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Exploring and addressing the unmet healthcare needs of Indian adolescents

The article by Dogra *et al* made for an interesting read.¹ However, the use of only the self-report Strengths and Difficulties Questionnaire (SDQ) and lack of validation of the SDQ in Indian adolescents – which the authors acknowledge – pose serious methodological concerns. The authors also mention the absence of SDQ reference standards for children of Indian ethnic backgrounds. In contrast, the study by Goodman *et al* makes an attempt to use the Development and Well-Being Assessment (DAWBA) scale (although strictly not a gold standard) subsequent to the SDQ in an attempt to validate the latter in a sample of British Indian children.² The mean SDQ score for Indian children from this study could have been used as a reference point by Dogra *et al*.

In trying to explore the reason why adolescents of Indian ethnic backgrounds have better mental health than their White peers, the authors have not explored ‘cultural integration’, which has been hypothesised as a significant factor in previous studies.³ This is measured by the number of friends of other ethnic backgrounds, including the majority community. It is understood that migrants to high-income countries tend to be intelligent, resilient and resourceful, and could also possibly have a better level of cultural integration. Although comparison had been drawn between Indian and White adolescents who identify themselves with a single culture and those who do not perceive the same, a parallel comparison between Indian adolescents (an intragroup comparison) who perceive and do not perceive themselves as belonging to a single culture may have shed more light.

Furthermore, comparative studies of adolescents from the same ethnic community in their home setting and as immigrants elsewhere will help us to understand the role of migration and mental health in immigrant adolescents. Understanding and exploring the reasons behind an apparent mental health advantage of one ethnic community over another holds a lot of promise in addressing the unmet mental health needs of adolescents throughout the world. Well-replicated studies addressing the methodological issues highlighted here would go a long way towards achieving the above objectives.

- 1 Dogra N, Svirydzenka N, Dugard P, Singh SP, Vostanis P. Characteristics and rates of mental health problems among Indian and White adolescents in two English cities. *Br J Psychiatry* 2013; **203**: 44–50.
- 2 Goodman A, Patel V, Leon D. Why do British Indian children have an apparent mental health advantage? *J Child Psychol Psychiatry* 2010; **51**: 1171–83.
- 3 Bhui KS, Lenguerrand E, Maynard MJ, Stansfeld SA, Harding S. Does cultural integration explain a mental health advantage for adolescents? *Int J Epidemiol* 2012; **41**: 791–802.

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Authors’ reply: Gnanavel raises methodological concerns that in his view limit the validity of our findings and culture-related points that might enrich our understanding of the issues we raised in our paper. We would agree that self-report measures and the validity of the Strengths and Difficulties Questionnaire (SDQ) in Indian adolescents have some limitations as discussed in our paper.¹ However, evidence shows that health-related self-report is a reliable method of assessment in adolescents,² and that it also facilitates the recruitment of a larger sample, allowing for a reliable analysis of associated mental health factors. Additionally, there is further support for using the SDQ with Indian adolescents in the UK. First, Goodman and colleagues, although providing some validation of the SDQ, had a limited sample of Indian children with a wide age range, which limited the authors’ findings and their interpretive power.³ Second, the SDQ emotional subscale was comparable to the Short Mood and Feelings Questionnaire in our study. Finally, interpretive differences between Indian and White British adolescents that question the validity of our findings beg a broader question of how dissimilar these ethnic groups actually are in terms of their ability to understand SDQ items. It would be reasonable to compare the findings related to mostly UK-born English-speaking Indian adolescents in our sample with UK norms. Therefore, arguing that our findings may be due to the Indian adolescents’ lack of understanding of the SDQ is unlikely.

We agree that it is important to consider the role of cultural integration as a factor in the mental health of adolescents from migrant populations. Our ability to do so in our study was limited by our primary aim to establish a reliable evidence base for mental health needs in a previously unexplored population. However, understanding of cultural integration in ethnic minority groups in the UK needs to go beyond the suggested proxy measures of a friend’s ethnicity and dress. These factors may say more about the area of the family’s residence and hereditary traditions rather than conscious choices made by the adolescents. Cultural integration of ethnic minority migrants is a complex process that varies according to the cultural heritage of a particular migrant group, the dynamics of local cultures and the longevity of residence in the host country. All of these factors affect an adolescent’s internalised cultural norms and values as part of their ethnic identity, which can then affect their health.⁴ One therefore needs to be careful when generalising all migrant groups to high-income countries as possessing the same set of characteristics or similar abilities for integration.⁵

Discussions of the origins of mental health differences in immigrant ethnic minority groups are crucial in our need to fully understand the complex processes involved. Without question, the subject warrants further investigation and close collaboration, so that we can start asking the right questions and find answers using the best and most relevant methodologies that will make an impact on clinical practice.

- 1 Dogra N, Svirydzenka N, Dugard P, Singh SP, Vostanis P. Characteristics and rates of mental health problems among Indian and White adolescents in two English cities. *Br J Psychiatry* 2013; **203**: 44–50.
- 2 Riley AW. Evidence that school-age children can self-report on their health. *Ambul Pediatr* 2004; **4**: 371–6.
- 3 Goodman A, Patel V, Leon D. Why do British Indian children have an apparent mental health advantage? *J Child Psychol Psychiatry* 2010; **51**: 1171–83.
- 4 Weinreich P. ‘Enculturation’, not ‘acculturation’: Conceptualising and assessing identity processes in migrant communities. *Int J Intercult Relat* 2009; **33**: 124–39.
- 5 Dogra N, Singh SP, Svirydzenka N, Vostanis P. Mental health problems in children and young people from minority ethnic groups: the need for targeted research. *Br J Psychiatry* 2012; **200**: 265–7.

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