specific to both cultures...[and] refers to an individual's preference for one cultures artifacts or materials over the other" (Padilla, 1980, p.49). Acculturative change is therefore not exclusively dependent of the level of knowledge of either culture. According to Padilla's (1980) model, it is possible to possess a high degree of knowledge regarding the artifacts and materials of the majority culture, yet *prefer* the artifacts and materials of one's culture of origin, which impacts on acculturation as a psychological phenomenon. The three dimensions that remain constitute ethnic factors, which are ethnic pride and identity, inter-ethnic interaction and inter-ethnic distance, the latter two being moderated by perceived prejudice. The combination of these dimensions illustrate the interactional nature of acculturation.

1.5.4 Bi-dimensional Model of Cultural Identity

Sodowsky *et al.* (1995) expanded Berry's (1980) bi-dimensional model of acculturation to address the complex dynamics of cultural identity. They proposed that the cultural identity process might also be bi-directional, involving two dimensions: degree of adoption of 'Whiteness' and degree of retention of 'Asianness'. According to Sodowsky *et al.* (1995), these two dimensions create a multidimensional model of cultural identity similar to Berry's (1980) conceptual framework, whereby individuals are faced with two questions: 1) Is my cultural identity of value and to be retained and, 2) Is the White [British] identity to be sought? The combination of responses to the two questions result in four cultural identity orientations: *Bicultural Identity*, where the individual identifies with both groups; *Strong Cultural Identity*, where the individual values retention of culture of origin identity over the White identity; *Strong [British] White Identity,* which, in Sodowsky's terms, suggests that the

individual is not 'ethnically' defined and *Culturally Marginalised Identity*, which characterises individuals who identify with neither culture. Sodowsky *et al.* (1995) conceptualised this process to be 'nonlinear' to indicate that cultural identity orientation varies over time and across different situations.

1.6 Measuring Acculturation and Cultural Identity

The development of acculturation and cultural identity instruments is based on 'etic' or 'emic' approaches. According to Sue (1983), the "etic approach views human phenomena across cultures and emphasizes 'universals' or core similarities in all human beings" (Sue, 1983, p.584). However, many of the acculturation instruments available in the literature are based on the emic perspective, which utilises a culture specific orientation. For example, Cuellar *et al.* (1980) developed a scale for Mexican Americans, while Bhugra *et al.* (1999a) developed a scale for South Asians. Whilst there are some advantages to using scales based on the emic approach, for example, phenomena are explained with categories that are considered meaningful within a specific cultural context, the findings from these studies are not comparable with those of different cultural groups. The only measure that claims to be etic, by definition, is the American International Relations Scale (Sodowsky & Plake, 1991), which can be answered by diverse cultural and national groups (see Chapter Two, section 2.4.1). This is the measure selected for use in the present study. Acculturation theorists (e.g. Olmedo, 1979) recommend that both acculturation and socio-demographic variables are measured when assessing an ethnic minority individual's adjustment to majority culture.

1.7 Prevalence of Mental Health Problems

Research conducted within the UK over the last three decades has emphasised the increased vulnerability of particular populations in the experience of various mental health difficulties. Epidemiological studies have helped to provide some information on the prevalence of mental health problems among South Asian communities living in Britain. However, these findings are both limiting and conflicting. Early research suggested lower rates of psychopathology amongst Asians than in the indigenous population (Cochrane & Stopes-Roe, 1977, 1981) but there is now considerable evidence to suggest that the prevalence of psychopathology amongst South Asians is high in certain mental health domains. A range of mental health problems have been found among South Asian females in Britain which include depression, suicide, deliberate self-harm and eating disorders (Bhugra *et al.* 1999b, 1999c; Bhugra &

Bhui, 2003; D'Alessio & Ghazi, 1993; Littlewood, 1995). The various trends reported in prevalence studies will be discussed.

1.7.1 Depression

In considering the prevalence of depression, there are a number of inconsistent findings. Early research by Cochrane (1977) used hospital studies based on admission rates and showed that both Indian and Pakistani males and females had lower rates of hospital admissions for affective disorders than their native White counterparts. However, this study was criticised for the way in which ethnicity was recorded, as some of the White sample had been born in India before independence and were categorised as 'Indian'. In addition, thirty percent of the patients, whose place of birth had not been recorded during admission, were included as UK born. Further, Bengalis were not treated as a separate group and there is evidence to suggest that Bengalis are the most affected by poor housing and low income which increases the risk of depression (Cochrane & Stopes-Roe, 1980a). These factors would have distorted the accuracy of any findings. In comparing between groups of South Asian women in Bradford between 1968-1970), Hitch (1980) found high rates of depression among Pakistani women and low rates for Indian women. (as cited in Hussain & Cochrane, 2001). In contrast to these findings, Dean *et al.* (1981) reported high rates of depression in Indian women and low rates in Pakistani women in their sample from the South East of England.

A recent epidemiological study conducted by Nazroo (1997) took a detailed survey of minority ethnic groups living in England and Wales between 1996-1997 to chart their changing positions. Interviewers were matched according to ethnicity and language and unstructured interviews were conducted with 1,273 Indians, 1,185 Pakistanis and 591 Bangladeshis. A sample of 2,867 white participants was included for comparative purposes. Version 9 of the Present State Examination (PSE) was used to assess morbidity in cases indicative of potential mental illness. The findings indicated that all subgroups of South Asian women had comparatively lower rates of depression compared to their white counterparts. The study showed that between group comparisons (where the South Asian women were grouped together as a homogenous group), white women had an estimated prevalence of 4.8% and South Asian women had a prevalence of 2.5%. Nazroo (1997) also distinguished between the South Asian subgroups and reported that Pakistani women had similar rates of depression to white women and Indian and Bengali women showed the lowest rates overall. Nazroo's (1997) study also showed differences between migrants who had

higher rates of depression than non-migrants and also between immigrant women who had higher rates than immigrant men.

Although these findings suggest that South Asian women are mentally 'healthier' than indigenous white women, Nazroo (1997) maintained that the instrument used to assess prevalence (the PSE) was insensitive in conceptualising terms into South Asian languages where words commonly used to describe/diagnose depression had no direct translation. This limitation leads to what Kleinman (1987) described as the 'category fallacy', where the use of research or treatment developed in one population fails to identify the same issues in a different cultural group on the basis that it lacks any meaning in that culture.

Community based studies have yielded inconsistent findings and presented a very different picture to that of hospital admission rates (Cochrane, 1977). Shah and Sonuga-Barke (1994) found that first generation Pakistani Muslim mothers living in extended families were more anxious and depressed than those living in nuclear families. Similarly, Sonuga-Barke *et al.* (1998) found evidence of a link between levels of intergenerational differences in opinions over child related issues and the mental health of Muslim mothers living in extended families. The authors reported that the levels of depression found among their sample were 'particularly worrying' in that they were three times higher than the sample studied by Moorey *et al.* (1991) who were diagnosed with cancer (as cited in Sonuga-Barke *et al.*, 1998).

In a more recent British community study, Fazil and Cochrane (2002a) used the GHQ-28 to measure the prevalence of depression in a community sample of British Pakistani women and reported that Pakistani women (both first and second generations) were at an increased risk of depression. Fazil and Cochrane's study comprised 100 Pakistani women and 100 native white women. Pakistani women were found to have higher full-scale scores on the GHQ-28 and on three of the four sub-scales (Severe Depression, Anxiety & Insomnia and Somatic Symptoms). No differences were found between first and second generations although second generations were less likely to exceed the threshold score for depression than first generations. Significantly lower scores were found among both native white and Pakistani women who were in paid employment. An interesting finding was that the high levels of depression in their sample of Pakistani women was not associated with high levels of personal and social dysfunction as in the case of the native white women, indicated by the scores on the Severe Depression and Social Dysfunction sub-scales, respectively. This suggested that

the association between depression and social dysfunction is less apparent in Pakistani women. Fazil and Cochrane's (1998, 2002a) study provides further evidence for the 'hidden' prevalence of depression in the South Asian community.

1.7.2 Suicide

With the exception of a few published community studies, the low rates of depression cited by epidemiological studies are somewhat confusing as there is also parallel evidence to suggest that the rates of suicide amongst Indians in England and Wales between 1970-1978 was high among certain age cohorts (Soni-Raleigh *et al.* 1990). Soni-Raleigh *et al.* (1990) found that in the general indigenous population, suicide rates were highest in the elderly, widowed and divorced men, whereas in the South Asian population, the highest rates were found amongst the younger married women. D'Alessio and Ghazi (1993) reported that the rate of suicide amongst South Asian women aged between 15-24 was three times higher than the average for all women and sixty percent higher in South Asian women in the 25-34 age cohort. The authors explained their findings, in relation to arranged marriages and the socio-culturally based dowry system. Thompson and Bhugra (2000) identified the factors that increased suicidal behaviour in married South Asian women to include social isolation, alienation, cultural incompatibility, religious difference, lack of supportive community and pressure from the family to conform to old traditional values. Social stress was also suggested to explain the higher rates of attempted suicide among South Asian females aged between 15-24.

1.7.3 Attempted suicide/Deliberate Self-Harm (DSH)

In recent years, a distinctive pattern of findings has emerged on attempted suicide and DSH among South Asian communities in Britain. Both service based and community studies have found that rates of attempted suicide and self-harm are more prevalent amongst females than males (D'Alessio & Ghazi, 1993; Marshall & Yazdani, 2000) and more prevalent amongst South Asian females than white females (Bhugra *et al.*, 1999b, 1999c). In a prospective study in Birmingham, Merrill and Owens (1986) studied all cases admitted to hospital following suicide attempts over a 2-year period. South Asian females were found to be almost three times more likely to present with attempted suicide and were from a young age cohort (15-24 years). Arranged marriages and the rejection of arranged marriages (and associated problems) were reported as contributory factors in the mental distress experienced by the South Asian sample. Similarly, in a London based treatment study investigating the rates of attempted suicide, Bhugra *et al* (1999b, 1999c) used a sample of South Asian females, aged between 16-

64, who had presented to general medicine, accident and emergency or psychiatric services of local hospitals following acts of DSH. They found that the rates in the South Asian sample were 1.5 times higher than those found amongst white women. These differences became more apparent when age was considered, most notably in the younger age cohort (i.e. 16-24 years) which suggested that younger South Asian females were more likely to attempt suicide. Bhugra *et al.*'s (1999a) findings supported Merrill and Owens (1986) study.

1.7.4 Eating Disorders

Eating disorders is another area that has raised serious concerns in recent years where it has been shown that the prevalence of eating psychopathology among South Asian females is much greater compared to their White contemporaries. Several British studies have demonstrated that South Asian females have a higher prevalence of clinical bulimia (Schmidt *et al.*, 1992) and unhealthy eating attitudes both in adulthood (Dolan *et al.*, 1990; McCourt & Waller, 1996; Mumford & Whitehouse, 1988;) and in childhood and adolescence (e.g. Ahmad *et al.*, 1994b). McCourt and Waller (1996) reported that Asian females from the most traditional homes (i.e. those who are least integrated into British society) had greater levels of eating psychopathology. This finding is contrary to that of Bhugra *et al.* (1999c) who found in their sample of South Asian females that traditionalism was a protective factor in the predisposition to DSH. McCourt and Waller (1996) explained their findings in the context of *culture conflict* (see section 1.10 for an elaboration).

1.7.5 Summary

Different factors may account for such contradictory findings regarding the mental health status of South Asians. The limitations of epidemiological studies may have contributed to the conflicting results. For example, there are many sources of discrepancy in the prevalence studies reviewed in relation to depression. These range in scope and severity and concern semantic, methodological and interpretive differences. Discrepancies could directly or indirectly give rise to the observed results and help to explain some of the apparent contradictions between the studies reviewed. Another limitation of the epidemiological studies reviewed is related to small sample sizes, which sometimes are not large enough to take into account factors such as regional origin and religion. Moreover, estimates of the prevalence of psychopathology may conflict because they are based on different kinds of samples. Furthermore, each South Asian sub-group includes wide variations in educational

levels, family income and levels of acculturation. The effects of demographic variables are likely to produce different prevalence rates for psychopathology among British South Asians.

Community-based and qualitative studies have provided sufficient evidence to suggest that South Asian people in a number of cases are presenting with more mental health problems and the fact that treatment-based prevalence studies indicate lower rates among South Asian communities may be more a reflection of cultural differences in conceptualisations of distress and the inadequacy of western classifications in capturing the essence of the South Asian experience (e.g. Fazil & Cochrane, 1998; Malik, 2000; Marshall & Yazdani, 2000). Prevalence studies reporting different trends in morbidity across generations of South Asian people living in Britain have focussed attention on the different possible roles played by various cultural factors in the determination of mental illness. The notion of *culture conflict* has been offered by prevalence studies to account for such phenomena and will be elaborated in sections 1.10 of this chapter.

1.8 The Utilisation of Mental Health Services

Evidence about the under-utilisation of mental health services by South Asian people in Britain (Cochrane & Sashidharan, 1996; London, 1986; Webb-Johnson, 1991) has been a major concern and research in this area has generated a number of different explanations. The under-utilisation of mental health services by the South Asian population of the UK has sometimes been attributed to there being genuinely lower rates of psychiatric illness in South Asians than in the white population (Cochrane, 1977). Early explanations suggested that South Asians were 'psychologically more robust' than their Caucasian counterparts and had less need to utilize mental health services (Crowley, 1991).

However, the finding that South Asians tend to under-utilise clinical services is no longer interpreted as reflecting a lack of need for such services but as a reflection of the various cultural and institutional barriers to South Asians obtaining appropriate mental health services. Cultural and linguistic barriers have also been proposed as sources of inhibition to utilization of services by South Asian groups. The majority of mental health services that are available are geared to the English speaking population and many South Asian people may find these inaccessible (Cochrane & Sashidaran, 1996).

Recent studies have identified cultural factors such as differences in expressions and conceptions of mental health and alternative treatment options (Malik, 2000) as important factors that play a part in the utilization of mainstream mental health services. Attention has been drawn to the need to recognise alternative non-western perspectives of mental health (Webb Johnson, 1991). Research has also suggested that South Asians tend to express their psychological distress through somatic symptoms (e.g. Curer, 1986, Malik, 2000). For example, Malik (2000) reported that the personal experience of distress and depression in her study of British South Asian women, was associated not simply with the mind, but also with the 'emotional body' resulting in highly interconnected affective, somatic and socio-behavioural symptoms. As cultural factors have been found to influence expressions and conceptions of illness, it follows that British South Asians may well differ from their white counterparts in the types of intervention which are most appropriate to prevent or treat emotional disturbances and illnesses.

1.9 Mental Health and Acculturation

A review of the acculturation and mental health literature has revealed an abundance of theoretical writing, which far outweighs empirical investigations in this area. The paucity of empirical evidence indicates that findings are not definitive and remain largely inconclusive. Much of the research that is available on the mental health of Asians has been conducted in the USA. This research has predominantly concentrated on sub-groups such as Chinese Americans, Japanese Americans, Koreans, Filipinos and Pacific Islanders. Despite the fact that South Asians originating from the Indian sub-continent represent the fourth largest Asian group in the United States, they appear to be under-represented in the American mental health literature (Durvasula & Mylvaganam, 1994). This inhibits generalisations across continents.

The literature has generated inconsistent findings regarding the relationship between acculturation and psychopathology (including depression) and there is evidence to suggest that among the four outcomes suggested by Berry (1987), Integration (e.g. Berry, 1997; Krishnan & Berry, 1992) and Assimilation (Cochrane, 1977; Mehta, 1998) are the most adaptive. However, Integration and Assimilation have also been found to be related to poor psychological adjustment (e.g. Bhugra *et al.*, 1999c; Cochrane & Stopes-Roe, 1981). Some of these studies will now be reviewed.

An American study by Mehta (1998) used several socio-demographic variables, three aspects of acculturation (as measured by the three sub-scales of the AIRS) and three aspects of mental health (psychological distress, acculturative stress and satisfaction) to investigate the relationship between acculturation and mental health in a community sample of first generation Indian immigrants. Mehta's (1998) findings indicated that immigrants who reported greater social and cultural ties with the US culture and fewer ties with their culture of origin had better mental health scores compared to those who reported lower levels of involvement with US culture. The relationship between acculturation and mental health was also found to be independent of variables that were expected to influence and confound the relationship (i.e. demographic variables). These findings are in line with Berry's contention that acculturative stress is associated with poorer relations with the dominant society and not with the desire to maintain the ways of the culture of origin. Mehta's (1998) findings appear to link the 'Rejection' strategy to negative mental health outcomes (Berry, 1997). However, recent British evidence suggests that the lack of traditional attitudes and a greater orientation to the majority culture may be associated with a greater risk of psychopathology (e.g. Bhugra *et al.*, 1999c; Cochrane & Stopes-Roe, 1981; Guglani *et al.*, 2000).

Cochrane and Stopes-Roe (1981) undertook at national community survey and compared the psychological symptom levels amongst first generation Indian immigrants with their white native counterparts. Overall, the Indian sample had lower levels of psychological symptoms than the white natives. Psychological adjustment was found to be related to age (being young at the time of migration) level of acculturation (being more orientated to British culture and less orientated to the culture of origin) and social integration (being upwardly socially mobile). Within the Indian group, a higher social status subgroup of socially upwardly mobile females emerged as the only group with higher than average psychological symptom levels. However, these levels were still comparable with their white counterparts.

Based on the findings from a previous study (Cochrane & Stopes-Roe, 1980) where a link was found between socio-economic status and mental health (lower social status was associated with higher levels of psychological disturbance), Cochrane and Stopes-Roe (1981) compared the Indian and white native group, while controlling for social class, which was defined in terms of occupation. The native white group showed higher scores in the lowest social class and the Indian group showed higher scores in the highest social class. Further analysis revealed that this pattern was entirely accounted for by the sample of Indian females

in the non-manual group who scored highly on the symptom measure (Cochrane & Stopes-Roe, 1981). These findings suggest that upward social mobility is a predictor of psychological symptom levels for female Indian immigrants (the opposite was found for males). When marital status was related to symptom levels, Cochrane and Stopes-Roe (1981) found that single women had significantly higher mean scores compared to married women. Cochrane and Stopes-Roe (1981) concluded that unmarried, employed Indian women who were socially upwardly mobile and becoming more integrated in to British society and culture reported the highest levels of psychological disturbance.

In a recently published study using quantitative and qualitative methods, Bhugra and Bhui (2003) found tentative support for the hypothesis that the acculturation process and cultural identity influenced the development and form of eating disorders. Bhugra and Bhui's (2003) study used a community sample of 226 teenagers in a mixed sex school in East London and explored the variations in prevalence of bulimic symptomology in relation to acculturation indices. The authors found that South Asians had the highest scores on the bulimia measure BITE (Bulimia Investigation Test, Edinburgh) compared to whites, blacks and the 'other' group. Bhugra and Bhui (2003) highlighted the importance and role of the family when studying the links between acculturation and mental health, suggesting that the emphasis on expectations and conformity may manifest in eating psychopathology. These findings suggest that the 'Integration' strategy might predispose individuals to a greater risk of psychopathology.

Bhugra *et al.* (1999b, 1999c) investigated the associations between deliberate self-harm (DSH) and the different components of cultural identity (as measured by 'acculturation domains') in two London-based empirical studies of DSH among South Asian adolescents and women and found that acculturation on specific domains was associated with DSH. The sample consisted of three groups of clinical cases and controls. The participants were 54 South Asian women (twenty-seven clinical cases and twenty-seven controls) and 22 South Asian adolescents (eleven clinical cases and eleven controls). Comparisons were made between two generations of South Asian women and between subgroups.

In the domains of Social Contact and Aspirations, women who attempted DSH showed less traditional attitudes than controls. The most significant generational differences were found in the areas of 'language preference', 'marriage preference', 'inter-racial relationships'

'decision-making', 'work', 'leisure' and 'food shopping', where adolescents were found to show less traditional attitudes compared to their parents. Bhugra *et al.*, (1999b) identified adolescent/parent differences in these domains as potential risk factors for DSH amongst adolescents. These findings were interpreted as demonstrating generational differences in terms of traditionalism versus modernism with the former implicated as a protective factor in the development of psychopathology.

Generational differences in cultural attitudes amongst first, second and third generations have been reported elsewhere in the literature where it has been suggested that variations in the structure of family life might help to account for the higher levels of morbidity displayed by South Asians living in Britain (Guglani *et al.*, 2000). In a community survey, Guglani *et al.* (2000) investigated the influence of cultural identity on the psychological adjustment of Indian Hindu women in Britain. The sample consisted of Grandmothers and mothers (born in their country of origin) and British born adolescent Granddaughters. Associations were made between Grandmothers' mental health and adolescent cultural identity, cultural integrity, traditionalism, religious practice and demographic data. The authors found that the more the family was assimilated into British society (least traditional), the greater the mental health problems of the Grandmothers. A significant relationship was found between the adolescents' cultural identity and the Grandmother's mental health whereby the Grandmother's of adolescents who considered their cultural identity to be exclusively 'Asian' or 'Indian' or 'Hindu' had better psychological outcomes compared to Grandmothers whose Granddaughters considered themselves to be 'British' or 'English'. These findings were explained in terms of the 'interdependency of the generations in the context of psychological adjustment' (Guglani *et al.*, 2000, pp.1051) whereby the authors posited that adjustment was partly mediated by the level of traditional belief within the family. This finding provides some support for Bhugra *et al.'s* (1999c) notion of a protective effect of traditionalism.

However, although the (potential) protective characteristics of traditional families has been reported in the literature, there is also evidence to show that the traditional extended family may constitute a risk factor (e.g. Sonuga-Barke *et al.*, 1998). Research has demonstrated that traditionalism in family structures may have a detrimental effect for particular South Asian subgroups and for particular generations (Shah & Sonuga-Barke, 1994; Sonuga-Barke *et al.*, 1998). These studies have shown positive effects of extended family living for Muslim children and Grandmothers but negative effects for Muslim mothers. Mothers were found to

have significantly higher levels of depression and anxiety compared to those living in nuclear families and compared to Hindu mothers. Similarly, Fazil and Cochrane (1998, 2002b) found high levels of depression in the community among Pakistani women and identified factors such as low intimacy, loss of mother before the age of eleven, social isolation, living with the extended family, unhappy marriage and generational conflicts with offspring to be associated with depression.

In summary, the relationship between acculturation and mental health is unclear, complex and inconclusive as research has inconsistently shown that both high acculturation and low acculturation can have either positive or negative mental health outcomes (Berry, 1997; Bhugra *et al.,* 1999c; Cochrane, 1977; Cochrane & Stopes-Roe, 1981; Guglani *et al.*, 2000; Metha, 1998). The incongruities observed in the literature may be due to differences in the operational measures used to assess constructs and differences in the sample characteristics and demographic variables, including age, generational status, gender, socio-economic status, religion and geographic location.

1.10 Acculturation, Cultural Identity and Culture Conflict

Epidemiological studies can yield some interesting insights into the possible causes of psychological disturbance. The dominant explanation for distress leading to suicide (D'Alessio & Ghazi, 1993), self-harm (Bhugra *et al.*, 1999c; Merrills & Owen, 1986) and eating psychopathology (Bhugra & Bhui, 2003) in South Asian communities in the UK invokes the notion of culture change (psychological acculturation) and has been in terms of *culture conflict.* The literature suggests that the acculturation process may potentially become conflictual when there is incongruity between expectations (assumptions) and actuality (experience). The "disparity between traditional and modern attitudes in ones-self as well as social and gender role expectations from individuals' significant others" is considered to give rise to the experience of *culture conflict* (Bhugra & Jones, 2001, pp.219). Durvasula and Mylvaganam (1994) argued that traditional South Asian values encompassed values such as generational interdependence, conformity and obligation which are often in contrast to the qualities valued in the west. The source of conflict may thus be found in the dichotomy between values. Bhugra and Bhui (2003) articulated that this may result in an "internalisation of social constraints into the embodied self" (Bhugra & Bhui, 2003, pp.47).

Littlewood (1995) explained the patterns of increasing symptomology among South Asian women in terms of contemporary class and gender positions produced by a globalising cultural economy (Burnman *et al.*, 1998). Bhopal (1998) concurred that the position of South Asian women in British society had shifted over the years and this was reflected in the growing number of South Asian women entering higher education and the labour market. Bhopal (1998) found that married women and those with low levels of educational attainment might want to maintain and reinforce their religious identity as a means of strengthening their South Asian identity. Bhopal (1998) reported that single South Asian women who had achieved high levels of education, exercised more free choice not to participate in religious or cultural practices. These women defined their own sense of being; they accepted their British identity and were in a process of cultural re-definition and assimilation into British society.

The underlying assumption of studies which invoke the notion of *culture conflict* for British South Asian females is that "being successful and hence ambivalently autonomous in something approximating to a male Western norm may [lead] to considerable identity conflict for these women" (Littlewood, 1995, pp.56). Cochrane and Stopes-Roe (1981) found a positive relationship between upward social mobility and psychological symptom levels amongst first generation Indian women. These findings were explained in terms of the strain placed upon women who were participating in the labour market and becoming materially successful.

Burnman *et al.* (1998) articulated that South Asian women (whether Indian or British nationals) "of a certain education and class/caste background may access and inhabit forms of femininity that are sufficiently congruent to manifest distress in ways equivalent to white women in Europe or the US" (Burnman *et al.*, 1998, pp.235). In this way, modernisation and industrialisation are implicated in changing individual subjectivity, self-determination and instrumental agency (psychological acculturation), which may give rise to the experience of social inequalities for South Asian females when functioning in two opposing cultures and may lead to depressive and anxiety states. According to the *culture conflict* hypothesis, such social and environmental changes may steer individuals away from identity based on kinship factors (such as family or gender) towards an identity that is more egocentric, self-deterministic and competitive in nature (Bhugra & Bhui, 2003).

'Culture conflict' therefore appears to encapsulate pressures to conform to two opposing cultures and psychopathologies (such as eating disorders and DSH) are construed as *manifestations* of depression and anxiety caused by acculturative distress. For example, Bhugra and Bhui (2003) interpreted the findings from their study to indicate that bulimic behaviour was associated with a 'state of culture flux' and the discomfort caused by this state may contribute to the alienation felt by individuals who feel 'torn' between the British culture and their culture of origin. The authors suggested that such alienation might translate into psychological distress for some individuals whereby the 'eating disorder' becomes the means by which they manage their distress. Bhugra and Bhui (2003) suggested that the notion of culture conflict may produce a state of 'cognitive dissonance' between the collectivist expectations of the in-group (e.g. interdependence) and the individualistic expectations (e.g. independence) of the wider cultural environment, which make opposing demands on young people's role positions, behaviour and sense of self (Ghuman, 2000). This may produce a distance between the two generations and a barrier to communicating emotional distress whereby young people may attempt to exert some control over their unhappiness or their predicament through bingeing or controlling what they eat.

Culture conflict has been used to explain the rates of attempted suicide and DSH in adolescent and South Asian women where cultural and social factors have been found to play an important role in the causation of these behaviours. Marshall and Yazdani (2000) used discursive analysis to explore constructs of self-harm behaviours as construed by a clinical sample of South Asian women and the location of culture within their accounts. Findings indicated that self-harm behaviours were not construed as a 'problem', but as a coping strategy for managing emotionally distressing circumstances. Marshall and Yazdani's (2000) study identified the importance of the role of shame within their accounts of culture, which was seen to shape constructs of acceptable behaviour. Articulations of self-harm were described in relation to traditional family expectations for South Asian young women as 'causative' of pressure and distress, for example, to marry by a certain age. This was expressed in terms of a failure to fulfil gendered familial role expectations, not just for the individual or their family, but in relation to the importance of maintaining the family's *'izzat'* (see section 1.17.1) within the community. Marshall and Yazdani (2000) concluded that experiences of self-harm are shaped by culture but remain individual, thus cautioning clinicians against overgeneralisations and encouraging them to work from the understandings and perspectives of their clients.

Bhugra *et al.* (1999b, 1999c) attempted to measure aspects of cultural identity in relation to DSH and found that South Asian females were particularly vulnerable to experiencing culture conflict, which was described in terms of managing the discrepancies in family expectations and social behaviour. Cultural identity measurement in South Asian females in Bhugra *et al.*'s (1999c) study indicated that females who attempted suicide were more likely to be more liberal in their views towards arranged marriage, cohabitation and sharing domestic household duties, be more in favour of intercultural sexual relationships and more inclined to change their religion. Thompson and Bhugra (2000) also implicated conflicts in relation to marriage and lifestyle, pressures of economic competition, the loss of self-esteem associated with failure and anxiety attached to non-conformist behaviour as vulnerability factors in the development of DSH. These pressures are exacerbated for South Asian females by the rigidity of gendered roles within South Asian cultures. These findings lend support for the hypothesis that Integration (or bicultural identity) might compromise traditional aspects of identity (implicated in the literature to be a protective factor by Bhugra *et al.*, 1999b) and make individuals more vulnerable to experiencing psychopathology.

1.11 Conclusions

Cultural identity is regarded by some to be a 'crucial aspect of an individual's sense of self' and 'disturbances' in cultural identity have been associated with psychopathology (Bhugra *et al.*, 1999b, 1999c). The concepts of acculturation and cultural identity have important relevance for understanding the cultural aspects of first and second-generation British South Asian individuals and it has been advocated that individuals should be assessed through measurement of their acculturation and cultural identity. The conceptualisation of a 'cultural self' taps into key components that have been theorised to impact cognitions, emotions, behaviours and motivations (Berry *et al.*, 1987; Bhugra *et al.*, 1999b).

Rates of undetected depression in the community in addition to the increased rates of suicide, self-harm and eating pathology are curious and raise important research questions regarding the notion of *culture conflict* that need to be addressed. Whilst the interaction of demographic, social and cultural factors identified in the literature (such as generational status, social class, religion, gender, family structure, non-conformity and traditionalism) have been implicated to play a role in the development of psychopathology, it is not sufficient to describe the cause of psychopathology in terms of 'culture conflict', as a more robust understanding of what exactly is meant by the term is required (Thompson & Bhugra, 2000).

The experience of shame has been tentatively identified in the literature (e.g. Marshall & Yazdani, 2000) to shape constructs of acceptable behaviour in South Asian cultures in relation to traditional family expectations (particularly for females) where a strong emphasis is placed on conformity. These factors have also been implicated in the causation of pressure and distress. In view of the high prevalence of psychopathology among South Asian females and the influence of cultural factors in mental health, this review would suggest the need for further research investigating the relationships between acculturation, cultural identity, shame and psychological distress (depression specifically) among British South Asian women. Furthermore, positioning shame in the processes of acculturation and cultural identity may yield further understanding into the notion of *culture conflict*.

1.12 An Evolutionary Approach to Shame

Despite earlier references to shame as 'the hidden emotion' and the 'sleeper of psychopathology' (Lewis, 1987a), it is now regarded as one of the most powerful, painful and debilitating experiences known to humankind that can cause major disturbances to the self (Gilbert, 1992, 1998, 2000; Lewis, 1971, 1987a). In evolutionary terms, the predisposition to experience shame is a universal human phenomenon. Evolutionary theories of shame are bio-psychosocial in nature and study the 'adaptive' function of shame for individual physical survival, social decision making and psychological well being.

Humans are faced with managing a complex array of emotions and behaviours if they are to maintain themselves in their social network and maximise 'fitness'. In evolutionary terms, affects such as shame play an important role in guiding the individual's behaviour to match well with the values of their particular group. These values are based on a number of factors that are related to inclusive fitness within that social setting. Shame thus constrains behaviour into channels that are socially approved of and/or culturally appropriate. In doing so, shame aids in the control of behaviour that would be destructive to fitness in the areas of group identity and social bonding (Greenwald & Harder, 1998).

1.12.1 Models of Shame

According to Lewis (1986, 1987a), the conceptualisation of shame within the domain of social awareness involves concepts of disturbed power relationships, which stem from negative self-other comparisons. Lewis (1987) contended that individuals feel shame when

others are viewed as powerful, while the self is exposed as weak, bad and inferior. Shame is thus conceptualised as relating to a damaged sense of self-identity. In a similar vein, Gilbert (1997) argued that shame is derived from an innate desire to be seen as socially attractive. These dispositions mediate appraisals of status, social acceptance and social bonds in relation to rank judgements. Shame is part of the *affective consequences* that accompany detrimental changes to social status and is produced by losses in social standing, being disgraced, dishonored, ridiculed and ostracised (Gilbert, 1997; 2000). The function of shame therefore is to reduce damage to one's social standing, status and attractiveness in the eyes of others and self.

Gilbert used social rank theory to suggest that shame displays, such as submissive behaviour, may be seen as damage limitation strategies (Gilbert, (1992, 1997 & 2000). He argued that human social rank and status are gained and maintained via displays of attractiveness. The term used to describe this element is 'social attention holding power', or SAHP (Gilbert, 1997). Social status rank varies considerably in accord with different cultural values across cultures. Therefore, for many societies, there are a number of ways in which status is acquired, but in evolutionary terms, all status hierarchies relate, indirectly or directly, to fitness (Greenwald & Harder, 1998). Thus from an evolutionary point of view, shame is concerned with power, rank and dominance conflicts and the expression of socially and culturally attractive qualities and abilities (Gilbert, 2000).

1.13 Domains of Shame

According to evolution theory, humans have evolved to be capable of operating in different social roles (Gilbert, 1992, 2000) and in different social contexts and so for some individuals, shame only becomes alive in certain roles and contexts. There are various domains of shame described in the literature which are related to distinct areas of human functioning and can be seen as vital to promoting fitness (Greenwald & Harder, 1998). Discussion of all the different domains of shame will not be provided here due to the constraints of time and space. The domains that are most relevant to the present study will be considered (for a more inclusive discussion, see Gilbert & Andrews, 1998).

1.13.1 Internal and External Shame

The theoretical literature (e.g. Gilbert, 1998) has focused on cognitive domains of shame based on self-other comparisons, which focus on either the social world (beliefs about how others see the self), the internal world (how one sees oneself) or both (how one sees oneself as a consequence of how others see them). *Internal shame* relates to cognitions and affects that an individual has about their character, individual attributes, personality characteristics or behaviours. *External shame* relates to negative evaluations of the self, based on those aspects believed to evoke rejection, disapproval or attack if exposed (Gilbert, 1998, 2000).

1.13.2 Relational or Reflected Shame

This domain refers to the loss of SAHP that is personal in addition to the shame brought onto an individual's associates (e.g. family, community). It specifically relates to the disgrace and dishonor brought onto others as a result of an individual's actions (Gilbert, 1997, Gilbert *et al.*, in press).

1.13.3 Conformity Shame

Humans show strong tendencies to conform to the standards of a group. In evolutionary terms, they link their strategies to gain status and acceptance with group values (Greenwald & Harder, 1998). It has been suggested that the capacity to experience shame due to a lack of conformity is helpful in regulating behaviour that identifies members of a group (Greenwald & Harder, 1998). Conformity shame regulates many behaviours related to dress, language, food, rituals and so forth. It determines what is acceptable for the social self in different roles, which are defined according to ethnicity, gender, class, profession and so on. The importance of conformity in group identification has been considered by Greenwald and Harder (1998) who proposed that identification with similar individuals "would insure acceptance by the genetically linked group most committed to aiding one's own survival and rejection of those who do not belong. Those who act too differently will be seen as non-members or strangers and will be regarded with suspicion. This explanation would account for the enormous importance of identification with an in-group, a community, tribe, ethnic group or nation to the psychological well-being of an individual" (Greenwald & Harder, 1998, pp.230). The potential to experience shame can prevent the social rejection that may result from non-compliance. As cultures differ on their emphasis on conformity, Greenwald and Harder

(1998) predicted that a greater emphasis on shame associated with non-conformity is likely to occur in cultures with collectivist values or where there is a strong need for social cohesion.

1.14 Measuring Shame

Much of the current research on shame utilizes questionnaire measures that have been developed to assess an individual's propensity to feel shame. Shame has been measured as a disposition (trait) which may manifest in repeated reactions to specific situations. The main objective of research using dispositional measures has been to identify the characteristics of individuals who are likely to experience shame and investigate associations between shame and psychopathology (Allan *et al.,* 1994; Andrews & Hunter, 1997; Gilbert *et al.*, 1994; Oatley & Jenkins, 1992).

In a review of methodological and definitional issues in shame research, Andrews (1998) examined the content and construction of existing measures and suggested that studies investigating the expression of shame *do not* explicitly reflect shame as a disposition. Andrews (1998) articulated that studies which conceptualise the characteristics of high-shame individuals use scales designed to assess the degree to which individuals fall into the following categories:

1) Those who are particularly sensitive to feel shame in potentially shame-eliciting situations, which is termed 'shame-prone' in the literature.
2) Those who frequently or continuously feel generalised or global shame.
3) Those who are chronically ashamed of their behaviour or particular personal characteristics (Andrews, 1998).

1.14.1 Shame-Proneness

The conceptualisation of shame-prone individuals is based on the notion that shame is felt in the context of evaluating personal behaviour in particular situations. Questionnaires that purport to assess shame prone-ness include the Dimensions of Consciousness Questionnaire (DCQ, Johnson *et al.*, 1987), the Test of Self-Conscious Affect (TOSCA, Tangney *et al.,* 1989) and the Self-Conscious Affect and Attribution Inventory (SCAAI, Tangney, 1990). These scales present a series of hypothetical, potentially shame-inducing scenarios involving social and moral transgressions and respondents are asked to imagine themselves in such situations, indicating how bad they would feel. Although questionnaire measures which utilise this approach are based on real life shame experiences (i.e. generated by individuals during the development of the instrument), their ecological validity may be compromised in

that they fail to capture what individuals do or feel in real life situations (Andrews, 1998). The scenarios describe some kind of behaviour about which the respondent might feel more or less ashamed and do not account for the fact that personal behaviour is not the only source of shame. Andrews (1998) argued that it is likely that salient characteristics of high-shame individuals may go unnoticed if 'no account is taken of shame about particular personal characteristics that may be independent of a propensity to feel shame in response to personal behaviour' (Andrews, 1998, pp. 42). Dispositional shame can therefore manifest in different ways and may involve a specific focus on physical and non-physical personal characteristics, which may or may not be reflected in everyday behaviour (Andrews, 1998).

1.14.2 Generalised or Global Shame

Within this approach to measurement, high-shame individuals are conceptualised as frequently or continously feeling global or generalised shame. Scales which purport to assess generalised/global shame include the Internalised Shame Scale (ISS; Cook, 1996) and the Personal Feelings Questionnaire- 2 (PFQ-2, Harder & Zalma, 1990). The assumption is that these scales reflect dispositional shame (or shame-proneness). However, as the scales fail to assess the length of time over which feelings have been experienced, the dispositional nature of such measures is questionable. Moreover, given that global negative self-referent shame questionnaires tend to be highly mood dependent it is not clear whether they are simply reflecting negative affective mood states such as depression rather than an enduring characteristic of global shame (Andrews, 1998).

1.14.3 Chronic Shame of Personal Attributes or Behaviour

A different approach to measuring shame has involved assessment based on interview. Andrews and her colleagues (Andrews, 1995; Andrews & Hunter, 1997; Andrews *et al.*, 2002) employed a semi-structured interview with investigator ratings to assess shame of personal characteristics and behaviour. The measure was originally designed to assess bodily shame, and was later developed to assess additional sources of shame and is based on the distinction made by Janoff-Bulman (1979) between negative judgements directed at one's *behaviour* and at one's *character*. The measure, now known as the Experience of Shame Scale (ESS; Andrews *et al.*, 2002) asks respondents directly if they had felt ashamed in relation to their body, character or behaviour and the duration of their feelings. According to Andrews (1998), this feature makes the measure less vulnerable to mood states than the previously discussed measures, which tend to rely on global self-judgments. Shame can be

understood as a negative evaluation involving the entire self in relation to one's behaviour and one's character and is assessed in terms of two dimensions: internal shame (focussing on negative self-evaluation) and external shame (the fear of negative judgement from others).

The view taken in the design of the interview-based measure is that there may not be one distinct type of high-shame individual. Andrews (1998) contended that all of the different types might be characterised by feeling chronic shame about different aspects of themselves or their behaviour. This approach to measuring shame supports the notion that shame proneness involves related but independent types of shame. According to Andrews *et al.* (2002), the ESS taps a specific disposition to experience shame rather than assessing a "transient and non-specific negative affective state" (Andrews *et al.,* 2002, pp. 37) and has also been reported to be effective in prospective studies predicting depressive disorder. Andrews *et al.*'s (2002) approach to studying the role of cognition and affective factors in psychopathology highlights the need to consider the global and specific aspects of cognition and affect in the context of the individual's personal experience.

1.15 Shame and Psychopathology

A growing number of studies have examined the role of shame in the development of psychopathology. The most well known of these is the work offered by Paul Gilbert and his colleagues (e.g. Gilbert *et al.*, 1994, Gilbert, 1997, Gilbert & Allan, 1998, Gilbert & Andrews, 1998), who have contributed vastly to current understandings of shame, its evolutionary roots and manifestations in relation to psychopathology.

The social rank theory of psychopathology suggests that with the evolution of social hierarchies, 'various psycho-biological mechanisms become attuned to the success or failure in conflict situations' (Gilbert & Allan, 1998, pp.585). Within this conceptualisation, Gilbert and Allan (1998) argued that subordinates and those who have lost status are at greater risk of pathology. The experience of shame is often linked with perceptions that one has personal attributes, personal characteristics or has engaged in behaviours that others will find unattractive and will result in disapproval, rejection or some kind of putdown (Gilbert, 1997). These features have also been implicated to play a role in depression (Beck *et al.*, 1979) and there is now evidence that connects shame with the onset of depression based on the assumption that people who experience depression see themselves in low rank positions in comparison with others (Gilbert *et al.*, 1995a). The literature indicates that negative self-

attitudes are related to shame and are likely to be manifestations of shame but as Andrews (1998) points out, these features may be independent of and not exclusive to shame.

Much of the current research has found cross-sectional associations between shame and depressive symptoms using various measures of shame and depression. For example, Gilbert and Allan (1998) demonstrated a clear link between shame, subordination, defeat and entrapment to depression. The only studies to date that have investigated the role of shame in the *course* of depression are by Andrews and her colleagues. Andrews and Hunter's (1997) small-scale study consisted of a clinically depressed sample. Their study was successful in demonstrating higher levels of bodily, characterlogical and behavioural shame in the patients who were chronically depressed as opposed to those who had only experienced one episode of depression. They interpreted these findings as tentatively suggesting that shame might affect the course of depression, although the authors acknowledged that some of the cases might have been a consequence of persistent depressive symptoms.

In a more recent study, Andrews *et al.* (2002) attempted to replicate their findings by developing a new scale based on their interview measure called the Experience of Shame Scale (ESS), which was specifically designed to predict depressive symptomology. Andrews *et al.'s* (2002) findings supported previous investigations in which the role of shame was shown to influence the onset and course of depression. Specifically, they found the characterlogical and bodily indices of the ESS made 'superior independent contributions to current depressive symptoms' (Andrews *et al.*, 2002, pp.37) compared to the behavioural shame domain. The behavioural shame domain made the strongest contribution to predicting subsequent symptoms and characterlogical shame made the weakest contribution to subsequent symptoms (once prior symptoms were controlled). Andrews *et al.* (2002) suggested that the characterlogical domain of the ESS might reflect a more global shame and the behaviour and bodily shame domains were more suggestive of specific and discreet areas of self and personal performance.

Given the number of available scales which appear to offer various measures of shame as a single construct, the ESS is the only measure to date which has upheld the link between shame and psychopathology and appears to be the most sensitive in predicting depression.

1.16 Shame, Identity and 'Self'

Kaufman (1974) argued thirty years ago that 'the experience of shame is inseparable from the search for self...the search for true relatedness with others and for answers to the question 'who am I?' is central to our experience as human beings" (Kaufman, 1974, pp.568). He suggested that the need for a 'self-affirming' identity that provided 'value' and 'meaning' was at the core of an individual's sense of 'self' and this was largely shaped by the experience of shame. Kaufman and Raphael (1987) argued that 'messages from the wider culture become internalised through scenes of shame experienced in many different contexts' (Kaufman & Raphael, 1987, pp.30). The authors believed that it is through this process that enduring beliefs about the self are created. In this sense, Kaufman and Raphael (1987) construed shame as a 'principal source of (negative) identity'.

The literature has divided the diverse elements that comprise the identity of an individual into two distinct constructs. *Social identity* involves a person's social roles and relationships and denotes belonging to formal and informal groups (e.g. religion, nationality, ethnicity). *Personal Identity* refers to an individual's private conception of self and comprises specific characteristics such as feelings of competence, ways of relating to others and psychological characteristics (Cheek & Briggs, 1982). The literature suggests that moral affects such as shame may have an influence on one's sense of identity and shame has been associated with social identity orientation (Lutwak *et al.,* 1998). In short, shame has been found to be related to the public aspects of the self, that is, the perception that one's core self is 'bad' or 'wrong' due to an incorporation of other people's negative evaluations (Parker & Schwartz, 2002).

More recently, research has focussed on the 'self' as a cultural product (Dhawan *et al.*, 1995). In cultures that originate from the Indian sub-continent, the self is defined as an aspect of the collective (e.g. family, religious community). Research has indicated that members of collectivist cultures tend to define the self primarily by referring to aspects of their social roles and group membership and to their relatedness to others. The literature suggests that this relatedness to others is made possible by keeping the internal, private or independent aspect of the self (e.g. personal goals) subordinate to the collectivist or interdependent aspect of the self (Markus & Kitayama, 1991; Triandis, 1993).

1.17 Shame and Collective Cultures

Shame has different meanings and implications for different cultural groups and is conceptualised in relation to the norms, values and rules of a specific cultural system (Greenwald & Harder, 1998; Ha, 1995). Hence, the focus of *what* is shaming and *what* is acceptable (or gives status) varies according to the social values that are culturally conveyed (Gilbert, 1997; Gilbert *et al.,* in press). Social groups thus define the characteristics that give rise to the experience of shame. In evolutionary terms, differences in social expectations and in what is regarded to be shameful may be related to the conditions that affect 'fitness' in a given group (Greenwald & Harder, 1998).

Hui and Triandis (1986) elaborated that collectivist cultures (such as those originating from the Indian sub-continent) are primarily concerned with the value judgement and approval of in-group others. When approval is not given, shame tends to be the emotion that is felt. In evolutionary terms, shame and a sense of moral obligation can be seen to be used within South Asian cultures as a primary mechanism of social control (Segal, 1991). The control has a positive aspect in that it provides the structure for the community, which is necessary to maintain the family's integrity and is shaped by cultural norms, beliefs and obligation to duty. Shame thus serves as a moderator of behaviour when associated with honour systems (Gilbert *et al.*, 1995). A belief in the integrity of the group provides the family with in-group identity and strengthens the family's stability, albeit at the expense of individual autonomy (Segal, 1991; Triandis, 1993). Collectivist cultures are thus described as group-focussed and link emotions, such as pride and shame, to how behaviours reflect on in-group others (e.g. the family), whereas in individualistic cultures, emotions are thought to reflect on the self (Mesquita, 2001). Thus, it has been postulated that collectivist cultures function within strong dynamics of *reflected* (relational) shame and honour systems (Gilbert *et al.*, in press).

1.17.1 Shame in South Asian Cultures: 'Izzat'

The concept of 'izzat' within South Asian cultures captures the essence of shame (a western concept) and represents the desire for moral standing, honour, respect and approval within the community (Gilbert *et al.*, in press; Marshall & Yazdani, 2000). 'Izzat' has been described as "a learnt, complex set of rules an Asian individual follows in order to protect family honour and keep his/her position in the community" (Gilbert *et al.*, in press, pp.4). Based on focus group discussion with South Asian women, Gilbert *et al.* (in press) proposed that 'izzat' is related to *reflected (relational) shame*. This refers to the fear of bringing shame on to others

as a direct result of an individual's behaviour and the shame bought on to an individual as a direct result of others' behaviour. 'Izzat' thus functions as a measure of relative standing within the community (Ballard, 1994), hence the importance of not damaging it. Gilbert *et al.*'s (in press) study offers insight in to the potential sources of shame, subordination and entrapment within South Asian cultures. Their study highlighted the importance of maintaining family honour (*izzat*) for group identity. The identification with *izzat* was associated with personal shame, which was related to failings in role and loss of identity. The theme of *izzat* and its relationship to subordination was made explicit in terms of obeying group rules in order not to threaten the family's *izzat*.

The way in which 'izzat' is applied within South Asian cultures inherently implies a gender dimension. Within the family and the community, the upholding of 'izzat' is largely dependent on the female members of the family (Khanum, 1992). This is in line with the evolutionary perspective, which views females as the 'upholders of the prosocial aspects of a culture, representing what is moral and well behaved' (Greenwald & Harder, 1998, pp.237). Prosocial behaviour connects individuals to each other and to social groups and increases 'fitness' because it strengthens kinship and support networks. In many South Asian cultures, females are the carriers of family honour and place 'izzat' most at risk in that there is more to be lost if a female contravenes the rules and brings exposure. The behaviours of males are not considered to be so strongly related to 'izzat' (Raza, 1993). Gilbert *et al.* (in press) suggested that shame (and stigma) within collectivist cultures may be related to a complex power interplay between the genders e.g. the concept of honour killing is acceptable in some South Asian cultures (Channel 4 Productions, 15 June 2003).

As South Asian cultures are collective in orientation, the family is considered to be more important than the individual (Segal, 1991). An individual's rank within the group structure defines gender roles and codes of behaviour. Each role and relationship carries with it different responsibilities for the individual. The primary role of children is to bring honour to the family through their achievements and respect for cultural values and rules. For example, individuals are highly valued in their culture (other in-group members) when they have fulfilled their cultural obligation (e.g. expectations of gender roles) at the expense of individual choice.

Moral obligation and *izzat* are believed to be the two concepts that permeate all significant relationships within South Asian cultures. 'Kinship' in South Asian cultures is seen to be integral to social organisation and the violation of rules is felt to reflect badly on whole families and groups (Krause, 1989). An individual is expected to be largely selfless and obligated to significant others (especially within the family) and children are taught from an early age not to bring shame onto themselves or their families (Segal, 1991). This may cause second generation South Asian individuals who engage in socially *acceptable* behaviours in the wider cultural context (which is a dimension of the acculturative- integration process) to experience more shame in the context of their cultural and religious communities (in-groups), where the same behaviours might receive strong disapproval. For example, South Asians who are unable to speak in their mother tongue language, who smoke/drink alcohol or who openly have intimate (sexual) inter-cultural relationships may threaten the good name of the family ('izzat') if these attributes and behaviours were made public to other in-group members. Based on this hypothesis, it is predicted that there will be a relationship between psychopathology and shame among South Asian women who adopt Berry's (1980, 1997) 'Integration' strategy.

The literature indicates that there are two key social outcomes associated with low rank: social defeat and entrapment (Gilbert & Allan, 1998) and there is also increasing evidence to suggest that shame is linked to feelings of subordination (Gilbert, 2000b), entrapment (Gilbert, 2000a,) and depression (Allan & Gilbert, 1998) and these concepts have been found to be associated for South Asian females (Gilbert *et al.*, in press).

1.17.2 Shame, Acculturation and Cultural Identity

Findings from British qualitative studies have indirectly positioned the experience of shame in the process of acculturation and cultural identity (also see Marshall & Yazdani, 2000, discussed in section 1.9). Meldrum (1996) explored the relationship between second generation Pakistani Muslim females' cultural identity and the meanings attributed to professional help seeking regarding eating disorders. Perceptions of what the Pakistani community 'might think, say or do' were a major concern for the participants in her study. This concern was not so much individualistic (i.e. for their own reputation) but collective in terms of the family's position within the community. Implicit in the construction by which the individual and family were linked was the concept of *izzat*. Meldrum (1996) found that explanations of the kinds of judgement made by the community concerned the belief that

having an emotional problem would be construed as being 'mad' or having done something 'wrong'. This had implications for both the individual and their family. The fear of community judgement gave rise to the consideration of a range of strategies to manage help seeking in which controlling information about the need for services was paramount. The fear of exposure and negative judgement from both the community and peers was seen to act as a barrier to service use. Fazil and Cochrane (1998) proposed that inherent in the perception of mental illness as 'mad' within South Asian cultures is the assumption that mental illness is 'incurable'. This may partly explain the reason why shame is overemphasised in South Asian cultures in that arranged marriage prospects might be affected (Qureshi, 1988).

Interestingly, Meldrum (1996) found that whilst the influence of the community and family suggested that the teenagers viewed emotional problems in the context of their roles and responsibilities to family and community, they also expressed some reluctance to involve parents. Despite pressure to 'keep it in the family', Meldrum (1996) found that some of the teenagers in her study spoke of accessing help outside of the family and community. Several hypotheses could explain this finding. One explanation that Meldrum (1996) suggested was that the teenagers were developing a more individualised understanding of their problems in the context of their experience within mainstream culture. Meldrum (1996) also found that issues around relationships with boys were inherent in the meanings attributed to eating disorders, which suggested that the teenagers had 'amalgamated both eastern and western understandings' to eating disorders, indicative of adopting the 'Integration' strategy proposed by Berry (1987).

1.17.3 Closing Comments

There are no British empirical studies that address how acculturation and cultural identity influence the experience of shame for South Asian individuals. Based on the findings which have emerged in the recent literature where 'culture conflict' (e.g. Bhugra *et al.*, 1999b) and shame (e.g. Gilbert *et al.,* 1998) have both been implicated in the development of psychopathology and specifically depression, it follows that shame may mediate the relationship between acculturation/cultural identity and psychopathology (including depression). A review of the literature has indicated conflicting findings regarding the four strategies suggested by Berry (1980, 1997) in relation to psychological adjustment and raises important questions regarding the relationship between these constructs (acculturation/cultural identity and psychopathology).

To date, our understanding of 'culture conflict' remains vague. The present study tentatively proposes that the experience of shame may provide some insight into understanding the dynamics involved in what constitutes 'culture conflict'. It is hypothesised that shame might mediate the relationship between acculturation/cultural identity and psychopathology (specifically depression). However, it is important to bear in mind the many inconsistencies generated in the literature regarding the relationship between acculturation/cultural identity and psychopathology (including depression). As mentioned previously, early British work by Cochrane (1977) and recent American research has suggested that a failure to acculturate to the majority society and culture, indicative of low acculturation, was related to psychological problems whereas high acculturation and social integration were related to better mental health outcomes (e.g. Berry, 1997; Mehta, 1998). However, recent British evidence appears to suggest that Integration and Assimilation are associated with a higher vulnerability to experiencing psychopathology (Bhugra *et al.*, 1999c; Cochrane & Stopes-Roe, 1981).

No previous attempt has been made in the literature to position shame within this relationship or to examine whether a particular acculturation strategy (Berry, 1987, 1990) influenced the propensity to experience shame. This is an important research endeavour as it may carry important implications for clinical practice and inform future research in the assessment and treatment of South Asians. However, the lack of congruity in the research literature makes this a difficult task and is reflected in the inherent inconsistency between the hypotheses of the present study. All of the hypotheses of the present study are derived from previous trends in the literature but are not congruent with each other in every case, as one would expect.

1.18 The Present Study

There is no empirical research that explicitly addresses the relationship between acculturation/cultural identity and psychological distress (specifically depression) in relation to the experience of shame among South Asian populations. Although there is evidence of a strong association between shame and psychopathology and depression in the psychological literature (Gilbert *et al.* 1998), this research has been conducted on general UK populations (mainly student samples) and not on a specific ethnic minority group. The higher than expected rates of depression, self-harming behaviours and eating disorders amongst British South Asian females provides a rationale to investigate the role of shame in the acculturation process and cultural identity in relation to psychological distress and depression, specifically. This may provide a link in to understanding the high rates of psychopathology within this

population and may also yield further insight into the rather ambiguous notion of *culture conflict*. As the relationship between acculturation/cultural identity and psychopathology (including depression) has generated inconclusive findings in the research literature, the hypotheses of this study are not congruent with each other due to the contradictory nature and inconsistency of previous research.

1.18.1 Aim of the Study

The broad aim of the study was to position shame in the relationship between acculturation/cultural identity and psychological distress and depression specifically among a sample of British South Asian women.

1.18.2 Hypotheses

1. There will be a positive relationship between acculturation (in the case of first generations) or cultural identity (in the case of second generations) and overall psychological distress and depression.

2. Compared to individuals with an identity firmly located in either their culture of origin (corresponding to Berry's Rejection strategy) or in the majority white British culture (corresponding to Berry's Assimilation strategy), individuals with bi-cultural identity (corresponding to Berry's Integration strategy) will experience higher levels of shame.

3. The experience of shame will be positively correlated with depression and overall psychological distress.

4. The relationship between acculturation/cultural identity and overall psychological distress (and depression, specifically) will be mediated by the experience of shame

The hypotheses are operationalised in terms of the variables as they are measured in this study in Chapter two, section 2.6.

CHAPTER TWO

2. METHOD

2.1 Ethical Approval

The research proposal for the present study was submitted to and approved by the University of Leicester, School of Psychology ethics committee (see Appendix one).

2.2 Design

The present study may be described as an exploratory study utilizing a questionnaire based design. The design involved the use of self-report measures to obtain data from participants on factors relevant to the research questions raised in the Introduction and Chapter Two. Scores on measures of acculturation/cultural identity, shame and psychological distress were collected for each participant. The relationship between these scores enabled a statistical exploration of these factors based on socio-demographic variables, many of which are considered to be a dimension of acculturation (Olmedo, 1979).

2.3 Participants

The sample consisted of 90 British South Asian women drawn from the general population of five culturally diverse cities in the UK: London (North and Central), Birmingham, Leicester, Leeds and Bradford. All participants were required to be proficient in the English language, as this was the language the measures were written in. The age of participants ranged between 18 and 37. The mean age was 25 years with a standard deviation of 5 years.

2.4 Measures

A questionnaire booklet, which comprised of three measures and a demographic questionnaire, was used as the tool for data collection. The booklet was divided into six sections: (1) A front sheet, written in the style of a covering letter, which introduced the study and the author and thanked individuals for their participation. (2) An information/consent sheet, which provided an orientation to the study and information relating to task requirements. The issue of anonymity was made clear and participants were requested to sign at the bottom as a statement of their consent to participate. (3) A demographic questionnaire, which asked participants to report on socio-demographic information regarding their age,

marital status, occupation, generational status, religion, languages spoken and self-defined ethnicity. (4) An acculturation scale (AIRS-B) developed by American authors Sodowsky & Plake (1991), which was adapted for use in the present study by the author to a British format. (5) A measure of psychological distress (GHQ-28) developed by Goldberg and Hillier (1979); and finally (6) a recently developed measure of shame (ESS) by Andrews, Qian and Valentine (2002).

A discussion of each of the three measures used in the present study will be provided in terms of their design, scoring and psychometric properties. A copy of the questionnaire booklet (inclusive of front sheet, information sheet, demographic questionnaire, AIRS-B, GHQ-28 and ESS) may be found in Appendix two.

2.4.1 The American International Relations Scale – British version (AIRS-B, Sodowsky and Plake, 1991)

This is a 34-item self-report measure of acculturation, which was designed to measure within and between group differences in the acculturation attitudes of international groups in the USA and first and second-generation immigrants. The AIRS was also designed to study the relationship between acculturation and mental health indices.

The AIRS was piloted on a sample of 123 South Asians (Indian) in an academic community in Texas and standardised on a total sample of 925 international students, scholars, academics and permanent residents in the USA. The structure of the AIRS was hypothesised by Sodowsky and Plake (1991) to be multidimensional with three factors: Perceived Prejudice, Social Customs, and Language Usage. Following Mehta (1998), the name of the second sub-scale will be changed from Social Customs to Cultural Orientation. The AIRS has been shown to demonstrate very good psychometric properties (Mehta, 1998, Sodowsky & Plake, 1991). The alpha coefficient for the full-scale acculturation score was 0.89. Internal consistency reliabilities for each of the three sub-scales (perceived prejudice, cultural orientation and language usage) were 0.88, 0.79 and 0.82, respectively. The sub-scale intercorrelations are claimed by Sodowsky and Plake (1991) to provide support for Cuellar *et al.*'s (1980) hypothesis that 'acculturation occurs along a number of different planes, some of which may or may not be related to each other' (Cuellar *et al.* 1980, p.209).

The Perceived Prejudice sub-scale consisted of twenty items. Their factor loadings ranged between 0.33 and 0.63 and their item-to-total sub-scale correlation's ranged between 0.31 and 0.62. The content of the Perceived Prejudice items included the individual experience of stereotypes, discrimination and social isolation; the individual's belief that their physical appearance, national dress, customs, religion, national history and values were discounted by the majority culture, their perception of communication difficulties with individuals from the majority culture and their sense of alienation from the majority culture. Such items are considered to reflect Berry's (1983) theoretical conceptualisation of acculturation that the apparent domination of one cultural group over another may be related to a process of *contact* and *change*, which can be difficult, reactive and conflictual.

The Cultural Orientation sub-scale consisted of eleven items. Their factor loadings ranged between 0.38 and 0.60 and their item-to-total sub-scale correlations ranged between 0.23 and 0.65. The content of the items indicated the individual's perception of acceptance regarding majority (white) cultural practices and social behaviours. These included preferences for friendships, trusting relationships, group identity, community and family ties, food, entertainment, religion, culture and festivals. These items are considered to support Padilla's (1980) contention that cultural orientation is a reliable predictor of the degree of acculturation and that strong family ties and ethnic community support may impede cultural change (Sodowsky & Plake, 1991).

The Language sub-scale comprised three items. Their factor loadings ranged between 0.77 and 0.83 and their item-to-total sub-scale correlations ranged 0.66 and 0.74. Item content included facility with spoken languages, the languages used when communicating with others from the same culture of origin and the language used for processing thoughts and images. According to Olmedo (1979), language proficiency, preference and/or use is a major dimension of acculturation and is also the best predictor of low acculturation (Sodowsky & Plake, 1991).

The AIRS has both a mulitiple choice and Likert format with values of 1 through to 5 for items 1 to 8; and a 6-point Likert scale for items 9 through to 34. For the 8 multiple choice and 26 Likert items, 1 indicated a strong affiliation with the white majority culture, suggesting 'Assimilation' and 5/6 indicated a strong affiliation with one's culture of origin, suggesting a 'Rejection' of the majority white culture or the observance of traditionalism. Middle scores

indicated 'Integration' (bicultural identity) i.e. an ability to integrate both cultures, with denial of neither (Sodowsky & Plake, 1991).

As the AIRS was devised in America, it required minor modifications for use with a UK sample. This was done with the approval of the instrument's author (G. Sodowsky, personal communication, January 2003). Modifications included replacing some of the terminology used in the American version with words that were more appropriate to a British context. Where there was no British equivalent available, the word was omitted from the questionnaire. Specific changes involved replacing the term 'Americans' with 'British people'. The term 'US' was replaced with 'UK' and the term 'American' was replaced with 'British'. The words used in the instructions were changed from 'Please check the appropriate blank' to 'Please tick the appropriate space'. The words 'fraternities and sororities' were omitted from question twenty-five, as they had no relevance to a British population. The adapted version of the AIRS to British format will be referred to as the AIRS-B. Within the questionnaire booklet the title of the AIRS measure was changed to the 'Cultural Orientation Scale' for simplicity.

Although the Cultural Orientation sub-scale within the AIRS-B is the closest to reflecting the concept of acculturation/cultural identity used in this study, given the high alpha co-efficient reported for the full scale Acculturation score (i.e. 0.89) it will be the full scale score that will be used as the independent variable for the main analysis. The present study did not intend to examine the separate contributions of the Perceived Prejudice, Cultural Orientation and Language Usage sub-scales, but rather the overall levels of cognitive and behavioural acculturation. The author of the instrument (AIRS) had previously used the combined sub-scales as one scale to investigate the relationship between acculturation and acculturative stress (Sodowsky & Lai, 1997).

The AIRS was chosen to measure acculturation in the present study as the items covered three of the four variations of acculturation suggested by Berry *et al.*, (1987): Assimilation, Integration and Rejection. The AIRS also included psychologically relevant components of culture (e.g. values, cultural customs and practices) suggested by Betancourt and Lopez (1993) and the notion of ethnic pride and inter-ethnic distance recommended by Padilla (1980). As most of the acculturation scales that have been validated on British South Asian populations have been mainly used with adolescents (e.g. see Ghuman, 1998), the author's

choice was limited to the scales available in the American literature. The AIRS was chosen, as most of the acculturation measures in the USA are culture specific (e.g. SL-ASIA, Suinn *et al.*, 1987) whereas the AIRS can be used across generations, with different nationality, cultural, and religious groups and is purported to tap individualistic versus collectivist coping strategies (Sodowsky & Impara, 1996).

Following the advice of the author of the scale (G. Sodowsky, personal communication, 19 May 2003) the total sample was divided into three equal groups based on their full-scale scores on the AIRS-B (in order to test hypotheses two). The lowest scoring third were considered as the most acculturated (i.e. a greater perception of acceptance and involvement in white British society: Assimilation), the highest scoring third were considered to be the least acculturated (i.e. a lower perception of acceptance and involvement in white British society: Rejection) and the middle third were considered as the 'Integration' group (Bicultural identity).

2.4.2 The Experience of Shame Scale (ESS; Andrews, Qian & Valentine, 2002)

The construction of this newly developed scale is based on the experiences of shame derived from the findings of a previous interview measure by Andrews and Hunter (1997), the purpose of which was to investigate the role of shame as a 'prospective predictor' of depressive symptomology (Andrews *et al.*, 2002).

The ESS is 25-item self-report questionnaire designed to measure three different but related manifestations of shame: characterlogical, behavioural and bodily. The four aspects of characterlogical shame assessed: (1) shame of personal habits, (2) manner with others, (3) sort of person (you are), (4) personal ability. The three aspects of behavioural shame assessed: (5) shame about doing something wrong, (6) saying something stupid, (7) failure in competitive situations. The area of bodily shame is assessed by: (8) feeling ashamed of your body or any part of it. For each of the eight areas of shame that are assessed, there are three related items, which address the (1) *experiential* component, which asks respondents whether they had felt ashamed about their body, (non-physical) personal characteristics or their behaviour, with no explicit mention of the word 'shame' itself; (2) a *cognitive* component, which gauges the concern over what *other* people think; and (3) a *behavioural* component, which asks about concealment or avoidance. This approach is the first to measure 'dispositional shame'.

Respondents are asked to rate on a 4-point scale ranging from 1 (not at all) to 4 (very much) how they have felt over the past year. Total scores range between 25 – 100. The scale was constructed using a student population. The mean total scale score was 55.58 (SD= 13.95, range 29-95). The total scale yields high internal consistency (Cronbach alpha = 0.92) and test-retest correlation over 11 weeks was 0.83. The sub-scale means were: characterlogical shame, 24.43 (SD = 7.25); behavioural shame, 21.25 (SD = 5.5) and bodily shame, 9.82 (SD = 3.40). The internal consistency reliabilities for the sub-scales were 0.90, .87 and 0.86 (Cronbach alpha) and the test retest reliabilities were 0.78, 0.74 and 0.82.

For the purpose of this study, the total full-scale score of the ESS will be used in the final analysis. High levels of shame experienced (indicated by the full-scale score) equates with a high degree of shame 'prone-ness'. Within the questionnaire booklet the title of the 'Experience of Shame Scale' was changed to 'Feelings About Myself' (in line with Andrew's (1998) recommendation of not mentioning the word shame) in order to minimise response bias.

2.4.3 The General Health Questionnaire – 28 (GHQ-28; Goldberg & Hillier, 1979)

This was used as the measure of psychological distress. The GHQ-28 is a self-report questionnaire and was designed as a screening instrument for use in a community setting to detect 'psychiatric caseness' (minor psychiatric illness). It can therefore be used to estimate the prevalence of mental health problems in a particular population. The original measure used sixty items (GHQ-60) each of which differed by forty percent in differentiating proportions of 'normals' and 'severes' based on clinical assessments (Goldberg & Williams, 1988). A twenty-eight item version of the scale was developed and is based on a four- factor solution of the original scale (Goldberg & Hillier, 1979). Banks *et al.,* (1980) demonstrated consistent clinical validity in a number of empirical studies using the GHQ to assess its linear associations with independent clinical assessment (r = 0.70 or greater). Goldberg (1972) reported that the GHQ-28 yielded high internal consistency and good test-retest reliability over six months. The GHQ-28 has also been used with community samples of South Asian migrants in the UK (e.g. Bhugra *et al.*, 1999b; Fazil & Cochrane, 2002a).

The GHQ-28 asks respondents to indicate whether they had recently experienced a particular symptom or item of behaviour on a scale ranging from "less than usual" to "more than usual". Different scoring methods are available when using the GHQ-28. The present study

employed the simple Likert scoring method, which ranges from 0-3, as this method is considered to be more superior in terms of sensitivity and specificity and is recommended for use in order to produce less skewed distribution. The highest possible score would be 84 (21 for each sub-scale). In addition to a single 'severity' (total) score, the GHQ offers 4 sub-scale scores for (1) Somatic Symptoms, (2) Anxiety & Insomnia, (3) Social Dysfunction and (4) Severe Depression. The sub-scales represent 'dimensions of symptomology and do not necessarily correspond to psychiatric diagnosis' (Goldberg & Williams, 1988, pp.41). A number of empirical studies have explored the use of cut-off thresholds when applying the GHQ-28 as an indicator of psychopathology or 'caseness' (Goldberg & Williams, 1988). The best threshold score for psychiatric 'caseness' was 39/40 (of the total score). The use of the GHQ-28 does not require the assumption that the factor structure in the sample is the same as that in the sample on which the questionnaire was developed (Goldberg, 1986).

2.5 Procedure

Two sampling strategies were utilised in the study. These were opportunity/convenience and snowball sampling. Females who appeared to be of South Asian decent and over the age of eighteen were approached by the author in the public domain of the city centre area in the following cities: London (North and Central), Birmingham, Leicester, Leeds and Bradford. Inclusion criteria were clarified from the outset by asking participants to confirm if they were of South Asian origin and over the age of eighteen. When confirmation was obtained, participants were given a brief verbal overview of the study and were assured of the anonymous nature of the research. Participants were then asked if they would be willing to complete a questionnaire booklet as part of the study. Those who agreed to participate were provided with a questionnaire booklet and a stamped addressed envelope (SAE) for return post.

The author 's existing personal contacts in each of the target cities were also drawn upon to help identify further potential participants for inclusion in the study. The author's personal contacts' agreed to pass on questionnaire booklets and SAE's in the author's absence. The distribution of questionnaires using this sampling technique permitted a wider sample to be recruited.

The average completion time was estimated to be twenty minutes. Participants were asked to return the questionnaire booklet in the stamped addressed envelope provided within two

weeks of its receipt. Participants were encouraged to complete the questionnaires *individually* and refrain from consultation with others (friends and family). The author was available (via telephone) to clarify any concerns that arose. All questionnaires were anonymised by numeric code upon their return.

The limited nature of the sample is acknowledged. Due to the use of samples of convenience and the snowballing strategy to recruit participants, the sample was not random and may have been systematically biased. This calls into question its representativeness, the implications of which will be considered later in Chapter Four (see Discussion).

2.6 Operational Statement of Hypotheses

The hypotheses stated in Chapter one (section 1.18.2) can now be framed in terms of the variables as they are measured in this study:

1) There will be a positive relationship between acculturation (in the case of first generations) or cultural identity (in the case of second generations) (as measured by the AIRS-B in both cases) and overall psychological distress (as measured by the total score of the GHQ-28) and depression, specifically (as measured by the Severe Depression sub-scale of GHQ-28).

2) Individuals in the 'Integration' group will experience higher levels of shame (as measured by the total scores on the AIRS-B and ESS, respectively) compared to those in the 'Assimilation' and 'Rejection' groups.

3) The experience of shame will be positively correlated with depression and psychological distress (as measured by the total score of the ESS and the Severe Depression sub-scale and total score on the GHQ-28, respectively).

4) The relationship between acculturation/cultural identity (as measured by the total score of the AIRS-B) and overall psychological distress and depression specifically (as measured by the total score and Severe Depression sub-scale score of the GHQ-28, respectively) will be mediated by the experience of shame (as measured by the total score on the ESS).

CHAPTER THREE

3. RESULTS

3.1 Analysis Plan

Data analysis was performed using SPSS for Windows, version 11. Preliminary statistical tests were carried out to establish the characteristics of the data and to determine the appropriateness of parametric or non-parametric tests. In order for parametric tests to be used, the level of measurement must be interval scaling, the scores within the data set must be normally distributed and there must be homogeneity of variance within the scores in each condition. Following initial data checks, reliability calculations for all the measures used in the present study were reported (computations for each measure may be found in Appendix Three). Summary descriptive statistics on the demographic characteristics of the total sample and the demographic profile across the three acculturation groups were presented followed by the psychological profile of the total sample and three acculturation groups and sub-group analysis in relation to sub-scale scores and total scores on all outcome measures. This was followed by inferential statistical analyses for individual hypothesis testing.

The data from all the outcome measures were assessed for normality of distribution using the Kolmogorov-Smirnov (z) distribution test. Results indicated that the data from three of the four outcome variables, namely, Severe Depression sub-scale scores, total GHQ-28 scores and total Shame scores were not normally distributed ($p < .05$) therefore violating the second assumption of parametric analysis. The total AIRS-B scores were normally distributed.

However, Howell (1997) has argued that it is safe to assume that parametric statistics are robust enough even when assumptions are violated to a moderate degree. Many authors drawing on the *central limit theorem* agree that a sample size of over 40 is sufficiently large enough to allow use of a parametric test even when a set of scores are not normally distributed (e.g. Clarke-Carter, 1997, Howell, 1997). As the sample size in the present study was 90, the use of parametric tests was considered to be permissible and it was decided that parametric analyses would be performed to maximise power. An alpha level of .05 was set for all statistical tests (unless otherwise stated).

The Levene's statistic was used to test the assumption of the homogeneity of variances for dependent variables (age, shame total, GHQ total and sub-scale scores and AIRS-B total and sub-scale scores) across the three acculturation groups. Results indicated no serious violations of this assumption for ANOVA ($p > .05$).

The data derived from the measures used in the present study were mainly continuous and the level of measurement was thus treated as interval. Therefore, as no serious violations of normality were noted and in accordance with the design and research questions of the study, scores were analysed using bivariate Pearson's product-moment correlation coefficient (hypotheses one and three), Analysis of Variance (ANOVA) (hypothesis one and two) and partial correlation analysis with Pearson's *r* (hypothesis four). As a specific direction was predicted in hypotheses one and three, one-tailed significance tests were used; elsewhere, two-tailed tests were used.

3.1.1 Reliability

The internal reliabilities of all the measures used in this study were calculated using Cronbach alpha coefficient calculations (at an alpha level of .01). All scales offered high internal consistencies (alpha range .91 to .94) (raw data calculations can be found in Appendix Three).

3.2 Sample characteristics

During the two-month data collection period, of the 180 questionnaires that were distributed, 90 were returned giving an overall response rate of 50%. The average age of the total sample was 24.67 years with a standard deviation of 5.19 years and participants ranged in age from 18 to 37 years. The ethnicity and gender of the sample (N= 90) was entirely British South Asian females.

3.2.1 Demographic profile of total sample

The demographic profile for the total sample is summarised in Table 1 according to religious, generational, marital and occupational status, living arrangements and geographical location.

Table 1. Demographic characteristics of the total sample (N= 90).

Demographic Variable	**N = 90**	**%**
Generational Status		
First generation	14	16%
Second generation	76	84%
Religious affiliation		
Hindu	25	28%
Sikh	28	31%
Muslim	37	41%
Marital status		
Single	60	67%
Married	28	31%
Separated/Divorced	2	2%
Occupational Status		
Student	33	37%
White Collar	39	43%
Manual	18	20%
Living Arrangements		
Alone	11	12%
Partner	21	23%
Family	54	60%
Friends/Housemates	4	4%
Geographic Location		
London	22	24%
Leicester	23	26%
Birmingham	15	17%
Leeds	14	16%
Bradford	16	18%

The total sample predominantly consisted of second generation British South Asian females. In terms of religious orientation, most of the participants were Muslim. In terms of marital status and occupation, the sample contained higher proportions of single females and non-manual workers. Most of the participants lived with their families. In terms of the geographic dispersal of the sample, the majority of participants were recruited in Leicester, followed by London, Bradford, Birmingham and Leeds, respectively.

3.2.2 Demographic profile of the three acculturation groups.

The total sample (N = 90) of British South Asian females were split in to three (approximately) equal acculturation groups for subsequent between-subjects analysis of variance (ANOVA). The between subjects factor (the independent variable) had three levels: Assimilation, Integration and Rejection. As explained in Chapter Two (section 2.4.1) the total score of the AIRS-B was used to determine the three comparison groups based on the distribution of scores in the current sample. Scores ranging between 34 -95 formed the Assimilation group (N= 30), scores between 96 -111 formed the Integration group (N= 31) and scores between 112 -196 formed the Rejection group (N= 29).

The breakdown of sample characteristics according to age and the demographic profile across the three acculturation groups is shown in Table 2 and 3, respectively.

Table 2. Mean age of participants across acculturation groups.

	Assimilation	**Integration**	**Rejection**
AGE (years)	(N = 30)	(N = 31)	(N = 29)
Mean	22.73	25.74	25.52
S.D	4.07	5.38	5.58
Range	18-34	18-35	18-37

A one-way ANOVA was conducted to explore differences in age across the three acculturation groups. Individuals in the Assimilation group were significantly younger than individuals in the Integration and Rejection groups: F (2,89) = 3.30, $p < .05$. However, despite reaching statistical significance, the actual difference in mean scores between the groups was only small. The effect size calculated using eta squared was 0.07, which is reported as a *medium* effect size (Howell, 1997). Consequently, post-hoc comparison using the Scheffe test was unable to detect where the difference occurred (i.e. the mean age scores did not differ significantly between alternate pairs of the three groups).

Table 3. Demographic profile of the three acculturation groups.

Demographic Variable	Assimilation (N= 30)		Integration (N= 31)		Rejection (N= 29)	
	N	%	N	%	N	%
Generational status						
First Generation	0	0	6	19.4	8	27.6
Second Generation	30	100	25	80.6	21	72.4
Religious affiliation						
Hindu	10	33.3	11	35.5	4	13.8
Sikh	11	36.7	9	29.0	8	27.6
Muslim	9	30.0	11	35.5	17	58.6
Marital status						
Single	26	86.7	17	54.8	17	58.6
Married	4	13.3	14	45.2	10	34.5
Separated/Divorced	0	0	0	0	2	6.8
Occupational status						
Student	18	60.0	9	29.0	6	20.7
White Collar	10	33.3	18	58.1	11	37.9
Manual	2	6.7	4	12.9	12	41.4
Living arrangements						
Alone	4	13.3	2	6.5	5	17.2
Partner	3	70.0	12	38.7	6	20.7
Family	21	6.7	16	51.6	17	58.6
Friends/Housemate(s)	2	10.0	1	3.2	1	3.4
Geographical location						
London	8	26.7	10	32.3	4	13.8
Leicester	12	40.0	8	25.8	3	10.3
Birmingham	3	10.0	6	19.4	6	20.7
Leeds	6	20.0	4	12.9	4	13.8
Bradford	1	3.3	3	9.7	12	41.4

Pearson's Chi-Square analysis for categorical variables (generational, occupational, marital status, religious affiliation, living arrangements and geographical location) was used to explore the distribution of demographic data across the three acculturation groups (assimilation, integration and rejection). However, a number of the demographic variables violated the assumption for Chi Square (i.e. a number of cells had expected counts less than 5) and in such cases, a Fisher's Exact Probability Test was conducted.

Results indicated that there were no significant differences in the distribution of marital status, living arrangements and religious affiliation across the three groups but there was a significant difference in the distribution of occupational status across the three groups (X^2 =17.54, d.f. = 4, $p < .05$) with the Assimilation group having more students and fewer manual workers than the other two groups. This may well be related to the significantly different generational status distribution across the three groups with a complete absence of any first generation migrants in the Assimilation group (X^2 = 10.60, d.f. = 2, $p < .05$). The geographic location of respondents also differed significantly between the three groups (X^2 = 21.30, d.f. = 8, $p < .05$).

3.3 Psychological profile of total sample and sub-group analysis

Table 4. Mean scores and standard deviations on psychological variables.

	Assimilation (N= 30)		**Integration** (N = 31)		**Rejection** (N = 29)		**Total** (N = 90)	
Psychological Variable	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**	**Mean**	**SD**
AIRS-B[1]								
Perceived Prejudice	39.53	9.26	59.83	6.18	75.72	9.99	58.19	17.03
Cultural Orientation	33.33	6.19	38.26	4.43	42.52	6.56	37.99	6.83
Language Usage	5.87	1.96	6.65	1.78	8.14	2.66	6.87	2.32
Total	78.73	12.99	104.74	5.06	126.37	11.75	103.04	22.01
GHQ-28[2]								
Somatic complaints	6.43	4.49	6.97	4.46	7.38	5.29	6.92	4.71
Anxiety & Insomnia	5.70	4.79	6.71	4.71	8.20	6.25	6.86	5.32
Social dysfunction	6.97	2.55	7.61	3.20	7.83	4.09	7.47	3.31
Severe depression	2.00	3.51	1.74	3.18	4.14	4.46	2.60	3.86
Total	21.10	12.01	23.03	12.99	27.55	16.13	23.84	13.89
ESS[3]								
Total	39.17	12.45	48.84	14.42	48.00	15.38	45.34	14.64

[1]American International Relations Scale- British version (Sodowsky & Plake, 1991)
[2]General Health Questionnaire- 28 (Goldberg & Hillier, 1979)
[3]The Experience of Shame Scale (Andrews *et al.*, 2002)

Ten one-way between-group ANOVAs were performed to explore group differences on all of the psychological variables used in this study. As expected, given the way the three acculturation sub-groups were formed, they differed significantly on each of the AIRS-B sub-scales: Perceived Prejudice: F (2,89) = 132.57, p = < 0.05; Cultural Orientation: F (2, 89) = 18.67, p = < 0.05 and Language Usage: F (2, 89) = 8.44, p = < 0.05.

There were no significant group differences on levels of Somatic Complaints, Anxiety & Insomnia and Social Dysfunction and overall Psychopathology: F (2, 89) = 0.29, p > .05; F (2, 89) = 1.68, p > .05; F (2, 89) = 0.54, p > .05; F (2, 89) = 1.70, p > .05, respectively. However, there was a statistically significant difference between the three groups on levels of Severe depression: F (2, 89) = 3.64, p = < 0.05. Post hoc comparisons using the Scheffe test was unable to detect any specific differences between the groups (p > .05). There was also a statistically significant difference between the three groups on levels of shame: F (2, 89) = 4.33, p < .05. Post hoc Scheffe comparisons revealed that the difference occurred between the Integration and Assimilation group. However, there were no significant differences between the Assimilation and Rejection group and between the Integration and Rejection groups (p < .05).

3.4 Statistical Analysis of Hypotheses.

3.4.1 Hypothesis One

There will be a positive relationship between acculturation (in the case of first generations) or cultural identity (in the case of second generations) (as measured by the AIRS-B in both cases) and overall psychological distress (as measured by the total score of the GHQ-28) and depression, specifically (as measured by the Severe Depression sub-scale of GHQ-28).

In order to explore the strength of the relationship between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression, data from the AIRS-B total and GHQ-28 total and sub-scales were correlated using Pearson's product-moment correlation coefficients (r).

The AIRS-B total was significantly correlated with the GHQ-28 total (r = 0.19, N = 90, p < .05), the GHQ Severe Depression sub-scale (r = 0.18, N = 90, p < .05) and the GHQ Anxiety & Insomnia sub-scale (r = 0.21, p < .05). The AIRS-B total did not correlate significantly with the Somatic Complaints or Social Dysfunction sub-scales of the GHQ-28.

In terms of the three acculturation groups formed for this study (see Hypothesis two) the Rejection group had a higher GHQ-28 total mean score (M =27.55, SD = 16.13) than either the Assimilation group (M = 21.10, SD = 12.01) or Integration group (M = 23.03, SD = 12.99). These group differences did not quite reach statistical significance (see Table 4).

To examine whether the observed differences in the generational and occupational status of the three acculturation groups (section 3.2.2) might be confounding the relationship between acculturation/cultural identity and overall psychological distress and acculturation/cultural identity and depression, these demographic variables were also analysed in relation to GHQ total and Severe Depression sub-scale scores, as shown in Table 5.

Table 5. GHQ Total and Severe Depression sub-scale means and standard deviations for demographic variables (N = 90).

Demographic variable		**GHQ-28 T[1]**			**Sev Dep[2] sub-scale**		
	N	Mean	SD	*F*	Mean	SD	*F*
Generation							
First	14	26.50	12.99		3.14	4.75	
Second	76	23.36	14.08	0.60	2.50	3.70	0.33
Occupation							
Manual	18	24.28	15.57		2.50	3.49	
White Collar	39	25.79	15.03		3.10	4.70	
Student	33	21.30	11.31	0.94	2.06	2.83	0.66

[1]GHQ-28 (Goldberg & Hillier, 1979) full scale score
[2]GHQ-28 Severe Depression sub scale

Four one-way ANOVAs indicated that there were no significant differences in the total GHQ-28 or Severe Depression sub-scale scores between the two generations or between the three occupations. Thus generation and occupation are unlikely to be confounding the relationships observed between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression.

A Fisher's Exact Probability test indicated that there was a significant difference between the three acculturation groups in the proportion of women exceeding the total GHQ-28 clinical cut-off threshold (X^2 = 10.10, d.f. = 2, $p < .05$). While only 1 woman in the Assimilation group and 2 in the Integration group exceeded the threshold, 9 women in the Rejection group exceeded the GHQ-28 threshold (above 39 of the full-scale score).

To summarise, the tentative conclusion drawn from the bivariate correlation analyses is that there is a statistically significant positive weak association between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression in the predicted direction, thereby supporting Hypothesis one. This relationship does not appear to be influenced by demographic variables such as generational and occupational status as no significant main effects were found for these variables. Furthermore, the Rejection group showed the highest mean score for overall psychological distress and had a higher proportion of individuals (31%) exceeding the clinical threshold for psychiatric 'caseness' compared to individuals in either the Integration group (6.5%) or Assimilation group (3.3%).

3.4.2 Hypothesis Two

Individuals in the 'Integration' group will experience higher levels of shame (as measured by the AIRS-B and ESS, respectively) compared to those in the 'Assimilation' and 'Rejection' groups.

In order to test the prediction that there would be an effect of acculturation/cultural identity on the experience of shame, a one-way between subjects ANOVA was computed to enable a comparison between the three groups (Table 4). Results indicated that there was a significant difference in total shame scores between the three acculturation groups: F (2,89) = 4.33, $p <$ .05. Post-hoc comparisons using the Scheffe test indicated that participants in the Integration group differed significantly from participants in the Assimilation group (p = .03). There was

no difference in the mean shame scores of the Rejection group and Integration group or between the Rejection group and Assimilation group.

To summarise, a significant main effect of acculturation/cultural identity was found on the experience of shame whereby individuals in the Integration group differed significantly from individuals in the Assimilation group on levels of shame. Overall, individuals in the Integration group (i.e. those with a bi-cultural identity) experienced greater levels of shame compared to individuals in the Assimilation but not individuals in the Rejection group, thereby partly supporting Hypothesis two.

3.4.3 Hypothesis Three

The experience of shame will be positively correlated with depression (as measured by the ESS and Severe Depression sub-scale of the GHQ-28) and with overall psychological distress (as measured by the total score on the GHQ-28).

Pearson's product-moment correlation coefficient indicated a significant positive relationship between shame and depression (r = 0.36, p < .01) and shame and overall psychological distress (r = 0.47, p < .01) in the predicted direction, thereby tentatively supporting Hypothesis three. According to Cohen (1988), correlations of this size are regarded as medium strength.

3.4.4 Hypothesis Four

The relationship between acculturation/cultural identity (as measured by the total AIRS-B) and overall psychological distress and depression specifically (as measured by the total score and Severe Depression sub-scale score of the GHQ-28) will be mediated by the experience of shame (as measured by the total ESS).

A partial correlation was carried out in an attempt to position shame in the relationship between acculturation/cultural identity and psychological distress and depression. The original simple correlation between acculturation/cultural identity and overall psychological distress was r = 0.19 (p < .05) and for depression it was r = 0.18 (p < .05). However, the partial correlations of acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression suggests that when the effect of shame is partialed out, the correlations between acculturation/cultural identity and overall

psychological distress and depression, are no longer significant ($r = 0.07$, $p > .05$; $r = 0.09$, $p > .05$, respectively). In passing, it can also be noted that the significant correlation between acculturation/cultural identity and the Anxiety & Insomnia sub-scale of the GHQ-28 ($r = 0.21$, $p < .05$) was also removed when shame was partialed out ($r = 0.12$, $p > .05$).

To summarise, there were originally significant positive relationships between acculturation/cultural identity and psychological distress and depression (Hypothesis one) but these are removed when shame is controlled for. This result suggests that the experience of shame has a mediating effect on the strength of the relationship between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression, thereby tentatively supporting Hypothesis four.

CHAPTER FOUR

4. DISCUSSION

4.1 Overview of study

The aim of the present study was to gain a measure of acculturation/cultural identity within a sample of British South Asian women drawn from the general population in relation to levels of overall psychological distress, depression specifically and shame. As there were no consistent trends in the literature, the hypotheses of this study were derived from the findings of previous inconclusive and incongruent empirical research and theory. The first goal of the study was to examine the relationship between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression. The study was also designed to investigate whether there was a relationship between acculturation/cultural identity and the experience of shame and to examine the relationship of shame to psychological distress, specifically depression. In an attempt to position shame in the relationship between acculturation/cultural identity and psychological distress and depression, it was tentatively proposed that the experience of shame might play a mediating role between these related constructs.

4.2 Summary of key findings

- As anticipated, the constructs acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression were related. In particular, modest positive significant associations were found between scores on the AIRS-B (indicative of low acculturation) and scores on the total GHQ-28 (indicative of higher levels of overall psychological distress) and the Severe Depression sub-scale of the GHQ-28.

- A significant main effect of acculturation/cultural identity was found on levels of shame whereby individuals whose scores were indicative of the 'Integration' and 'Rejection' strategies experienced significantly higher levels of shame compared to individuals adopting the 'Assimilation' strategy. There was no significant difference between the level of shame experienced by the 'Integration' and 'Rejection' groups.

- As anticipated, a moderate positive significant relationship was found between shame and psychological distress and between shame and depression, thereby upholding the previously established theoretical linkage between these constructs.

- The relationships between acculturation/cultural identity, psychological distress and depression specifically were mediated by the experience of shame.

4.3 Interpretation of findings and theoretical implications

As the sample of South Asian women used in the present study may not have been truly representative of the general population of South Asian women in Britain, interpretations are offered tentatively and with caution.

4.3.1 Hypothesis one

Using the theory of acculturation options and Berry's (1980, 1997) bi-dimensional model of acculturation, the present study investigated three of the four adaptation options proposed by Berry and his colleagues to understand the psychological acculturation/cultural identity of British South Asian women in relation to psychological distress, specifically depression. The bi-dimensional model allows for bi-culturalism, or the adherence to both the culture of origin and the white majority culture, which are independent of one another. It also recognises that individuals differ in the extent to which their self-identity includes culturally based values, attitudes and behaviours. Thus, individuals may adopt many of the values, attitudes and behaviours of the majority culture without necessarily giving up facets of their self (cultural) identity developed in their culture of origin (Ryder *et al.*, 2000). For some individuals, culture may play a greater role in their sense of identity, while for others, identity may be more based on demographic factors such as occupation or religion. Furthermore, the bi-dimensional model recognises that individuals are capable of having multiple cultural identities, each of which may vary independently in strength (Ryder *et al.*, 2000). Individuals who adopt the 'Integration' mode of acculturation are considered to have a bi-cultural identity and find value in both cultures. The bi-dimensional model therefore provided a useful framework to understand the two-way interaction process between minority and majority cultures to determine the adaptation of individuals living in a bi-cultural context. The fourth option, called 'Marginalisation' (which indicates no affiliation to either cultural group) was

not included as Sodowsky & Plake (1992) have argued that theoretically, this option is not amenable to measurement in that it is not possible to define an individual as 'culture-less'.

Although a statistically significant link was found between acculturation/cultural identity and psychological distress and acculturation/cultural identity and depression, the strength of these relationships were fairly weak and caution is needed in interpreting the associations. High scores on the AIRS were indicative of low acculturation, or the 'observance of traditionality' (Sodowsky & Plake, 1992, p.54). This option is characterised by a rejection of the white British culture and a strong orientation towards the culture of origin, a greater perception of prejudice, a lower perception of acceptance by white British people, low involvement in the majority white British culture and greater use of mother tongue (Asian) languages.

Inherent in the relationship found between acculturation/cultural identity and psychological distress and depression is the finding that the 'Rejection' group reported poorer psychological health. Mean differences between the three acculturation groups on the GHQ-28 (total score) were congruent with the relationship found as the 'Rejection' group did indeed appear to experience the highest levels of overall psychological distress and depression. However, differences between the three acculturation groups were not statistically significant. A significant difference was found between the three acculturation groups in terms of the distribution of total GHQ-28 scores exceeding the clinical cut-off threshold for psychological distress. Thirty-one per cent of the 'Rejection' group scored above the threshold for psychiatric 'caseness' compared to 7% of the 'Integration' group and 3 % of the 'Assimilation' group. This adds some support to findings in the literature claiming undetected ('hidden') rates of psychopathology among the South Asian community in Britain (e.g. Fazil & Cochrane, 2002a).

The data of the present study show that feeling accepted by the majority white British culture, perceiving lower levels of prejudice (e.g. experiencing less racism), being more adept to British culture and life (i.e. in terms of leisure activities, friendships, trusting relationships, group identity, community and family ties, food, entertainment, religion, culture and festivals) and being proficient in the English language, were all related to fewer psychological symptoms for South Asian women living in large cities in the UK.

In the present study, the total sample of British South Asian women reported lower levels of perceived prejudice, were more acculturated into the white majority culture and showed a greater usage of the English language than the South Asian migrants in Sodowsky and Plake's (1992) study in the USA, as indicated by mean scores on the AIRS. For the Perceived Prejudice acculturation dimension, the mean score for the sample in the present study was 58.19 compared to 70.41 in Sodowsky and Plake's (1992) study; for the Cultural Orientation acculturation dimension the mean score for the present study was 37.99 compared to 41.80 in Sodowsky and Plake's study, and for Language Usage acculturation dimension, the mean score for the present study was 6.87 while in Sodowsky and Plake's study it was 10.35. These differences suggest that the South Asians who participated in the present study were more acculturated than the South Asians who participated in Sodowsky and Plake's (1992) study, who showed a lower level of acculturation toward American life and culture. This may be more a reflection of the difference inherent in the pluralistic nature of both British and American societies in terms of their acceptance of diverse cultural groups.

Participants in the present study experienced lower levels of Severe Depression and psychological distress compared to those who participated in Fazil & Cochrane's (2002a) study. In terms of overall psychological distress, the mean score for the total sample in the present study was 23.84 compared to Fazil and Cochrane (2002a) who found the mean level of overall psychological distress in their study to be 32.49. For Severe Depression, the mean score in the present study was 2.60 and in Fazil and Cochrane's (2002a) study it was 6.37. However, these differences might be explained in terms of the higher proportion of Pakistanis recruited in Fazil and Cochrane's (2002a) study. Differences in the psychological profile of Indians and Pakistanis have been (inconsistently) reported in the prevalence literature; in some studies (e.g. Dean *et al.*, 1981) Indians have shown higher psychological symptom levels than Pakistanis and in other studies, Pakistani females have shown higher levels than Indians (e.g. Nazroo, 1997).

The acculturative 'change' phenomenon is likely to be much more complex than just being the result of continuous contact between two autonomously different cultural systems. For example, 'change may be derived from non-cultural causes such as ecological or demographic modifications' (Berry, 1980, p.10). Furthermore, individuals who are undergoing acculturation do not necessarily experience mental health difficulties. Acculturation

adaptations may be accounted for by several contextual *mediating* factors (Berry and Kim, 1988): the nature of the majority culture and society (i.e. promoting assimilation), the nature of the ethnic minority group (i.e. in terms of their immigration status), generation, religion, socio-economic status and level of education. Levels of psychological difficulties may vary considerably depending on group and individual characteristics and the variables mediating the relationship between acculturation and adaptation.

The socio-political nature of the majority culture refers to its pluralistic or assimilationist ideology (Sodowsky, 2002). Psychological adjustment difficulties are considered to be less predominant in multicultural societies on the basis that they are cosmopolitan and accept and encourage diversity and difference. Regarding South Asians in Britain, public views expressed on the subject of immigration indicate that a high proportion of white British people are, in fact, against immigration, and more in favour of the British government exercising stricter controls on entry in to the country, which does not promote feelings of acceptance amongst Britain's immigration communities. In Ghuman's (1994) opinion, these factors combined with the Salman Rushdie affair and the first Gulf war (in the early 1990's) and also the recent Iraq war have created a general climate of insecurity and anxiety among South Asian communities in Britain, particularly Muslims. In such situations, it might be hypothesised that some may seek psychological security from within their roots and a sense of pride in their culture of origin might serve as a protective factor in the event of negative societal reactions. This interpretation may partly apply as most of the Muslim participants utilised the Rejection strategy. However, data from this study do not appear to conform to this hypothesis as individuals who showed a stronger affiliation towards their culture of origin (those adopting the 'Rejection' strategy) showed a higher level of psychological distress and proportionally more individuals in the 'Rejection' group scored above the clinical threshold for psychiatric 'caseness' compared to individuals who showed a weaker affiliation towards their culture of origin.

The second mediating variable refers to the nature of the acculturating group. Berry and Kim (1988) identified five groups that varied in degree of voluntariness, movement and permanence of contact: immigrants, refugees, native peoples, ethnic minority groups and sojourners. Individuals who voluntarily participate in the acculturation process such as voluntary immigrants who are more permanently established in their communities, as is the

case for most ethnic minority groups in the UK, are considered to experience less stress than those whose contact with the majority culture is involuntary and/or making temporary contact (e.g. international students, refugees). This provides a good basis for further comparative research comparing the effects of socio-cultural variables to investigate differences between two acculturating groups (e.g. South Asian immigrants and refugee cultural minority groups), particularly in the current political climate where a large proportion of refugees and asylum seekers have taken temporary residence in the UK.

The third mediating variable, and the most relevant to the present study, is the mode of acculturation adaptation adopted: Assimilation, Integration, Rejection or Marginalisation. According to Berry (1997), acculturation strategies have been shown to have substantial relationships with positive adaptation: 'Integration' has previously been found to be the most successful, the 'Assimilation' strategy is considered to be intermediate, 'Marginalisation' has been found as the least adaptive strategy and 'Rejection' is considered to be less adaptive than 'Assimilation' but more adaptive than 'Marginalisation' (Berry, 1990, Berry, 1997). Why this is the case, however, is unclear. One interpretation is that the 'Integration' strategy incorporates many protective factors: a willingness for mutual accommodation, involvement in two cultural communities and being more flexible in personality. Lafromboise *et al.* (1993) concluded that 'the more an individual is able to maintain active and effective relationships through alternation between both cultures, the less difficulty he/she will have in acquiring and maintaining competence in both cultures' (Lafromboise *et al.*, 1993, pp. 402). However, findings in the literature have been unable to demonstrate any consistent patterns regarding the relationship between acculturation and mental health and in the British literature, 'Integration' has sometimes been reported to be the strategy that may carry an increased risk for developing psychopathology. This will be elaborated more fully under discussion of Hypothesis two. The present study found that a low level of acculturation was related to higher self-reported psychological distress and depression. The hypothesis was based on the assumption that low acculturation limits an individuals access to health care resources and isolates the individual from potential sources of help in the majority culture. This may create a perceived lack of agency and helplessness, which have been associated with low self-esteem and depression (Gallagher-Thompson *et al.*, 1997; Littlewood, 1995). Elsewhere, however, low acculturation and traditionalism has been found to *protect* against psychological distress (Bhugra *et al.*, 1999c; Guglani *et al.*, 2000). The implication inherent in this interpretation is

that increasing acculturation leads to estrangement from one's culture of origin and to the internalisation of the dominant groups negative stereotypes towards one's culture of origin. Deprived of social support, a positive sense of self, and still faced with discrimination, the highly acculturated individual may be more prone to experiencing psychological distress. Rejection of the majority culture and the maintenance of traditionalism may help first generation migrants to survive the culture shock, prejudice and economic competition with the majority culture. However, no firm conclusions have been reached about the functional effect of traditionalism.

The nature of the relationship found in the present study is in accord with other previous research which has found low acculturation to be related to poorer psychological adjustment and better psychological outcomes have been associated with 'Assimilation' (Berry, 1990; Cochrane, 1977; Mehta, 1998). Support for the present study is provided by an early UK study by Cochrane (1977) who found that a failure to acculturate to British society and culture was related to psychological problems whereas high acculturation and social integration were related to better mental health outcomes. Similarly, Mehta (1998) used the AIRS to investigate the relationship between acculturation and mental health and found that immigrants, who reported greater social and cultural ties with the US culture and fewer ties with their culture of origin, had better mental health outcomes compared to those who reported lower levels of involvement with US culture. The relationship between acculturation and mental health was independent of other variables that might be expected to influence and confound the relationship (i.e. demographic variables).

The findings of the present study are also congruent with Berry's (1980, 1997) study which found that minority communities in Northern Canada with the highest levels of stress preferred the Rejection mode of adaptation. Conversely, minorities in Canada with the lowest levels of stress preferred the Integration mode. In the British literature however, *culture conflict* has been hypothesised to be a prominent feature of the Integration mode and is considered to increase the risk of depressive and anxiety states, which may manifest in psychopathologies such as eating disorders and deliberate self-harm. In the UK then, the Integration strategy has been associated with higher levels of psychological distress. Data from the present study are more consistent with early British research by Cochrane (1977), the findings of Berry's (1980, 1997) Canadian studies and Mehta's (1998) study in the USA, than

with the more recent UK studies (e.g. Bhugra *et al.*, 1999a, 1999b, 1999c, Bhugra & Bhui, 2003; Cochrane & Stopes-Roe, 1980, 1981).

The fourth mediating factor includes demographic, social and psychological characteristics of the acculturating individual that can mediate the acculturation/cultural identity and mental health relationship. Various demographic characteristics have been identified in the literature as influencing the acculturation process. Gender has been reported to have variable influence on the acculturation process (Berry, 1997). According to Berry (1997) there is evidence to suggest that females may be more at risk for experiencing psychological problems in the acculturation process than males (Carballo, 1994, as cited in Berry, 1997). This generalisation is likely to be due to the relative status and differential treatment of females in both of the cultures. Where there is substantial difference, females may attempt to take on roles in the majority culture which may bring them into conflict with their culture of origin (Berry, 1997). The patriarchal set up of many South Asian families emphasise the difference between gender roles and generally expresses a preference for males over females (Ghuman, 2000). British research has shown that South Asian boys are generally given preferential treatment by their parents (e.g. Dosanjh & Ghuman, 1996). In contrast, the education system and employment market in the west are committed to promoting gender equality and equal opportunities and are therefore seen to directly challenge the values espoused within South Asian families. As a result, conflict may ensue and proportionally more females than males have been reported to experience psychological difficulties in South Asian cultures partly due to the greater freedom afforded to males. However, it was not possible to test this hypothesis as there was no male comparison group included in the present study.

Level of education appears as a consistent factor associated with positive adaptations: higher education is predictive of lower stress (Berry, 1997). A number of reasons have been proposed for this relationship. Firstly, education is a personal resource. According to Berry (1997) problem solving is facilitated by formal education and likely to contribute to better adaptation. Secondly, education is a correlate of other resources such as income, occupational status, support networks and so on, all of which are considered to be protective factors. Although education level was not directly recorded in the present study, the second highest proportion of individuals included were students in higher education. Further, there was a higher concentration of students in the 'Assimilation' group (60%) compared to the

'Integration' group (29%) and the 'Rejection' group (21%) which appears to be consistent with the literature linking educational level to acculturation strategy. The contextual nature of acculturation is important to consider in that it may influence students to acquire the behaviours and values of the British majority culture and not practice or value aspects of their culture of origin in an attempt to 'fit in to' university life, characterised by social behaviours such as dating, consuming large quantities of alcohol, experimentation with drugs and sexuality and so on. In this way, second-generation South Asian women may find themselves in situations in which a weaker cultural identity and high acculturation is the most adaptive and may temporarily (i.e. during university life) adopt the 'Assimilation' strategy.

Previous studies have also shown that acculturation is affected by generational status (e.g. Bhugra *et al.*, 1999c; Guglani *et al.*, 2000; Sodowsky & Lai, 1991). First generation South Asians in the UK have been most frequently reported to use the 'Rejection' strategy of adaptation (Ghuman, 1991). Similarly, Olmedo and Padilla (1978) contended that level of acculturation should be lowest for the first generation and should increase with later generations. This pattern was observed in the present study as the 'Rejection' group (the least acculturated) contained the highest proportion of first generation migrants (28%) compared to the 'Integration' group (19%) and the 'Assimilation' group (0%). However, further statistical analyses indicated that there was no significant effect of generational status on the relationships observed between acculturation/cultural identity and overall psychological distress and depression. The finding that generational status did not yield significant differences between groups may be more reflective of the uneven proportion of the two generations recruited for the present study. These findings provide very limited support for the suggestion that first generation migrants experience a higher degree of adaptation difficulties than second-generation migrants.

Regarding socio-economic status (defined in terms of occupation), the majority of women in the 'Rejection' group (41%) came from manual backgrounds and lived in Bradford, indicative of low social mobility. This is in line with previous research that has suggested that lower social status is related to a lower degree of acculturation and South Asian migrants from professional and skilled backgrounds are more acculturated than those from unskilled and manual backgrounds (Ghuman, 2000). In the present study, all of the participants in the 'Assimilation' group were second generation and of these, 93% were collectively made up of

participants from non-manual backgrounds (i.e. students and white-collar workers), indicative of upward social mobility. Participants in the 'Assimilation' group were predominantly from London, Leicester and Leeds, which may be considered to be more cosmopolitan and affluent cities in comparison to Bradford. These results deviate from the findings of Cochrane and Stopes-Roe (1981) who found a negative correlation between upward social mobility and psychological symptom levels, indicating that upward social mobility among South Asian females (Indians, specifically) was related to poorer mental health. Contrary to these findings, the present study found that upward social mobility was related to better psychological health. As with generational status, no significant effect of occupation was found on the relationship between acculturation/cultural identity and psychological distress and so any conclusions drawn regarding the influence of socio-economic status (defined in terms of occupation) are somewhat speculative.

Religion has traditionally been considered to be an influential shaper of morals and values (Sodowsky & Frey, 2003) and is an important background factor to consider in the acculturation process. Many studies have indicated that religion has a moderating effect on acculturation/cultural identity (e.g. Stopes-Roe & Cochrane, 1990). In the present study, Hindus and Sikhs appeared to be the most highly acculturated. However, as no statistically significant differences were found between the three religious groups in the present study, it is not possible to draw any firm conclusions regarding the influence of religion on the relationship between acculturation/cultural identity and psychological distress and depression.

The present study tentatively suggests that not feeling accepted by white British culture and society and perceiving more prejudice appears to lead to poorer psychological adjustment. However, as the present study is correlational in design, the reverse relationship is also possible. That is, being maladjusted and suffering from mental health problems may lead an individual to feel rejected and perceive more prejudice and not form social ties so they are less able to integrate with white British society and culture. These interpretations are not mutually exclusive in that they may work together to form a vicious cycle (Mehta, 1998). As Mehta (1998) contends, poor adjustment is conducive to rejection by the white majority. Rejection, in turn, causes less adjustment and this may hamper acceptance. These findings are in line with Berry's contention that psychological difficulties are associated with poorer

relations with the dominant society and *not* with the desire to maintain the ways of the culture of origin (Berry & Annis, 1974).

4.3.2 Hypothesis two

The present study proposed that acculturation/cultural identity influenced the propensity to experience shame. It was predicted that individuals with a bi-cultural identity ('Integration' group) would be more vulnerable to experiencing shame. A significant effect of acculturation/cultural identity was found whereby individuals in the 'Integration' group did indeed score higher on the shame scale than those in the 'Assimilation' group. However, the level of shame experienced by the 'Integration' group was virtually identical to that found for the 'Rejection' group.

4.3.2.1 *The culture conflict hypothesis*

The rationale behind the original prediction that there would be an effect of acculturation/cultural identity on levels of shame was based primarily on the assumption that bi-cultural individuals experience *culture conflict* as they deal with changes in family and societal expectations regarding social behaviour as a result of dual socialisation processes, which may make conflicting demands on their role positions and behaviour. Therefore, the *culture conflict* hypothesis appears to be specifically relevant to Berry's 'Integration' strategy and has previously been used to explain the high prevalence rates of various psychopathologies among second-generation British South Asian females. In view of the competing cultural pressures faced by many South Asian females, Bhugra and Thompson (2000) suggested that British South Asian females were particularly vulnerable to experiencing such *culture conflict*.

Negotiating different cultural worlds and frames of reference can potentially become problematic when the values and norms considered 'Asian' are those that subordinate women (Dasgupta, 1998). The problematic values are mostly manifested in areas such as marriage, inter-cultural pre-marital sexual relationships and career (Bhugra *et al.,* 1999c; Ghuman, 2000). Three dimensions to this *conflict* have been identified in the literature: collectivity versus individuality, religious affiliation versus secular orientation and gender role differentiation and inequality versus gender role equality (Ghuman, 2000). According to Sodowsky (2002) culture conflict can be 'inter-personal' (which involves having conflicts

with one's own cultural group and/or with members of the majority culture) such as intergenerational conflict, or 'intra-personal' (which involves a personal sense of inferiority as a member of one's cultural group and/or as a member of the majority culture) such as an identity crisis and can result in feelings of anger or guilt towards either culture.

The dichotomy between the value systems of the two cultures (collectivist versus individualistic) is considered to produce a state of cognitive dissonance and conflict within the individual when the acceptance of cultural patterns from one culture are at variance with pre-existing ones (Cuellar, 2000). In Ali and Northover's (1999) view, second-generation South Asians formulate their own opinions on a range of different subjects (such as pre-marital sex) and may 'forge conceptions' of themselves which are not approved of by either their parents or their white native peers. The authors concluded that 'if this is the case, they have to withstand considerable psychological conflict' (Ali & Northover, 1999, pp.31). Ballard (1994) referred to this as 'code switiching' and argued that British South Asians were skilled navigators adapting themselves to the different contexts in which they function. He argued that the process becomes difficult due to the negative perception each culture has of the other, rather than the different value systems underlying both cultures.

However, partial support for the prediction that 'Integration' would be associated with higher shame levels suggests that it is apparently *not* culture conflict as such that is producing shame as the 'Rejection' group reported a similar level of shame to the 'Integration' group, yet the 'Rejection' strategy should not be associated with conflicts in identification (Ali & Northover, 1999). In the present study, individuals who affiliated strongly with their culture of origin and individuals who showed a partial affiliation toward their culture of origin both showed higher levels of shame compared to individuals who were more assimilated in to British society and culture.

As one of the acculturation dimensions measured by the AIRS-B was related to the experience of acceptance and prejudice, it was evident that participants with a bi-cultural identity (Integration) and those with a strong South Asian cultural identity (Rejection) experienced more prejudice and racism and this may be due to them retaining some of their South Asian cultural distinctiveness. In other words, the notion of 'difference' is more pronounced in those individuals who identify with their culture of origin, compared to those

who 'fit in' to the white British ways. In relation to shame, Andrews (1998) suggested that individuals who do not measure up to the majority group identity norm have to manage their 'shameful different-ness' as best they can. The extent to which an individual is able to successfully do this is, in Andrews (1998) view 'a likely sign of an individuals tendency to feel shame' (Andrews, 1998, pp.44). Therefore, the data of the present study indicate that South Asian females who identify with their culture of origin, to whatever degree, may be more 'shame prone' compared to those who blend in to and conform entirely to the British way of life (Assimilation). This finding potentially highlights the powerful role of shame as a salient emotion experienced by British South Asian women.

4.3.2.2 *Shame in relation to the Rejection strategy*

According to Gilbert *et al.* (in press) there are many cultural reasons why individuals may find themselves in low rank subordinate positions. For example, findings from studies comparing the mental health of South Asian women living in extended family structures compared to those living in nuclear families have demonstrated poorer psychological outcomes for those living in traditional extended families (see Chapter one, section 1.9, Sonuga-Barke *et al.*, 1998). In the present study, individuals adopting the 'Rejection' strategy were defined as more traditional in their cultural identity and therefore, more strongly affiliated to the norms and values of their culture of origin (compared to those adopting the 'Assimilation' or 'Integration strategies'). Thus, the finding that individuals adopting the 'Rejection' strategy experienced similar levels of shame to those adopting the 'Integration' strategy appears to implicate the propensity to experience shame specifically within South Asian cultures. In other words, 'shame prone-ness' appears to be associated with an affiliation toward the culture of origin for British South Asian women. This finding can be understood in relation to the evolutionary view of shame which contends that: '...shame constitutes the means by which human beings are alerted to behave in ways that have been, over evolutionary time, important for their genetic fitness' (Greenwald & Harder, 1998, pp.238). Shame therefore appears to play an important role in guiding an individual's behaviour to match well with the values of their particular group, which are based on a number of factors that are related to inclusive 'fitness' within their social setting. These values are culturally defined and communicated via social norms including those regarding what behaviour will be seen as shameful. Individuals adopting the 'Rejection' strategy were high shame prone and therefore more likely to behave in ways that enhance their 'fitness'. In

this way, shame can be viewed as a powerful strategy for enforcing conformity, especially among females. When shame functions to enforce conformity, this essentially maintains the regulation of behaviours related to aspects of cultural identity such as language, food, cultural practices and so on. These regulations determine what is appropriate for the social self in a variety of roles according to class, ethnic group, gender and status (Greenwald & Harder, 1998). Shame can thus be understood in relation to an individual's rank within the group structure, which defines gender roles and codes of behaviour within South Asian cultures. Women are generally placed in a low rank position in that they are generally seen as inferior to males and this essentially demonstrates the steep hierarchical structure of many South Asian cultures and the traditional value of male dominance and female submissiveness in relation to gender role positions.

Another important point to consider is that relations with the majority white culture may be discouraged due to the negative view each group has of the other, as suggested by Ballard (1994). The recent war in Iraq has been given a high and somewhat negative profile as a result of the events of September 11th (2001) where Muslims all over the world have been, to a certain extent, demonized as a result of the political actions of Islamic leaders such as Saddam Hussain and Osama Bin Laden. This may give rise to a pervasive feeling of non-acceptance and increased perceived prejudice and many (non-political) British Muslims have found themselves having to defend their faith from denigration. Within such a political climate, individuals may feel constrained in their choice of strategy even to the point where personal preference in limited.

Thus, it is suggested that shame may function within South Asian cultures as a primary mechanism of social control to induce conformity and regulate behaviour, especially for women. In this way, shame constrains behaviour into channels that are socially approved of and/or culturally appropriate. These findings provide support for Gilbert *et al.*'s (in press) assertion that South Asian cultures function within strong dynamics of shame and that the concept of shame plays a powerful role in the psychology of South Asian women.

4.3.2.3 *Shame in relation to the Integration strategy*

According to evolution theory, humans are highly motivated to join groups and shame proneness, can to some degree, aid social cohesion (Gilbert, 2000). Usually, this means

adopting the behaviours and values of the high-ranking members (in an Integration context, white British people). Applied to the present study, it follows that bi-cultural individuals are more driven (compared to individuals who *only* identify with their culture of origin) to adopt the values and behaviours of British culture in order to become competent and valued members of British society and culture. In other words, to gain and maintain status and acceptance in the majority cultural group, South Asians have to comply with the basic values of the majority group and display qualities that are valued in that group. Crucially, the social judgments, values and behaviours many second-generations conform to in order to gain social acceptance in white British culture may receive strong disapproval in their own cultural group. For example, these may include inter-cultural relationships, pre-marital sex and even wearing British fashions that reveal parts of the body.

British South Asian women may be particularly susceptible to the prevailing social attitudes within their cultural group about the way that they *should behave* and how they *should appear*. Individuals with a bi-cultural identity may therefore be vulnerable to experiencing shame, due to the pressures to conform to two different cultural systems that place value on opposing attributes and personal qualities (Bhugra *et al.*, 1999c; Ghuman, 1998). As one of the key features of shame pertains to how one appears in the eyes of others (it relates, above all to fear of exposure), shame may be experienced by the bi-cultural individual as an incapacitating emotion, relating to feelings of self-consciousness and inferiority and may lead to behaviour involving hiding and concealment with increased self-attention and rumination on the negative aspects of the self (Beck *et al.*, 1985). For example, integration, or adopting western values may be viewed from the culture of origin's point of view as a shedding of cultural roots and becoming more westernised may not be considered desirable nor valued within the more traditional South Asian cultures. In fact for some, it may be that becoming more westernised in itself is regarded as 'shameful'.

This interpretation appears to fit well with Gilbert *et al.*'s (in press) study which found that personal shame was related to a *failing* in roles and a *loss* of identity and is also in line with Marshall and Yazdani's (2000) study which identified shame as shaping constructs of acceptable behaviour. Articulations of self-harm were described in relation to traditional family expectations for South Asian young women and expressed in terms of a failure to fulfil

gendered role expectations in relation to the importance of maintaining the family's *'izzat'* (see section 1.17.1) within the community.

Therefore, shame, for the bi-cultural individual may serve the evolutionary function of *maintaining* cultural and (group) identity and as an alerting mechanism to those aspects of self that should stay hidden from others. It can be tentatively argued that, being shamed or bringing shame on one's family is such a powerful social threat for British South Asian females with bi-cultural identity and this may activate various defensive behaviours such as secrecy, social withdrawal, inhibition, internalisation, depression and anxiety (Gilbert, 2000).

4.3.2.4 *Shame in relation to the Assimilation strategy*

As an individual's disposition (vulnerability) to experience shame was found to be related to the partial or full identification with South Asian culture, it is suggested that shame may operate through the *moral* dimension of cultural identity (see Chapter one, section 1.4.6, Suthakaran & Sodowsky, in press), which includes cultural values and a sense of moral obligation to one's own cultural group (e.g. marrying within the same cultural group). This interpretation would certainly explain why individuals who exclusively affiliated with the white British culture experienced significantly lower levels of shame compared to the other two groups. In other words, the concept of *izzat*, cultural rules, practices and the preservation of cultural identity appear to be less important for individuals with a more diluted sense of South Asian cultural identity i.e. those who have assimilated fully in to white British society and culture. Thus, the control and regulatory function of shame is less powerful for individuals adopting the 'Assimilation' strategy.

4.3.3 Hypothesis three

The ESS was used in the present study to elicit global negative beliefs about the self and performance, in order to understand the shame experiences of British South Asian women. The ESS assesses an individual's disposition to experience shame based on the assumption that shame prone-ness involves related but independent types of shame (i.e. behavioural, characterlogical and body). These three types of shame are, according to Andrews and Hunter (1997), associated with a chronic or recurrent course of depression.

In the present study, a moderate positive relationship was found between shame and depression and shame and overall psychopathology. In accord with Andrews and Hunter (1997), these findings suggest that the propensity to experience shame (shame prone-ness) may be a vulnerability factor for depression and overall psychological distress for British South Asian females. Due to the relative recency of the development of the ESS, there is only one previous study to date (to the authors knowledge) conducted by the authors of the scale (Andrews *et al.,* 2002) that has used the ESS to predict depressive symptomology. The findings of the present study have thus, in part, replicated those of Andrews *et al.* (2002) by demonstrating the use of the ESS as a predictive measure of psychological distress and depression among South Asian populations in the UK.

There were two main reasons why depression was specifically concentrated on in the present study. Firstly, depression is regarded as one of the most common forms of psychopathology and secondly, much of the available research (from a rank theory perspective) has been focussed on depression. As the main theoretical link is between shame and depression, these studies will constitute the focus of this discussion. Although it was not part of any of the formal hypotheses of this study, the finding of a significant link between shame and anxiety supports Gilbert's (2000) contention that shame may also induce social anxiety.

The majority of research linking shame to depression has tended to be theoretical and speculative rather than based on empirical evidence (Lewis, 1987). Social rank theory draws attention to the inferiority aspects in both shame and depression and suggests that the internal perceptions of low rank are associated with three inter-related constructs: negative self-other comparisons (Lewis, 1987), submissive behaviour (Gilbert, 1992) and shame prone-ness (Tangney *et al.,* 1992a). These three constructs have been found to be significantly associated with each other (e.g. Gilbert *et al.*, 1994; Goss *et al.*, 1994) and with depression (Allan *et al.*, 1994).

Gilbert (2000) used social rank theory to explore the relationships between shame, depression and social anxiety. According to social rank theory, emotions and mood are significantly influenced by self-perceptions of social status/rank (i.e. the degree to which an individual feels inferior to others). A common outcome of such perceptions is submissive behaviours. Gilbert (2000) suggested that many of the safety behaviours associated with social anxiety

(Clarke & Wells, 1995) can be viewed as submissive defensive strategies and damage limitation behaviours. Similarly, depression is viewed as a defensive response to positions of low rank and powerlessness (Price *et al.*, 1994). In Gilbert's (2000) view, extensive submissiveness may not be adaptive as it can lead to a lack of control over social outcomes, rejection and marginalisation. This, in turn, confirms judgements of one's low rank and need to be submissive. Gilbert's (2000) findings imply that the pathogenic effects of shame may be due to its operation through submissive strategies. However, more research is needed in this area before any conclusions can be drawn.

Gilbert's (1989) bio-social theory of depression is also relevant as it specifically addresses the relation of shame to depression. Drawing on the evidence from ethological studies, Gilbert (1994) found an association between submissive behaviour, shame prone-ness and depression by implicating constructs such as defeat and subordinate status to the bio-chemical changes associated with depressive states. As depression is associated with non-assertive behaviour (Arrindell *et al.*, 1990) depressed people are reported to engage in submissive behaviours significantly more than non-depressed individuals (Gilbert *et al.*, 1995b; Allan & Gilbert, 1997). The relation of shame to depression has also been demonstrated in cross-sectional studies utilising student samples, which have shown significant correlations between questionnaire measures of shame prone-ness and depression (Hoblitzelle, 1987; Tangney *et al.*, 1992a). These findings offer support to Lewis's (1987) and Gilbert's (1997, 2000) description of the phenomenology of shame in terms of the self's experience as inferior, subordinate and in a low rank position.

In summary, there is considerable evidence that suggests that the vulnerability to experience shame is related to various psychopathologies, specifically depression (Gilbert, 2000). There is also evidence to suggest that depression is associated with both internal (Tangney *et al.*, 1995) and external shame (Allan *et al.*, 1994) and Andrews and Hunter (1997) demonstrated a mediating role between shame and psychopathology, specifically, chronic depression. Negative views of self and cognition's that one is judged negatively by others have been found to be central to shame experiences in relation to other types of psychopathologies (Beck *et al.*, 1985; Gilbert, 2000; Lewis, 1987) and depression (Allan *et al.*, 1994; Andrews, 1995, Andrews & Hunter, 1997; Gilbert *et al.*, 1994).

Due to the correlational nature of the present study, the causal direction of the association between shame and depression requires further investigation. As Andrews and Hunter (1997) point out, it may be that a propensity to feel shame slows down recovery from depression and may be involved in triggering subsequent episodes. On the other hand, shame may be a function of persistent depression in that the longer one is depressed, the more shame one may feel about personal characteristics and behaviour.

4.3.4 Hypothesis four

The present study has followed trends in the literature over the last decade which have attempted to unmask the 'hidden emotion' and the 'sleeper in psychopathology' (Gilbert, 1997, 2000; Lewis, 1987). However, it is novel and unique in its endeavour to position shame in the relationship between acculturation/cultural identity and psychological distress, specifically depression, in order to understand more clearly the psychological experience of British South Asian women.

The present study found a relationship between low levels of acculturation (stronger cultural identity) and psychological distress and depression (Hypothesis one) and found evidence of an effect of acculturation/cultural identity on levels of shame (Hypothesis two). Shame was also found to be positively associated with depression and psychological distress (Hypothesis three). There was also a significant correlation between shame and anxiety as measured by the GHQ-28 Anxiety and Insomnia sub-scale. However, the original associations found between acculturation/cultural identity and psychological distress, specifically depression (and anxiety), were removed once shame was controlled for. This does not imply that acculturation/cultural identity and psychological distress, and specifically depression, are no longer associated or that acculturation/cultural identity does not play a role in the development of psychopathology (including depression), but that shame prone-ness plays a role in determining the *strength* of the association. The mediating effect of shame on the relationship between acculturation/cultural identity and overall psychological distress and depression, has been revealed in the present study as a hidden variable that helps the relationships between acculturation/cultural identity and psychological distress and depression to exist. Therefore, as several mediating variables have been considered previously (under discussion of Hypothesis one) to understand the possible confounding influences on the relationship between acculturation/cultural identity and psychological distress, specifically

depression, the present study has contributed to current understandings by identifying another key variable that has been shown to have a significant effect on the related constructs.

4.3.4.1 *The relation of acculturation/cultural identity to shame and psychological distress (including depression)*

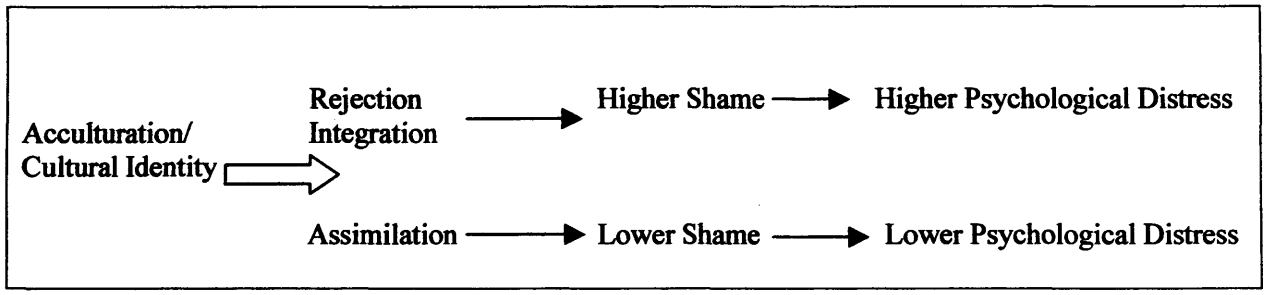
It is well accepted that culture plays an influential role in shaping an individual's sense of self. Indeed, it has been argued that one facet of an individual's self-identity is that they belong to a cultural group (Ryder *et al.*, 2000). For individuals living in a bi-cultural context (predominantly second-generation migrants), many aspects of self-identity are modified to accommodate information and experiences within a different cultural context. Such modifications are observed in a number of different domains such as attitudes, values and sense of cultural identity. The present study has demonstrated empirically that individuals exposed to two cultures can incorporate, to varying degrees, two co-existing cultural identities.

Moral affects such as shame can influence an individual's sense of cultural identity particularly when the self is defined as an aspect of the collective (as in South Asian cultures) in terms of group membership, social roles and relatedness to others. Many South Asian cultures are steeply hierarchical in terms of group structure and so gender roles and codes of behaviour are rigidly defined. Shame may therefore serve the evolutionary function of enforcing conformity and this regulates behaviour and determines what is appropriate for the social self in a variety of roles according to class, ethnic group, gender and status. The need for a 'self-affirming' identity, as suggested by Kaufman & Raphael (1987), that provides value and meaning, is therefore at the core of an individual's sense of self (cultural identity) and this is powerfully shaped by the experience of shame. Shame is thus an important aspect of cultural identity.

Acculturation/cultural identity influences the disposition to experience shame and this is associated with the development of psychological distress (including depression and anxiety). As disturbances in cultural identity have been associated with increased psychological distress and various specific psychopathologies, such as eating disorders and DSH (Bhugra *et al.*, 1999a, 1999c), these have been construed in the previous literature as *manifestations* of

depression and anxiety caused by *culture conflict* (Bhugra & Bhui, 2003). One of the key features of shame pertains to how one appears in the eyes of others and a fear of exposure. Therefore, shame may be experienced as an incapacitating emotion for bi-cultural individuals, relating to feelings of inferiority and self-consciousness (e.g. in terms of loss of identity or failing in roles) in the eyes of the family and community and the white majority culture (e.g. in terms of managing their 'different-ness' as suggested by Andrews, 1998). This may result, as Bhugra and Bhui (2003) suggest, in an "internalisation of social constraints in to the embodied self" (Bhugra & Bhui, 2003, pp.47) and lead to behaviour involving concealment, increased self-attention and psychological distress (Beck *et al.*, 1985) and in more serious cases, develop in to psychopathology. Figure 1. shows a preliminary model developed from the findings of the present study.

Figure 1. A preliminary model developed from the findings of the present study of the relations between acculturation/cultural identity, shame and psychological distress (including depression).



Thus, relations between the psychological constructs of acculturation/cultural identity and shame demonstrate the complex processes involved in shaping an individual's sense of self and provides a tentative understanding of the dynamics involved in the development of psychological distress for British South Asian women. While the results of this study support the preliminary model of relations between the different constructs measured, caution must be exercised in interpreting the associations found, particularly regarding the causal implications of related constructs.

The preliminary model developed here appears to be the most consistent with the previously established theoretical and empirical conceptualisations and patterns observed in the literature. Although the detailed findings in the literature have been somewhat inconsistent, the *direction* of the relationship, that acculturation is a determinant of psychological distress rather than vice versa, has been universally assumed (Berry, 1980, 1997; Bhugra *et al.*, 1999c;

Cochrane, 1977, Cochrane & Stopes-Roe, 1981). Further, shame is generally accepted to be a precursor of depression and other psychopathologies (Andrews & Hunter, 1997, Andrews *et al.*, 2002; Gilbert, 1997, 2000). However, these relationships are not mutually independent as different people, in different contexts can be affected by these variables in different ways. It is also recognised that other models may be compatible with the pattern of data found in the present study and that inverse relationships are possible. For example, it may be that depression (or any other form of psychopathology) causes an individual to become socially withdrawn and low in mood and this may cause them to feel more shame, more rejected and to not want to integrate with white British culture.

4.4 Research Critique

The present study may be regarded as a preliminary, exploratory study that has brought together a number of disparate areas of research to emphasize the conceptual links between the psychological constructs that may affect the behaviour of a complex and vulnerable population. The findings of the present study are promising in that they have contributed somewhat to current understandings of the relationship between acculturation/cultural identity and psychopathology, specifically depression, and have helped to clarify some of the inconsistencies in the previous literature. Although the hypotheses of the present study were not entirely congruent with each other (due to the numerous inconsistencies in the literature), the data do produce a logical picture. As one would expect, higher levels of overall psychological distress were associated with higher levels of shame across all three acculturation groups, which is in accord with the literature that indicates a positive relationship between shame and psychopathology and shame and depression. In positioning shame in the relationship between acculturation/cultural identity and psychological distress (and depression) the present study is among the first to provide empirical evidence for the saliency of shame for South Asian women. In doing so, the present study has contributed to the current research base and built upon Gilbert *et al.*'s (in press) recent research, which explored the meaning and source of shame within South Asian cultures. However, there were a number of methodological problems in the design of the study, which will now be discussed.

Firstly, in considering the sampling strategies employed (snowball sampling and opportunity sampling), one limitation relates to the non-random selection of participants, which may have

been systematically biased. Although these techniques generated a respectable response rate (50%), the generalisation of the present findings to the wider British South Asian population is dubious. A random selection of participants would have improved the reliability and representativeness of the sample. Although the sample size of the present study (N = 90) was reasonable, it would have been desirable to recruit a larger sample but the limitations of time would not permit this. In view of the statistical significance of the findings of the present study, the sample can be considered to be sufficient to indicate trends within the data set.

A second limitation of the present study may be that university students constituted a substantial proportion (37%) of the total sample. However, this may not be entirely unrepresentative of the status of young, mainly second-generation South Asian women in the UK at the beginning of the 21st Century. Further, the sample consisted entirely of females and so extrapolation to, and comparison with males is not possible. Research has suggested that males and females differ in their cultural identities (Ghuman, 1998) and the way in which they endorse shame items (Gilbert *et al.*, 1996) and so any conclusions drawn from this study have to be assumed to apply only to women.

Theoretically, the AIRS-B appeared to be a good choice of instrument in that it was multi-factorial with regard to domain (Perceived Prejudice, Cultural Orientation and Language Usage) and able to distinguish between three of the four acculturation strategies proposed by Berry's (1980, 1997) bi-dimensional model of acculturation. This model offered a broader conceptualisation of acculturation which was more inclusive than the earlier uni-dimensional models (assimilation). However, some of the participants in the current sample may have found the AIRS-B measure conceptually difficult to answer accurately as some of the items were not particularly relevant for second generation immigrants. For example, item 32 stated 'British people believe that my foreign accent or non-fluent English or lack of knowledge of British expressions is a sign of ignorance'. Most, if not all, second-generation South Asian migrants are unlikely to have a 'foreign accent' and are proficient in the English language. The ambiguous nature of the wording of some of the AIRS-B statements may have also confused participants. For example, the distinction made between 'British people' and one's 'nationality group' was confusing as the entire sample (as is the case for the majority of South Asian immigrants in Britain), were British nationals. For example, item 33 asked participants to say how much they believe it is 'more proper' to marry someone from one's nationality

group than a British person. Again, some participants might not have understood this distinction and this might have compromised their ability to answer accurately, which may have affected the overall results. However, it was not considered appropriate to amend the wording of the items or edit items on a standardised scale as these alterations may well have affected the psychometric properties of the measure.

The validity of dividing the total sample in to three acculturation groups may be regarded as questionable due to there being no specific criteria for defining the basis of each group. The method of defining each acculturation group in the present study was based on the distribution of scores on the AIRS-B for the total sample in order to determine the relevant cut-off's for the group under study (in this case, British South Asian females). This was done following the advice of the scale's author (G. Sodowsky, personal communication, 19 May 2003). The justification of using such a method is that acculturation is affected by various mediating variables and these differ depending on the nature of the immigrant group and it's individual members. Therefore, defining universal cut off points to apply to all populations may be unwise as each immigration group will differ in terms of socio-cultural characteristics. However, it is acknowledged that the method used here may not be a robust means of dividing the groups as scores between individuals may have been very similar but due to the arbitrary nature of cut-off thresholds, these subtleties might have been lost and individuals might have been allocated to different groups. As the hypotheses of the present study were not linear, it was necessary to divide the total sample in to three acculturation groups in order to test hypothesis two (and part of hypothesis one), as it was the middle set of scores (corresponding to Berry's Integration strategy) that the author was interested in for the main analysis. However, where it was possible to use the AIRS-B as a continuous variable (i.e. to test hypotheses one and four for the purpose of correlation analysis), the total scale scores were used.

Building on the work of Andrews *et al.*, (2002) the present study is the second (to the author's knowledge) that has measured the power of a newly developed shame instrument to predict depressive symptomology. The findings of the present study have demonstrated the usefulness of the ESS as a predictive measure of psychopathology and depression among South Asian populations in the UK but did not consider the individual dimensions of shame measured by the ESS. This was a deliberate omission as the author was only interested in

measuring an individual's overall disposition to experience shame (rather than the specific areas where individuals might feel shame). This was achieved by using the full-scale score to indicate the degree to which an individual experienced shame. That is, the overall level of shame on the ESS determined shame prone-ness. It was not considered viable to examine the three aspects of shame in relation to the different dimensions of acculturation/cultural identity and overall psychopathology and depression within the imposed time and word constraints. Such a task would constitute a separate study and provides a strong case for replication with consideration of the individual dimensions measured by the ESS and AIRS-B.

The items contained in the GHQ-28 did not appear to be influenced by global self judgements as the questions focussed more on somatic and behavioural changes (e.g. feeling 'run down and out of sorts') as opposed to, for example, the Beck Depression Inventory (Allan *et al.*, 1994) which includes items that are similar to shame items (such as feelings of failure) (Beck *et al.*, 1988). Further, the GHQ-28 did not appear to contain many items that related to rank (i.e. personal failure and/or submissive behaviour) and therefore may have yielded more reliable results by not artificially exaggerating the association between shame and psychopathology and depression. Therefore, the GHQ-28 was considered to be a useful tool to explore the relationships between shame and depression and shame and psychological distress and acculturation/cultural identity and psychological distress (including depression and anxiety).

The author wishes to comment on the use of the ethnic category of 'South Asian' within the present study, acknowledging the risk of giving rise to cultural stereotypes and distorting the clinical picture by characterising South Asians as one group. Stopes-Roe and Cochrane (1990) and Marshall and Yazdani (2000) among others have cautioned against combining different South Asian sub-groups as one homogenous group, however convenient this may be for the purposes of analysis, as this will mask the undoubted diversity between groups. However, the justification for treating South Asians as one group in this study is that, whilst the author acknowledges that people who originate from the Indian sub-continent are heterogeneous in culture, history, politics and religion, and this diversity gives rise to a number of different identities, it is also true that aspects of a collectively orientated culture are shared. Commonalties are found in cultural practices such as food, dress, ceremonies, cultural values and rules and personal experiences such as racism. Hence, although the term 'South

Asian' is geographically defined, it also denotes some overlap in cultural heritage and sense of identity that comprises more than just a region of origin. Further justification for combining all the sub-cultural South Asian groups together in the present study is that the Muslims, Sikhs and Hindus did not differ significantly on the key culturally relevant variables (AIRS-B and ESS) used in the main analysis, although a marginal significant difference was found on the measure of psychological distress (for GHQ-28 total: $F = 3.17, p = .05$).

The author's intention was not to homogenize individuals who share a diverse culture, but to engage with certain commonalties that bind groups of individuals together while not losing sight of the diverse ways in which individuals orient to and live in relation to shared cultural patterns. Following Marshall and Yazdani (2000), the present study supports the contention that an individual's identity and personal experiences of distress may be to some extent shaped by culture but remain individual, thus cautioning clinicians against overgeneralisations and encouraging them to work from the understandings and perspectives of their clients.

4.5 Clinical Implications

The implications of the findings from the present study are that involvement in British culture and society and developing positive attitudes toward the majority white culture are significant factors for the mental health of immigrants, both first and second generation. Functioning in a culture in which one perceives prejudice and non-acceptance as the main modes of interaction is likely to be very stressful for ethnic minorities living in Britain and may contribute to the development of psychological symptoms.

The acculturation level or cultural identity of a South Asian individual can indicate to the therapist how important cultural considerations are in the assessment of their client. The present study would thus encourage therapists to gain a measure of cultural identity (for second generations) or acculturation (for first generations) to indicate their client's sense of 'self' in cultural terms. As South Asians vary in their level of acculturation/cultural identity, important information pertains to the relevance of western conceptualisations in what causes mental health problems and what heals them. Thus, assessing an individual's cultural identity may help therapists to determine the appropriateness and relevance of their treatment plan. It is generally accepted that the more acculturated an individual is the more appropriate the western mode of assessment and treatment. Whereas individual's who have a more

traditional cultural orientation may require alternative assessment procedures that are culturally sensitive before any clinical presentation can be fully understood and interpreted. However, therapists should also bear in mind that levels of acculturation and cultural identity do not proceed in a uniform manner in the different acculturation domains. That is, many British South Asian women may appear to be highly acculturated in terms of their behaviour (e.g. in adopting western dress, manners and English proficiency) but may still substantially endorse the values and behaviours of their culture of origin (e.g.. within the family or community setting).

Furthermore, assessing clients on the acculturation dimensions of perceived prejudice, observance of cultural practices, social ties and language usage will provide clinicians with important insights about the nature of the interactive process as experienced by their client. For example, a high perception of prejudice may indicate that the client has endured substantial discrimination and so relations with and attitudes toward the white majority culture (and its members) may be an important clinical consideration, particularly if the therapist is from the white majority culture. This would suggest a case for matching therapist to client, however, this also imposes restrictions on cross-cultural learning. In line with the recommendations of the British Psychological Society's Briefing Paper (no. 16) (BPS, 1998) and the Diagnostic and Statistical manual of Mental Disorders (American Psychiatric Association, 1994) a cultural formulation may provide a systematic review of the role of the cultural context, psychological and social stressors, relational difficulties and available social support networks.

The present study has also highlighted the saliency of shame within South Asian cultures in understanding the experiences of British South Asian women and this has training implications. Understanding the adaptive function of shame in a cultural context is an important consideration for clinicians as by viewing shame only as a pathological emotion may obstruct the understanding of shame as a necessary and/or even desirable attribute that can sometimes go 'awry' (Greenwald & Harder, 1998). Thus, rather than attempting to heal the shame, clinicians may be required to work collaboratively with their client to modify its maladaptive or 'excessive manifestations'. Therapeutic implications may vary according to the domains of shame that are most influential on an individual and this may be affected by a range of socio-cultural factors (such as ethnic group, religion, socio-economic status,

education level). As shame may constitute the means by which individuals are alerted to behave in ways that have been important for the fitness of their cultural group in a social setting, therapeutic enquiry in to the domain most responsible for the shame experience may help inform interventions.

On the other hand, given that shame is related to the fear of exposure of inadequacy and motivates concealment, there are key aspects to therapeutic engagement with the shame prone client. Gilbert (1998a) has suggested that the therapeutic relationship becomes the central medium for working with shame, for it is via the relationship that shame is likely to become activated. For many British South Asian women, the very act of needing therapy may be regarded as 'shameful' due to the cultural beliefs underlying mental health problems. As shame prone individuals monitor their own internal world and also how they may appear to the therapist (i.e. how they exist in the mind of others), Gilbert (1998) advises that therapists need to attend to transference issues and 'here and now' feelings about the interaction.

Therapists are also drawn to potential shame-based issues that British South Asian women may present with in relation to cultural/familial expectations and roles. For example, some South Asian women may lack in confidence and have low self-esteem due to them falling short of the standard valued in their culture in terms of personal attributes such as for example, skin complexion or beauty, or in relation to role expectations and/or losses in cultural identity. This type of assessment may also signal to therapists the potential sources and function of shame in a cultural context. Shame has different origins and different manifestations and is experienced for different cultural reasons, but the effect (i.e. to conceal, hide and internalise) is universal across cultures.

Therapists are encouraged to take the stance of curious interest when working with clients who have different cultural backgrounds to themselves in order to develop clinical and therapeutic skills that will equip them when working in a multicultural context. This will help them to engage with and learn from their clients and to work from the understandings and perspectives of their clients.

4.6 Implications for future research

There are many potential areas for future research particularly given that the present study was preliminary and exploratory. Positioning shame in the relationship between acculturation/cultural identity and psychological distress has yielded limited understanding of 'culture conflict' as experienced by individuals with a bi-cultural identity, but has highlighted the saliency of shame in the psychology of the more traditional culturally orientated individual. Whilst the findings of the present study indicate that there may be something inherent within identifications with the culture of origin which appear to make individuals of South Asian origin more vulnerable to higher levels of psychopathology, this phenomenon, if it is replicated, needs careful unpacking.

The interpretation that cultural values and rules influence the experience of shame and that shame is used to maintain group identity and regulate and control behaviour appears to be a useful link in to other related concepts such as subordination, entrapment and defeat, which may also be operating as other powerful mechanisms in the psychology of British South Asian women (e.g. Gilbert *et al.*, in press). As there is growing evidence to suggest that the experience of entrapment (being in unwanted subordinate positions) has been found to be a significant vulnerability factor for mental health difficulties, future research could concentrate on examining the role of these constructs in the lives of British South Asian women. These associations could be explored further in relation to depression, anxiety, self-harming behaviours and eating psychopathology. A greater focus on this relatively neglected emotion within South Asian cultures is likely to provide an insightful line of enquiry in the study of shame and related constructs and their function within South Asian cultures.

As a significant main effect of acculturation/cultural identity was found on levels of shame and as shame was found to mediate the relationship between acculturation/cultural identity and psychological distress (specifically depression and anxiety) future research could concentrate on between group differences based on socio-cultural and demographic variables such as religion, socio-economic backgrounds, generation and gender. In particular, it would be interesting to replicate the present study with a male comparison group to further test the usefulness of evolutionary and social rank theories to understand the function of shame within South Asian cultures. It would also be interesting to examine relationships between the acculturation domains measured by the AIRS-B and the different domains of shame measured

by the ESS. As eating disorders have been highlighted as a particular area of concern for British South Asian women, it would also be interesting to examine the effect of acculturation/cultural identity and bodily shame on the development of eating psychopathology (using for example the BITE[1]). The relationship between acculturation/cultural identity and eating psychopathology may be mediated by bodily shame and this would provide an interesting line of enquiry.

Future research would do well to attempt to operationalise the concepts of 'culture conflict' and 'izzat' in terms of their reported dimensions and devise valid and reliable tools to measure them. For example, Ghuman (2000) suggested that 'culture conflict' included three dimensions: collectivity versus individuality, religious affiliation versus secular orientation and gender role differentiation and inequality versus gender role equality. 'Culture conflict' can be 'inter-personal' (which involves having conflicts with one's own cultural group and/or with members of the majority culture) such as intergenerational conflict, or 'intra-personal' (which involves a personal sense of inferiority as a member of one's cultural group and/or as a member of the majority culture) such as an identity crisis and can result in feelings of anger or guilt towards either culture (Sodowsky, 2002). It would be interesting to investigate more robustly the concept of culture conflict in relation to the experience of shame and the development of more serious psychopathologies (such as deliberate self-harm).

The results of the present study begs the question: what do the 'Rejection' and 'Integration' strategies have in common and what mechanisms are causing the greater levels of shame and psychological distress within these modes of interaction? The immediate and obvious answer to this question is the affiliation towards the culture of origin. However, further research would do well to further elucidate other mechanisms that are at play and the author strongly cautions clinicians away from the tendency to pathologise culture in the light of the findings of this research. Clearly, there is a strong case for further research to develop the findings of the present study.

4.7 Conclusions

The present study set out to explore the relationships between acculturation/cultural identity, shame and psychological distress. The conclusions drawn from the findings are that culture exerts an influence on the experience of shame and the development of

[1]Bulimia Investigation Test, Edinburgh, Henderson and Freeman (1987).

psychological symptoms for British South Asian women. Acculturation strategy and level of cultural identity are related to psychological distress, depression but these relationships are *mediated* by the intervening mechanism of shame. The type of acculturation strategy adopted (by first generations) and level of cultural identity (for second generations) determines the degree to which an individual experiences shame. Full or partial identification with South Asian culture is related to higher levels of shame. Furthermore, vulnerability to experience shame (shame prone-ness) increases the risk of developing depressive and/or psychological symptoms. Therefore, shame prone-ness appears to be a vulnerability factor for depression and psychological distress for British South Asian females.

There are various reasons why an individual may experience shame and these will differ from individual to individual. Although shame is experienced for different reasons, by different people, to different degrees of intensity and in different contexts, the *function* of shame for British South Asian women appears to be to induce conformity and regulate behaviour by constraining behaviour into channels that are socially approved of and/or culturally appropriate. Whilst the present study has tentatively identified shame as playing a role in the relationship between acculturation/cultural identity and psychological distress, specifically depression, among British South Asian women, it is unwise to locate the reason for the relatively high levels of shame and psychological distress found entirely *within* South Asian culture as, by doing this, one runs the risk of pathologising culture. Rather, what these findings apparently indicate is that shame appears to be a powerful emotion experienced by women living in South Asian cultures due to the saliency and significance of shame in those cultures.

APPENDIX ONE

(Letter of Ethical Approval)

From : "Moran, Dr P.M." <pmm8@leicester.ac.uk>
To : "aradhana anand" <anand_aradhana@hotmail.com>
Subject : RE: Updated ethics form and research protocol
Date : Thu, 3 Apr 2003 10:50:17 +0100

Dear Aradhana,

our secretary has just told me that you don't have access to our web-page. I didn't realise. I'll fill in your form for you for our records here, so don't worry about it. Consider your application accepted.

best wishes,

Paula Moran (chair Ethics Committee)

-----Original Message-----
From: Moran, Dr P.M.
Sent: 01 April 2003 20:40
To: aradhana anand
Subject: RE: Updated ethics form and research protocol

Dear Aradhana,
your application to alter your study has been approved by the School of Psychology ethics Committee. This approval is subject to your filling out one of the web-based forms that I told you about which is to be found at the School of Psychology web page.(The records for our files are all stored in same format hence requirement for this standardised form too).

Your study can go ahead now. Please retain a copy of this approval for your own records.

best wishes

Paula Moran (chair ethics Committee)

APPENDIX TWO

(Questionnaire Booklet)

Dear participant,

My name is Aradhana Anand and I am a final year postgraduate student studying the Doctor of Clinical Psychology course at the University of Leicester. The research you have been requested to take part in is for my doctorate thesis that I am currently undertaking.

The information sheet (please see overleaf) will explain the purpose of the research and hopefully answer any questions you may have. If you have any further questions or comments, please feel free to contact me (*see overleaf*) and I will be happy to discuss these with you.

Thank you for agreeing to take part in my research study.

With best wishes

Aradhana.

p.s.

Please do not detach the individual questionnaires from this booklet. After you have completed the questionnaires, please sign at the bottom of the Information sheet and return them directly to me in the stamped addressed envelope (attached).

Participant Information Sheet and Consent form

Principal Investigator: Ms. Aradhana Anand. You may contact Aradhana directly on: 07816 832914 or alternatively, leave a message with the course secretary (Judy Kibisu) at the Astley Clarke Building (Ground floor, room 8). Alternatively, you may telephone Judy at the University on (0116) 252 2185.

1. What is the purpose of the study?

I am interested in looking at the cultural identity of (mainly) second generation South Asian women living in Britain and how this relates to psychological functioning. This may help to understand the specific factors that contribute to the mental well being of British South Asians and may inform how we plan and provide services in the future.

I would like to give you 4 relatively short questionnaires to fill out. One of the questionnaires will ask you questions about personal information such as your age, religion and what your occupation is. Another questionnaire will ask questions about different aspects of your culture and covers areas such as languages spoken and food. The other 2 questionnaires will ask you questions about how you feel. I will be available (via telephone) to clarify any queries you may have.

2. Will the information obtained in the study be confidential?

The information gathered from the questionnaires is for research purposes only and all data will be completely anonymous. You will not be identified in any of the documents related to this study. Your participation is voluntary and you will be able to pull out of the research at any time you wish.

3. Who is supporting this study?

This study is supported by the University of Leicester, School of Psychology (Clinical Section) and has been ethically approved.

I have read the above information and agree to complete the questionnaires for the proposed study

(Please sign):
Signature of Participant: ----------

Demographic Questionnaire

Some of the following questions may seem quite personal. Please understand that we are not trying to pry into your personal lives but rather need to know this information for statistical purposes. Your responses will be kept strictly **confidential.** It is very important that you answer every question.

1. Please indicate your age ____

2. Marital status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Co-habiting ☐

3. Do you live with: with your partner ☐ on your own ☐ family ☐ friends ☐ Other (please specify) ☐ _____

4. Occupation: _____

5. If married or co-habiting, partners' occupation: _____

6. Were you born in Britain? Yes ☐ No ☐

7. If no, where were you born? _____
   Which years? _____

8. Have you lived somewhere else besides in England? Yes ☐ No ☐
   a. Where? _____
   b. Which years? _____

9.What is your mother's country of origin? (e.g. is she Punjabi *or* Gujurati *or* Mirpuri etc.)

   _____

   b) What is your father's country of origin? _____

10. Which generation did your family emigrate (move) to the UK?

    Your generation ☐ Your parents ☐ Your grandparents ☐
    Your Great Grandparents ☐ Further generations ☐

11. Number of relatives in Britain: _____

    Who are they (e.g., mother? father? brother? uncle? etc.):

_____

_____

12. What Asian languages do you speak (i.e. able to have a simple conversation in)?

_____

13. In which geographical area do you live (e.g. name the city, town)?

_____

14. Religious preference:

Hinduism □ Islam □ Sikhism □ Jainism □ Zoroastrian □
Christian □ Buddhism □ Other □ (please state)_____

15. I consider myself to be:
__ Gujerati, or Punjabi, or Pakistani or Bengali etc. (or whatever your home state affiliation is)
__ Asian only
__ British-Asian
__ British only
__ Other (please state) _____

THANK YOU VERY MUCH

If you wish to give additional information about yourself, please add, using the space below.

Feelings About Myself

These questions are about your feelings about yourself and the way you look **at any time in the past year**. There are no 'right' or 'wrong' answers. Please use the scale below and circle a number to indicate your response to each statement.

SCALE

1 = Not at all *2 = A little* *3 = Moderately* *4 = Very much*

1. Have you felt ashamed of any of your personal habits?	1	2	3	4
2. Have you worried about what other people think of any of your personal habits?	1	2	3	4
3. Have you tried to cover up or conceal any of your personal habits?	1	2	3	4
4. Have you felt ashamed of your manner with others?	1	2	3	4
5. Have you worried about what other people think of your manner with others?	1	2	3	4
6. Have you avoided people because of your manner?	1	2	3	4
7. Have you felt ashamed of the sort of person you are?	1	2	3	4
8. Have you worried about what other people think of the sort of person you are?	1	2	3	4
9. Have you tried to conceal from others the sort of person you are?	1	2	3	4
10. Have you felt ashamed of your ability to do things?	1	2	3	4
11. Have you worried about what others think of your ability to do things?	1	2	3	4
12. Have you avoided people because of your inability to do things?	1	2	3	4
13. Do you feel ashamed when you do something wrong?	1	2	3	4
14. Have you worried about what other people think of you when you do something wrong?	1	2	3	4
15. Have you tried to cover up or conceal things you felt	1	2	3	4

ashamed of having done?

16. Have you felt ashamed when you said something stupid?	1	2	3	4
17. Have you worried about what other people think of you when you said something stupid?	1	2	3	4
18. Have you avoided contact with anyone who knew you said something stupid?	1	2	3	4
19. Have you felt ashamed when you failed at something which was important to you?	1	2	3	4
20. Have you worried about what other people think of you when you fail?	1	2	3	4
21. Have you avoided people who have seen you fail?	1	2	3	4
22. Have you felt ashamed of your body or any part of it?	1	2	3	4
23. Have you worried about what other people think of your appearance?	1	2	3	4
24. Have you avoided looking at yourself in the mirror?	1	2	3	4
25. Have you wanted to hide or conceal your body or any part of it?	1	2	3	4

Thank you for your time.

Cultural Orientation Scale

This questionnaire attempts to understand some experiences of people from different countries (e.g. international students, non-immigrant professionals, permanent residents, naturalized citizens, second generation immigrants, etc.) living in Britain.

Please tick the appropriate space. Tick only one space per question, the one that you think describes you the best.

1. The language(s) I speak well
   - ___ 1. English only
   - ___ 2. Mostly English, some my first language (mother tongue)
   - ___ 3. English and my first language equally well
   - ___ 4. Mostly my first language, some English
   - ___ 5. My first language only

2. When I am with people from my country I speak
   - ___ 1. English only
   - ___ 2. Mostly English, some my first language/national language
   - ___ 3. English and my first language/national language equally
   - ___ 4. Mostly my first language/national language, some English
   - ___ 5. My first language/national language only

3. Friends with whom I am close are
   - ___ 1. British people only
   - ___ 2. Mostly British people, some people from my country
   - ___ 3. British people and people from my country equally
   - ___ 4. Mostly People from my country, some British people
   - ___ 5. People from my country only

4. When I think, my ideas and images best operate
   - ___ 1. In English only
   - ___ 2. Mostly in English, some in my first language
   - ___ 3. In English and my first language equally
   - ___ 4. Mostly my in first language, some in English
   - ___ 5. In my first language only

5. People I trust and turn to when I need help are
   - ___ 1. British only
   - ___ 2. Mostly British people, some my family
   - ___ 3. British people and my family equally
   - ___ 4. Mostly my family, some British people
   - ___ 5. My family only

6. I like to eat
   ___ 1. Only British food
   ___ 2. Mostly British food, some my country (or region) food
   ___ 3. British and my country (or region) food equally
   ___ 4. Mostly my country (or region) food, some British food
   ___ 5. Only my country (or region) food

7. I believe my group identity to be related
   ___ 1. Only to British society
   ___ 2. Mostly to British society and some to the country/state I come from
   ___ 3. To British society and to my country/state equally
   ___ 4. Mostly to the country/state I come from, some to British society
   ___ 5. Only to the country/state I come from

8. I believe myself to be an individual
   ___ 1. With many similarities with British people
   ___ 2. With some similarities with British people
   ___ 3. Equally similar to British people and to people from my country
   ___ 4. With some similarities with people from my country
   ___ 5. With many similarities with people from my country

Mark each of the following statements according to how much you agree or disagree with it. There is no right or wrong answer. The best answer is your personal opinion. Please express what you actually believe to be true rather than what you wish were true. If you do not have a definite opinion about a statement, choose a degree of agreement or disagreement (from 6 agree strongly to 1 disagree strongly) that comes closest to what you think. Please respond to every statement. The numbers 6, 5, 4, 3, 2, and 1 stand for the following:

6: Agree strongly
5: Agree
4: Tend to agree
3: Tend to disagree
2: Disagree
1: Disagree strongly

___ 9. British people try to fit me into the stereotypes that they have about my nationality group.

___ 10. I find British people overly concerned about their personal needs.

___ 11. I find that when I am with a group of British people, the British people almost always talk to each other and ignore me.

___ 12. If/when I don't dress in British fashions, British people think I am odd, backward, or not to be taken seriously.

___ 13. British institutions (e.g., professional associations, major universities, or government agencies) are trying to place official or unofficial restrictions on me or people from my country gaining admission into educational, work, or professional areas in which my nationality group has achieved visible numbers and success.

___ 14. I resent that I am often overlooked for recognition (e.g., an award for academic achievement), special projects, hiring, or promotion.

___ 15. No matter how adjusted to British ways I may be, I will be seen as a "foreigner" by British people.

___ 16. If I did not have some family members, or relatives, or some friends among people from my country living in the UK (or where I live in the UK), I would feel isolated.

___ 17. My physical appearance does not match the standards that British people have about good looks.

___ 18. I believe British people are only interested in me on the surface level (e.g., my national style of dress or when I came into this country).

___ 19. I prefer British music, films, dances and entertainment to those of my country of origin

___ 20. British people think that I come from a country that has strange, primitive customs.

___ 21. British people don't care to know about my religion, culture, national history, values, or life style.

___ 22. I have more British friends than friends among people from my country.

___ 23. I believe I will never fully understand how to function successfully in the British bureaucracy or "system" (educational, governmental, professional, or business operations).

___ 24. I adhere strictly to my religion and cultural values.

___ 25. I feel I am not fully accepted in organizations (e.g., private social clubs, professional associations, or physical fitness clubs) which have a majority of British members.

___ 26. British people are too assertive and verbal for my liking.

___ 27. I celebrate British religious or social festivals more than I celebrate my country's religious or social festivals.

___ 28. I believe that the best way to appear less "different" to British people is to become like British society and people.

___ 29. I seek the friendship and support of people from my country in the city/town I am living.

___ 30. The British people I study or work with feel threatened by my strengths and successes (e.g., hard work and professional/academic progress).

___ 31. In my study or work environment I follow British ways and standards, but at home I follow many customs of my country of origin.

___ 32. British people believe that my foreign accent, or nonfluent English, or lack of knowledge of British expressions is a sign of ignorance.

___ 33. I believe it is more proper to marry someone from one's own nationality group than a British person.

___ 34. I am rarely invited to the homes or parties of my British classmates, colleagues or neighbours.

General Health Questionnaire
(GHQ-28)

Name: PLEASE DO NOT WRITE YOUR NAME. Date:

Please read this carefully. We should like to know if you have had any medical complaints and how your health has been in general, **over the past few weeks.** Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Have you recently:

A1	Been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
A2	Been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
A3	Been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
A4	Felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
A5	Been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A6	Been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
A7	Been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
B1	Lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
B2	Had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
B3	Felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
B4	Been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
B5	Been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
B6	Found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
B7	Been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual

Have you recently:

C1	Been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
C2	Been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
C3	Felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
C4	Been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
C5	Felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
C6	Felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
C7	Been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
D1	Been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
D2	Felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
D3	Felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
D4	Thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
D5	Found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
D6	Found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
D7	Found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

A [ ] B [ ] C [ ] D [ ] TOTAL [ ]

APPENDIX THREE

(Reliability Calculations for GHQ-28, AIRS-B and ESS Measures)

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

		Mean	Std Dev	Cases
1.	S1	1.5667	.7939	90.0
2.	S2	1.8000	.9622	90.0
3.	S3	1.6222	.8815	90.0
4.	S4	1.3000	.6262	90.0
5.	S5	1.6333	.9174	90.0
6.	S6	1.2778	.6186	90.0
7.	S7	1.2222	.4921	90.0
8.	S8	1.7444	.8684	90.0
9.	S9	1.3889	.7297	90.0
10.	S10	1.4444	.6723	90.0
11.	S11	1.7111	.8899	90.0
12.	S12	1.4556	.7368	90.0
13.	S13	2.2111	1.0652	90.0
14.	S14	2.2556	1.0553	90.0
15.	S15	1.9667	.8925	90.0
16.	S16	2.2111	.9056	90.0
17.	S17	2.1889	.9818	90.0
18.	S18	2.0778	.9625	90.0
19.	S19	2.6778	.9924	90.0
20.	S20	2.3111	1.1282	90.0
21.	S21	1.6444	.8652	90.0
22.	S22	2.1222	1.0687	90.0
23.	S23	2.0222	1.0808	90.0
24.	S24	1.5000	.8380	90.0
25.	S25	1.9889	1.1367	90.0

Statistics for	Mean	Variance	Std Dev	N of Variables
SCALE	45.3444	214.5205	14.6465	25

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Alpha if Item Deleted
S1	43.7778	200.6017	.5909	.9410
S2	43.5444	196.9025	.6181	.9406
S3	43.7222	199.4164	.5755	.9412
S4	44.0444	205.8182	.4625	.9424
S5	43.7111	196.0954	.6844	.9398
S6	44.0667	204.9169	.5207	.9419
S7	44.1222	206.2433	.5684	.9418
S8	43.6000	197.7933	.6539	.9402
S9	43.9556	201.3014	.6127	.9408
S10	43.9000	203.6865	.5410	.9416
S11	43.6333	195.9427	.7139	.9394
S12	43.8889	203.1111	.5174	.9418
S13	43.1333	195.0157	.6175	.9408
S14	43.0889	191.6100	.7460	.9388
S15	43.3778	198.3501	.6115	.9407
S16	43.1333	198.9258	.5784	.9411
S17	43.1556	193.8407	.7212	.9392
S18	43.2667	197.0966	.6104	.9407
S19	42.6667	197.2360	.5847	.9411
S20	43.0333	190.6618	.7249	.9392
S21	43.7000	200.9539	.5225	.9418
S22	43.2222	194.6017	.6297	.9406
S23	43.3222	191.6591	.7249	.9391
S24	43.8444	200.3800	.5664	.9413
S25	43.3556	192.1418	.6692	.9401

Reliability Coefficients

N of Cases = 90.0 N of Items = 25

Alpha = .9429

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

		Mean	Std Dev	Cases
1.	A1	2.4000	.7313	90.0
2.	A2	2.5111	.9858	90.0
3.	A3	2.6111	.9445	90.0
4.	A4	1.9556	1.0046	90.0
5.	A5	3.4333	1.0499	90.0
6.	A6	3.1333	.6569	90.0
7.	A7	2.8889	.8539	90.0
8.	A8	2.6556	1.0930	90.0
9.	A9	3.4889	1.4319	90.0
10.	A10	3.3333	1.4221	90.0
11.	A11	2.3778	1.3868	90.0
12.	A12	2.6444	1.4087	90.0
13.	A13	2.6889	1.1674	90.0
14.	A14	2.6556	1.2193	90.0
15.	A15	3.4889	1.6023	90.0
16.	A16	3.8111	1.5499	90.0
17.	A17	2.3111	1.2053	90.0
18.	A18	2.5444	1.2909	90.0
19.	A19	3.8111	1.5715	90.0
20.	A20	3.1000	1.4919	90.0
21.	A21	2.9444	1.4250	90.0
22.	A22	3.7333	1.3391	90.0
23.	A23	2.2000	1.1823	90.0
24.	A24	3.7667	1.5868	90.0
25.	A25	2.6889	1.3038	90.0
26.	A26	2.6111	1.2693	90.0
27.	A27	4.2444	1.3517	90.0
28.	A28	3.9667	1.4414	90.0
29.	A29	3.7444	1.4027	90.0
30.	A30	2.9444	1.1932	90.0
31.	A31	3.6222	1.3373	90.0
32.	A32	2.6556	1.2909	90.0
33.	A33	3.6000	1.5921	90.0
34.	A34	2.4778	1.3002	90.0

Statistics for	Mean	Variance	Std Dev	N of Variables
SCALE	103.0444	484.6722	22.0153	34

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Alpha if Item Deleted
A1	100.6444	472.2991	.3724	.9090
A2	100.5333	465.3079	.4325	.9082
A3	100.4333	463.2371	.5053	.9074
A4	101.0889	468.5538	.3474	.9091
A5	99.6111	460.9819	.5010	.9073
A6	99.9111	469.4976	.5179	.9081
A7	100.1556	463.5036	.5559	.9072
A8	100.3889	463.0718	.4338	.9081
A9	99.5556	459.1935	.3818	.9090
A10	99.7111	446.4999	.6015	.9054
A11	100.6667	444.9438	.6462	.9047
A12	100.4000	450.1528	.5443	.9063
A13	100.3556	453.2205	.6053	.9058
A14	100.3889	450.1729	.6380	.9052
A15	99.5556	439.8002	.6295	.9048
A16	99.2333	451.5966	.4656	.9077
A17	100.7333	464.7596	.3552	.9091
A18	100.5000	448.7921	.6255	.9052
A19	99.2333	465.0573	.2530	.9114
A20	99.9444	448.9744	.5294	.9066
A21	100.1000	452.3382	.4999	.9071
A22	99.3111	466.5313	.2826	.9103
A23	100.8444	460.8295	.4422	.9079
A24	99.2778	445.8208	.5422	.9064
A25	100.3556	445.7149	.6768	.9044
A26	100.4333	445.1022	.7087	.9041
A27	98.8000	484.4090	-.0263	.9148
A28	99.0778	500.2523	-.2739	.9190
A29	99.3000	453.4708	.4893	.9072
A30	100.1000	459.8888	.4564	.9077
A31	99.4222	456.7411	.4574	.9077
A32	100.3889	451.7010	.5705	.9060
A33	99.4444	445.0811	.5516	.9062
A34	100.5667	448.5180	.6258	.9052

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

Reliability Coefficients

N of Cases = 90.0 N of Items = 34

Alpha = .9102

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

Item-total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Alpha if Item Deleted
G1	22.7889	182.5954	.5027	.9375
G2	22.8556	178.6194	.6173	.9361
G3	22.6333	177.6955	.5895	.9365
G4	22.9333	176.9169	.6213	.9361
G5	22.8444	178.9418	.4899	.9381
G6	22.8556	175.6081	.6333	.9360
G7	23.0778	179.4208	.5200	.9374
G8	22.6556	174.5879	.6386	.9360
G9	22.9556	175.2564	.6655	.9355
G10	22.7556	173.2879	.7358	.9345
G11	22.7889	175.2471	.6406	.9359
G12	23.1889	176.9414	.6342	.9359
G13	22.6667	174.0674	.7043	.9349
G14	23.0444	176.4250	.6883	.9352
G15	22.9778	185.3928	.3879	.9386
G16	22.7111	185.0617	.5133	.9375
G17	22.7222	180.8096	.6044	.9364
G18	22.7556	181.2879	.5678	.9368
G19	22.7778	181.0961	.6543	.9360
G20	22.8333	186.1404	.4022	.9384
G21	22.6667	183.3034	.5134	.9374
G22	23.4444	180.9014	.6305	.9362
G23	23.4556	182.6104	.5228	.9372
G24	23.5444	182.0935	.5848	.9367
G25	23.4556	183.2620	.5141	.9374
G26	23.4333	181.4169	.6728	.9360
G27	23.4889	183.0841	.5154	.9373
G28	23.4889	183.2864	.4461	.9381

Reliability Coefficients

N of Cases = 90.0 N of Items = 28

Alpha = .9388

R E L I A B I L I T Y A N A L Y S I S - S C A L E (A L P H A)

		Mean	Std Dev	Cases
1.	G1	1.0556	.7245	90.0
2.	G2	.9889	.8278	90.0
3.	G3	1.2111	.9179	90.0
4.	G4	.9111	.9198	90.0
5.	G5	1.0000	.9944	90.0
6.	G6	.9889	.9772	90.0
7.	G7	.7667	.9125	90.0
8.	G8	1.1889	1.0266	90.0
9.	G9	.8889	.9533	90.0
10.	G10	1.0889	.9674	90.0
11.	G11	1.0556	.9871	90.0
12.	G12	.6556	.9014	90.0
13.	G13	1.1778	.9666	90.0
14.	G14	.8000	.8638	90.0
15.	G15	.8667	.6737	90.0
16.	G16	1.1333	.5446	90.0
17.	G17	1.1222	.7162	90.0
18.	G18	1.0889	.7289	90.0
19.	G19	1.0667	.6500	90.0
20.	G20	1.0111	.5901	90.0
21.	G21	1.1778	.6633	90.0
22.	G22	.4000	.6837	90.0
23.	G23	.3889	.6982	90.0
24.	G24	.3000	.6611	90.0
25.	G25	.3889	.6653	90.0
26.	G26	.4111	.6162	90.0
27.	G27	.3556	.6756	90.0
28.	G28	.3556	.7542	90.0

Statistics for	Mean	Variance	Std Dev	N of Variables
SCALE	23.8444	192.9643	13.8912	28

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