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**An exploration of help-seeking among South Asians living
in the UK**

Section A: What are the attitudes and beliefs that prevent or
facilitate South Asians in the UK seeking professional
psychological help?

Word count: 6799

Section B: Second-generation South Asian adolescents'
experiences and management of psychological distress

Word count: 8000 (594)

Overall word count:
15393

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ
Church University for the degree of Doctor of Clinical Psychology

June 2015

SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

Firstly, I would like to thank the young Asian men and women who participated in this study, without whom, this project would not have been possible. I am honoured that they shared their experiences with me.

I am very grateful for the support from my supervisors Dr Helen Caird and Dr Nidhi Dholakia, for their words of encouragement and their invaluable feedback.

Finally, I would like to thank my friends and family for their encouragement and faith in me, particularly my mother, husband and mother-in-law for their continued patience, love and support.

Summary of the MRP

Section A outlines the existing literature regarding the mental health and help-seeking of South Asian adults and adolescents living in Britain. The review explores the attitudes and beliefs which prevent or facilitate South Asians seeking professional help. Alternative explanatory models of distress, social consequences of seeking help, and perceived cultural mismatch between participants and professionals appeared to prevent help-seeking.

Facilitators to help-seeking included providing information about mental health problems and increasing visibility of professionals in the community. Key methodological issues identified in the papers reviewed are discussed, followed by clinical implications and avenues for future research.

Section B presents a qualitative study exploring how South Asian adolescents make sense of their experiences of distress and the meanings attributed to help-seeking. Interviews were carried out with nine second-generation South Asian adolescents, and the data were analysed using interpretative phenomenological analysis. Five superordinate themes emerged from the analysis: overwhelmed by strong emotions, negative impact of family and cultural ideals on the self, connectedness to others, perception of seeking help outside of the family and intergenerational differences in help-seeking. The complexities of seeking help from the family are highlighted. Limitations of the study, clinical implications and areas for future research are discussed.

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Section A

What are the attitudes and beliefs that prevent or facilitate South Asians in the UK seeking professional psychological help?

Word count: 6799

Abstract

South Asians are the largest ethnic minority group in the United Kingdom (UK). Whilst research has suggested that this group experiences significant levels of psychological distress, there is also evidence to suggest that they under-utilise mental health services. This has highlighted a need to understand dynamic factors which influence help-seeking. In this scoping review, published research examining the attitudes and beliefs which prevent or facilitate South Asian adults and adolescents accessing professional psychological help was explored. A literature search of five electronic databases was carried out and articles were screened against inclusion and exclusion criteria. Sixteen studies were included in the review and the key themes identified are presented. Barriers to seeking help included alternative explanatory models of distress, social consequences of help-seeking, and perceived cultural mismatch between participants and professionals. Help-seeking might be facilitated by promoting greater understanding and visibility of services in Asian communities and emphasising client confidentiality. Future research should explore generational differences in attitudes to help-seeking, particularly among adolescents, as much of the existing research has focused on the perspectives of South Asian adults.

Keywords: South Asians, help-seeking, barriers, facilitators, mental health

Introduction

Cultural and religious beliefs can often influence the way in which psychological distress is understood, expressed and treated. Therefore, the consideration of these beliefs in mental health service provision is essential to meet the needs of an increasingly multicultural and multi-faith society (Sue, Zane, Nagayama-Hall, & Berger, 2009). In accordance with the Race Relations (Amendment) Act 2000 and the Government's Delivering Race Equality in Mental Health Care policy, services have a responsibility to identify barriers to access and address disparities in outcome and experience for different ethnic groups across the life span (Department of Health, 2005).

Three previous reviews discuss the mental health of South Asians in the UK, two focus exclusively on women and one specifically on depression (Anand & Cochrane, 2005; Hussain & Cochrane, 2004; Ineichen, 2012). These reviews highlight the underutilisation of mental health services by South Asian communities. Consequently, this paper presents a scoping review of published research examining the attitudes and beliefs that influence whether South Asian adults and adolescents living in the UK seek psychological help. Firstly, definitions of South Asian and help-seeking are given, followed by theories of help-seeking. Literature relating to the attitudes and beliefs of South Asian adults and adolescents is then reviewed. Finally, research and clinical implications are discussed.

South Asians in the UK

South Asia includes the countries of Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka (The United Nations, 2012). South Asian cultures share collectivist values which emphasise conformity and interdependence above pursuing individual interests (Furnham & Malik, 1994). Whilst this region shares some commonalities, it is important to note that a variety of customs and religions are practiced, and a range of

languages are spoken. According to the UK Census, 7.5% of the total population identify themselves as Asian/Asian British. Over 5% of the people within this category are of Indian, Pakistani or Bangladeshi origin, making South Asians the largest ethnic minority group in the UK (Office of National Statistics, 2011). This review includes first generation South Asians (those who were born in one of the aforementioned countries and immigrated to the UK) and second generation South Asians (those who were born in the UK and whose parents were born in one of the aforementioned countries).

Prevalence of Mental Health Difficulties

The prevalence of mental health problems among South Asians living in Britain has been difficult to establish as epidemiological studies have reported mixed findings. Early studies suggested that South Asian women experienced lower rates of anxiety and depression than their white counterparts (Cochrane & Stopes-Roe, 1977; Nazroo, 1997). However, more recent studies have found that South Asian women in particular have higher rates of depressive disorders compared to white women (Bhui, Bhugra, Goldberg, Sauer, & Tylee, 2004). These inconsistencies may be explained by the use of culturally inappropriate measures, as there is no direct translation for depression in some Asian languages, (Hussain & Cochrane, 2004) a limitation referred to as ‘category fallacy’ (Kleinman, 1987).

Bhugra, Desai and Baldwin (1999) studied suicide rates in men and women over 12 months across four ethnic groups accessing services in West London. They found that the rates of attempted suicide in South Asian women were 1.5 times higher than those of their white counterparts and 2.5 times those of Asian men. The greatest differences were observed among Asian women aged 16-24 years, the rate of attempted suicide for this group increased to 2.5 times higher than that of white women and 7 times that of Asian men. Bhugra (2002) suggests that this may be explained by differences in the cultural expectations of Asian men

and women, and intergenerational conflict between “traditional” parents and their “modern” children regarding lifestyle and marriage. However, it is important to note that these findings reflect ‘treated’ cases and excludes those who do not or are unable to seek treatment for their difficulties.

Under-utilisation of Mental Health Services

Whilst it has been difficult to establish ‘true’ prevalence rates, previous reviews of the mental health of South Asians in Britain have highlighted the experience of psychological distress among this group and their underuse of mental health services (Anand & Cochrane, 2005; Hussain & Cochrane, 2004; Ineichen, 2012). Research has suggested that general practitioners (GPs) are less likely to detect psychiatric disorders in South Asians compared to other ethnic groups, or refer to specialist care when psychological distress is identified (Bhui, Bhugra, Goldberg, Dunn, & Desai, 2001; Bhui et al., 2003).

This has commonly been explained by the propensity of South Asians to somatise feelings of psychological distress and report physical rather than emotional symptoms (Beliappa, 1991; Ineichen, 1990). However, this view overlooks the widespread and uncritical application of western conceptualisations of mental health and the implicit mind-body dichotomy. This is in contrast to Asian cultures which adopt a more holistic approach and view the mind and body as one (Fernando, 2010). This is illustrated by an illness referred to as ‘sinking heart’, a Punjabi conceptualisation of distress in which physical sensations in the heart may be accompanied by emotional symptoms (Krause, 1989). Therefore, it may seem entirely sensible and appropriate for South Asians to report both physical and emotional symptoms when describing difficulties to health professionals.

This suggests that it is important to consider individuals’ level of acculturation and familiarisation with western conceptions of mental health and services. Acculturation refers

to the “dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (Berry, 2005, p.698). These changes can occur for a number of reasons including the migration and settlement into receiving societies such as the UK. There are various ways in which groups and individuals engage in the process of acculturation. Berry (2005) described four acculturation strategies from the perspectives of both the immigrant (non-dominant) group and the larger society (dominant group). These are shown in Figure 1. These strategies are informed by two issues: (1) the desire to maintain one’s heritage and culture and (2) the desire to have contact with, and participate in the larger society with other cultural groups.

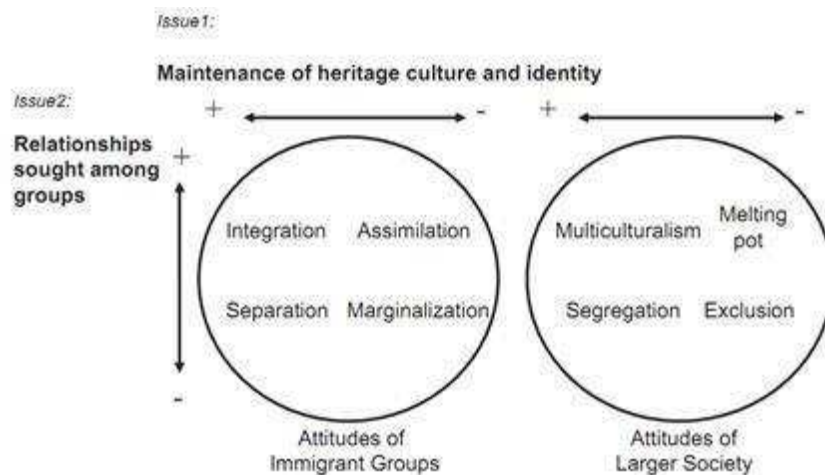


Figure 1. Berry’s (2005) model of acculturation

Berry, Phinney, Sam and Vedder (2006) suggest that integration, which refers to individuals maintaining aspects of their culture and incorporating aspects of the host culture, is the most psychologically adaptive strategy. However, it is important to note that the acculturation preferences of the non-dominant group may be constrained by the dominant group. For example, integration is only possible when the dominant society is open to cultural diversity and the non-dominant group adopts some of the norms and values of the larger society.

An individual's level of acculturation may inform their conceptualisation and the meanings attributed to the experience of distress. This may in turn influence where help is sought. It has been suggested that the low uptake of services among this group may be related to the use of alternative sources of help such as traditional healers or family members (Ineichen, 2012). However, Rudell, Bhui and Priebe (2008) examined help-seeking behaviours among White British, Black Caribbean and Bangladeshi individuals and found that alternative help-seeking was commonly utilised across ethnic groups.

Help-seeking

In this review, help-seeking is defined as, “attempts to maximize wellness or to ameliorate, mitigate, or eliminate distress” (Saint Arnault, 2009, p.260). Help can be sought from both informal and formal sources. Informal sources refer to friends or family. Formal sources of help include health professionals and religious leaders who have a recognised role to provide help and advice. However, help is increasingly being sought via the internet without direct contact with other people (Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Theories of Help-seeking

Many theoretical models have been proposed to understand the processes involved in help-seeking. Dominant approaches such as Andersen's socio-behavioural model have focussed on identifying characteristics of users and non-users of health services (Andersen 1968). This model suggests that service use is influenced by an individual's predisposition to using services, enabling resources and perception of need. Predisposing characteristics include age, gender, education and health beliefs. Enabling resources refer to both community and personal resources, such as the availability of services for people to access, and the means to travel to and use these services. Need refers to the individual's perception of their health problem and whether they feel professional help is warranted, and also

professionals' judgement about the individual's need for medical care. The model has been criticised for being too deterministic, and dynamic approaches which conceptualise help-seeking as a social process have been developed in response to this (Pescosolido, 1992).

The Network Episode Model (Pescosolido, 1991, 1992) asserts that interaction with one's social networks is crucial in motivating action. Social networks include family, friends and organisations. Social networks may facilitate or constrain use of certain sources of help depending on their beliefs and assumptions about the problem, whether it can be resolved, and how it can be resolved. Cultural routines are developed through interaction and inform appropriate courses of action. However, when these are not effective, individuals may employ a range of strategies and consult a number of people in an attempt to cope with their difficulties. The focus therefore, is not solely on the decision to seek professional help, as social networks are in themselves sources of help.

The models described attempt to understand adult help-seeking and health care use and overlook the specific systems that surround children and adolescents. Costello, Pescosolido, Angold and Burns (1998) revised the Network Episode Model to incorporate these. Costello et al. (1998) draw particular attention to the differences in power and control adults and children have over access to health care, and emphasise the role of the family and the school in recognising problems and facilitating the help-seeking process. However, it is unclear which aspects of their model are more salient at each developmental stage.

As a framework for understanding help-seeking across different cultures is essential in providing culturally sensitive care, Saint Arnault (2009) proposed the Cultural Determinants of Help Seeking theoretical model. Unlike the models presented above, Saint Arnault (2009) attends specifically to the influence of culture on the help-seeking process. She suggests that physical or emotional sensations are filtered through cultural models which

provide explanations about the cause of wellness and distress. When symptoms of distress are perceived, individuals evaluate their social significance. People then consider who in their social network they can ask for help and what the impact of this may be. If individuals evaluate their distress as negative, they may feel shame and avoid disclosing their difficulties. Cultural models differ in terms of their emphasis on the group or the individual. Given the collectivist orientation of South Asian cultures, individuals may be concerned that their distress will be perceived as self-indulgent by others (Furnham & Malik, 1994). They may also be concerned about the social consequences their distress may have on the family, such as being stigmatised. This may influence whether formal or informal sources of help are sought or whether distress is kept hidden.

The Mental Health Foundation (2000) carried out a survey in the UK and found that 66% of respondents felt they could not tell friends and family about their mental health problems due to the fear of being stigmatised and socially isolated. Erving Goffman defined stigma as an “attribute that is deeply discrediting” (Goffman, 1963, p.3). His theory of social stigma argued that individuals employ stereotypes to help them categorise and relate to others. These categories are associated with certain attributes which form the basis of an individual’s ‘virtual social identity’. The individual’s actual attributes are referred to as their ‘actual social identity’. Goffman (1963) suggested that stigma can stem from the perceived discrepancy between an individual’s ‘virtual’ and ‘actual’ social identities. The reaction of others to socially discrediting attributes such as ‘mental illness’ can ‘spoil’ identity which may prevent individuals from seeking help.

Link and Phelan (2001) argue that stigma exists when human differences are labelled and associated with negative stereotypes. Labelled individuals are positioned in categories in order to separate ‘us’ from ‘them’ and consequently experience status loss and discrimination. However, stigmatisation is contingent on a social, economic and political

context which allows these processes to evolve. Link and Phelan's (2001) conceptualisation of stigma refers to labels as opposed to 'attributes' to emphasise that the identification and social significance of the 'discrediting attributes' referred to by Goffman (1963) are a consequence of social processes rather than located in the stigmatised person. Given the importance of placing the needs of the group above the individual in South Asian cultures, being labelled with and treated for a psychiatric illness may have negative consequences for an individual's family.

Summary and Aim

South Asians are the largest minority group in the UK. Previous reviews of the mental health of South Asians in Britain have highlighted significant psychological distress among this population. This is particularly demonstrated by the high rates of attempted suicide in young South Asian women. Despite this, there is also evidence to suggest that this group underutilise mental health services. Given the emphasis in national policy to address health inequalities and provide culturally sensitive care, it is important for services to understand how to better engage and support this population. This paper aimed to review published research examining the attitudes and beliefs that prevent or facilitate South Asian adults and adolescents seeking psychological help.

Method

A scoping review of published qualitative and quantitative research was selected to summarise the existing research and identify gaps in the literature. This was conducted by following the five stages outlined in Arksey and O'Malley's (2005) framework. This included:

- 1) Identifying the research question
- 2) Identifying relevant studies

- 3) Selecting appropriate studies
- 4) Charting the data
- 5) Collating, summarising and reporting the results

Literature searches were carried out using five electronic databases: PsycInfo, Web of Science, Medline, Science Direct and Google Scholar. Only papers published since 1947 were included in the review. This marked the beginning of the large scale immigration of South Asian workers to Britain to address the labour shortage following World War II (Ballard, 2002). The final search was carried out in February 2015. The following search terms were used: South Asian or British Asian or cross-cultural and adolescent or young people and help seeking or help-seeking or mental health services or mental health or psychological or utilise or utilisation or access or barrier. Relevant articles were identified by screening titles of papers and abstracts against the inclusion and exclusion criteria. Reference lists from relevant articles were also hand searched. This led to 16 articles being included in the review. A flowchart of the review process is shown in Figure 2.

Inclusion and Exclusion criteria

Included studies met the following criteria:

- Peer reviewed research articles written in English.
- Studies which specifically asked South Asians adults and/or adolescents living in the UK about their attitudes or beliefs towards seeking psychological help.
- Studies that compared South Asian attitudes and beliefs with other ethnic groups.

The following types of papers were excluded:

- Studies which only asked where help was sought from and did not examine participants' attitudes or beliefs towards seeking help.

- Studies which did not include South Asians living in the UK as a separate group in their sample.
- Studies that focussed exclusively on domestic violence, substance abuse or learning disabilities (LD).
- Studies about the development of measures.

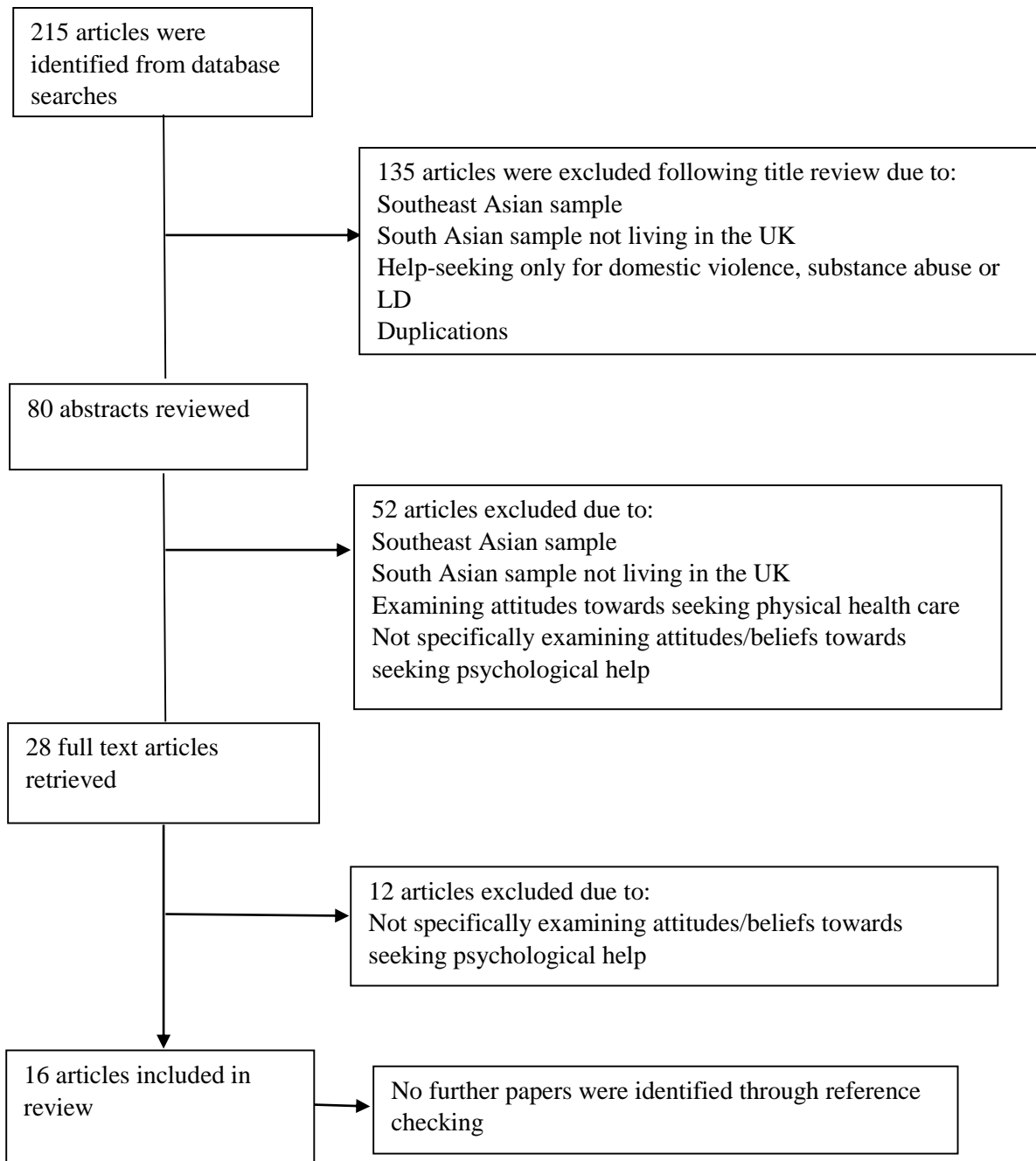


Figure 2. Flowchart of the review process

Charting the data from the studies reviewed involved recording key information from the articles and organising the material according to themes. The data charted from the studies are presented in Table 1 below.

Table 1. Key characteristics and findings of included studies

Authors	Main aims	Participants	Methods	Main findings
Hackett, Theodosiou & Patel (2006)	To carry out a needs assessment for South Asian families in Manchester	1 st , 2 nd & 3 rd generation Indian, Pakistani and Bangladeshi parents and female adolescents. Unclear how many participants took part or whether they had accessed services.	Recruitment methods unclear. Separate focus groups held with parents and adolescents. Presented with case scenarios to discuss. Method of data analysis not stated.	Barriers: Adolescents felt families can find attending services stigmatising and try and resolve difficulties at home. Also, not knowing where to get help from and fear prevent them from seeking help. Participants reported a lack of understanding of mental health services in their communities. Facilitators: Parents suggested offering information sessions to South Asian families to provide an understanding of child mental health problems and what CAMHS can offer. Adolescents suggested increasing understanding of services through advertising.
Hussain (2006)	To examine reasons for low uptake of statutory mental health services amongst Pakistanis.	33 1 st generation male and female Pakistani Muslims aged 55-62.	Purposive sampling and recruitment through community care programmes and traditional healers. Semi-structured interviews and participant observation. Constant comparative method.	Barriers: Kismet (fate as cause of distress), Sabr (endurance of distress as help-seeking) Purdah (gender role fulfilment) Izzat (family honour). Professionals lack understanding of cultural and religious beliefs.
Bhugra & Hicks (2004)	To pilot test the impact of an educational pamphlet about depression and suicidality on South Asian women's help-seeking attitudes.	180 South Asian women aged 15-75 years. Country of origin and generational status not given.	Prospective cohort time series design. Convenience sampling from waiting rooms at GP surgeries and South Asian community organisations. Very little information given about the measure used. Chi Square.	Facilitators: Both immediately after reading the pamphlet and 4-6 weeks later, the proportion of women who said that they would tell their GP, friends and family about their feelings of depression and suicidality significantly increased.

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Chew-Graham, Bashir, Chantler, Burman & Batsleer (2002)	To examine Asian women's experiences of distress and the barriers preventing access to services.	30 Pakistani and Bangladeshi Muslim women and 1 Indian Sikh woman aged 17-50 years. Unclear how many had accessed services. Generational status unclear	Recruited from four community groups for Asian women. Focus groups were held with existing groups of women from each community centre. Data analysed using 'framework analysis (a content analysis method)'. Structured interviews. Quota, convenience and snowball sampling. Thematic qualitative analysis.	<p>Barriers: Izzat, lack of trust, 'community grapevine' and concerns about confidentiality. Being unable to speak English was linked with a lack of knowledge of services and support. Participants felt services have little understanding of Asian culture or the consequences of help-seeking. They were also concerned about being judged by clinicians who have 'fixed ideas' about the Asian community.</p> <p>Facilitators: Advertising services and providing information in Asian languages about what is meant by 'psychology', 'counselling' and 'mental health' in places where the Asian community are located. Some participants would prefer to speak to a clinician from the same background, others preferred to speak to someone of a different background due to concerns about confidentiality.</p>
Cinnirella & Loewenthal (1999)	To map some of the key differences in beliefs about mental illness among 5 ethnic/religious groups. To explore the impact of religious beliefs on beliefs about causes and treatments for mental illness.	Non-clinical female adults. Ages were not given. 13 Pakistani Muslims and 9 Indian Hindus (1 st & 2 nd generation).	Structured interviews. Quota, convenience and snowball sampling. Thematic qualitative analysis.	<p>Barriers: Participants believed GPs were busy and may not have time to help. Concerns about breaches of confidentiality and community stigma. Family problems should be kept private and within the family. Some Muslim participants believed mental health problems were caused by a lack of faith and felt private prayer could treat this.</p> <p>Facilitators: Reassurance of confidentiality. Seeing a professional of the same background would provide a shared cultural understanding.</p> <p>Inter-generational differences in help-seeking: Second generation participants felt the older generation may adopt religious explanations of mental health problems and seek help from holy persons more than themselves.</p>

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Taylor, Brown & Weinman (2013)	To compare illness perceptions about depression and help seeking of North Indian and White British women	Non clinical sample of 70 White British and 70 North Indian women aged 18-55 years. (40% of Indian sample were 2 nd generation).	Cross-sectional survey design. Participants recruited from a shopping mall and asked to evaluate problems of a vignette character using the Brief Illness Perception Questionnaire (BIPQ). T-tests, Chi Square and content analysis was carried out on open-ended question.	<p>Significant differences were found between groups on three items of the BIPQ. The Indian women believed treatment would be less beneficial for the character, they felt they had less understanding of her difficulties and that the character's difficulties were having less of an impact on her emotionally compared with the British women.</p> <p>Significantly fewer Indian participants felt the character should see her GP and significantly fewer had sought help themselves in the past for emotional problems. Significantly more Indians reported seeking help from a religious/traditional healer for emotional difficulties.</p> <p>Inter-generational differences in help-seeking: Second generation Indian participants felt the character's difficulties would have a greater impact on her and were more likely to indicate that the character should seek help from her GP compared with first generation Indians.</p>
Sheikh & Furnham, (2000)	To examine the relationship between culture and causal beliefs of distress and attitudes associated with seeking professional help between British Asians, Pakistanis (resident in Pakistan) and White Westerners	287 male and female adults. 115 British Indians, Pakistanis and East Africans (21.5% 2 nd generation). 85 White Westerners and 77 Pakistanis.	Questionnaire study. Measures: The orientations for seeking professional help questionnaire and the mental distress explanatory model questionnaire (assessed 4 types of causal beliefs: stress, Western physiological, supernatural and non-Western physiological). Non-clinical sample recruited from community centres, dentist surgery and a park. Regression analysis	Cultural group was not a significant predictor for attitudes towards seeking professional help for mental distress. As a whole, causal beliefs about mental distress were significant predictors of positive attitudes to seeking help for the two Asian samples but not for the Western sample.

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Syed, Baluch & Duffy (2012)	To examine the attitudes of Indians living in the UK towards Western counselling compared with the attitudes of White British citizens and Indians resident in India.	162 male and female adults. 49 Indians in India, 51 Indians in the UK (1 st generation) and 60 White British.	Quasi- experimental design using questionnaires. Non-clinical sample of university students and local residents. Authors developed an attitudes to counselling questionnaire. ANOVA and t-test	Indians in the UK have more favourable attitudes towards counselling compared to Indians in India and White British participants. There was no difference in awareness of services between Indians in the UK and White British participants.
Lawrence et al. (2006)	To explore older adults attitudes and beliefs regarding appropriate help for someone with depression among three ethnic groups.	110 male and female older adults. 32 Black Caribbean, 33 Indian, Pakistani and East African (generational status not given). 45 White British.	Sample was stratified by ethnicity and experience of depression. Recruited from primary care, day centres and lunch clubs. Semi-structured interviews. Grounded theory.	Barriers: Emphasis on personal responsibility for coping with depression above other strategies e.g. using distraction/forcing self to get out and engage with activities. Belief that it is inappropriate to discuss personal problems with strangers. Participants did not feel GPs had a role in treating depression and were unclear about the role of a counsellor. Stigma attached to seeing a psychiatrist.
Soorkia, Snelgar & Swami (2011)	To examine the associations between attitudes towards psychological help-seeking, adherence to cultural values, salience of ethnic identity and cultural mistrust among South Asians.	148 male and female adults. 2 nd generation Indian, Pakistani, Bangladeshi and other South Asian	Opportunistic sample of university students. Questionnaire study. Measures: Asian values scale, Attitudes towards seeking professional psychological help scale, cultural mistrust inventory and multigroup ethnic identity measure. Partial correlations, regression analysis and ANOVA.	Participants reported negative attitudes to seeking psychological help. Greater ethnic identification and cultural mistrust of Whites was associated with more negative attitudes towards help seeking. Also, greater adherence to traditional Asian values were negatively associated with attitudes towards psychological help-seeking.

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Pilkington, Msetfi & Watson (2012)	To examine South Asian British Muslims intention to access psychological services. Examined the role of shame/izzat, levels of acculturation, levels of religiosity and beliefs about mental health problems.	94 male and female adults. Indian, Pakistani, Bangladeshi and other South Asian (65% 2 nd generation).	Sample recruited from social networking sites, a university and community centres. Questionnaire study. Measures used: Inventory of attitudes toward seeking mental health services, attitudes towards mental health scale, acculturation measure, mental health locus of origin scale and the moslem attitude toward religion scale. Regression analysis.	Higher levels of shame/izzat and more biological beliefs about the cause of mental health problems were related to lesser intention to access psychological services. Higher levels of education and acculturation predicted greater intent to access services. Intergenerational differences: When data from first and second generation participants were analysed separately, shame/izzat was only a significant predictor for the first generation.
Tabassum, Makaskill & Ahmad (2000)	To explore Pakistani families' understanding of mental health, their explanatory models and attitudes towards treatment	74 participants in total. Pakistani parents and their children (aged 12+ years). 31% 2 nd generation. All 2 nd generation participants were female. Unclear how many had accessed services.	Sample recruited via GPs, community workers and personal contacts. Families were interviewed together. Specific method of data analysis not stated. Responses were summated, tabulated and calculated into percentages.	Barriers: Lack of English language, stigma, biased attitudes from hospital staff, supernatural causes for mental health problems and the belief that families should manage problems on their own. Intergenerational differences: Fewer second generation participants would seek help from a faith healer compared to first generation participants.

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Gilbert, Gilbert & Sanghera (2004)	To explore the role shame and honour can play in subordination and entrapment for South Asian women, and how these might affect mental health and help-seeking.	South Asian women aged 16-57 years. Country of origin and generational status not given.	Participants were recruited from an Asian women's project. They were divided into three focus groups of different age ranges and presented with case scenarios to elicit beliefs and attitudes. Analysis procedures not stated.	Barriers: Izzat, fear of being 'found out', concern that confidentiality would be broken, shame and blame for seeking help outside of the family. Lack of awareness of services, belief that counsellors might give inappropriate advice due to lack of understanding of Asian culture. Reluctance to seek help from Asian male GPs due to concerns about being judged.
Neale, Worrell & Randhawa (2009)	To assess how access to mental health support from the Samaritans and other services could be improved among young South Asian and African-Caribbean communities.	Bangladeshi young men and women. Indian and Pakistani young men. All participants were aged 14-22. Number of South Asian participants and generational status not given.	Non clinical sample recruited from community contacts. Single sex focus groups. Authors cite O'Brien's (1993) coding technique.	Barriers: Emphasis placed on trying to resolve problems by themselves before seeking help from friends and family. Lack of awareness of services, what they offer and whether confidentiality will be maintained. Lack of confidence in themselves to approach services. Facilitators: 'word of mouth' from other people participants knew who had received effective help. Services need to be visible e.g. in schools (school visits) and have a community presence to build trust. Advertise services on Asian radio stations and enlist popular Asian actors in adverts.

Table 1. (continued)

Authors	Main aims	Participants	Methods	Main findings
Randhawa & Stein (2007)	To explore perceptions of mental health among South Asian and White British young people and who they seek help from if they or someone they knew had a mental health problem.	27 Pakistani Muslims, 22 Indian Sikhs and 46 White British (mean age 15.2 years). Generational status not given	Non-clinical sample recruited from schools. Mixed-methods. Participants completed a semi structured questionnaire devised by authors and took part in focus groups using vignettes. Authors cite O'Brien's (1993) coding technique.	Higher proportion of South Asians reported they would not access services if they were experiencing emotional difficulties compared to the White British group. A higher proportion of South Asians also reported that their friends and family were unlikely to use services. Both groups reported similar levels of awareness of services. Barriers: Did not want strangers to know their problems. Facilitators: 77% would prefer to see a therapist of their own gender and 63% would prefer to see a therapist of their own ethnic group. Advertising aimed at young people with accessible information about the benefits of services and an emphasis on confidentiality.
Bradby et al. (2007)	To explore attitudes and experiences of Child and Adolescent Mental Health Services among South Asian families.	35 adults participated in focus groups, 7 parents and/or young people accessing CAMHS and 5 carers of young people who had not been referred to CAMHS were interviewed. Participants consisted of 1 st and 2 nd generation Muslims, Hindus and Sikhs. Country of origin not given.	Purposive sampling. Focus groups with community members. Semi-structured interviews. Young people who had accessed CAMHS were interviewed with their parents. Data was analysed using 'thematic and logical methods'.	Barriers: Stigma of 'madness', izzat, fear of 'gossip' in the community, concerns about confidentiality and biased attitudes from professionals. Mothers were also concerned about being blamed for their child's 'madness'. Lack of awareness of mental health problems.

Results

The results are presented as a narrative summary of the key themes identified. Barriers to help-seeking are presented first, followed by a brief consideration of the facilitators.

Barriers to Help-seeking

Stigma. Five studies identified stigma as a barrier to seeking psychological help (Bradby et al., 2007; Cinnirella & Loewenthal, 1999; Hackett et al., 2006; Lawrence et al., 2006; Tabassum et al., 2000). Bradby et al. (2007) interviewed families with and without experience of using CAMHS. Families associated mental health problems with “madness” and considered them highly stigmatising. For those families who had sought help from CAMHS, the impact of stigma was minimised by parents referring to their child’s difficulties as ‘naughtiness’ and not ‘mental illness’ or by emphasising external causes of their child’s difficulties, such as discrimination at school. Parents of children with severe and enduring mental health problems reported that the illness was ‘cured now’. As parents and young people were interviewed together about their experience of using CAMHS, it was difficult to ascertain the views of the young people from the analysis and whether this differed from their parent.

Parents were very worried about gossip in their communities if it became known that their children had difficulties and were seeking help from a mental health service. Some mothers reported their concerns about the effect this may have on the family’s reputation and their children’s future marriage prospects (Bradby et al., 2007). These fears were also shared during individual interviews with Pakistani Muslim women in London (Cinnirella & Loewenthal, 1999). Consequently, participants preferred to confine help-seeking to close and

trusted family members. (Bradby et al., 2007; Cinnirella & Loewenthal, 1999; Hackett et al., 2006; Tabassum et al., 2000).

Fear of becoming ‘outcasts’ reduce the likelihood that this group will approach other community members for help (Cinnerella & Loewenthal, 1999). This was perhaps validated by Tabassum et al.’s (2000) finding that less than half of their sample would be prepared to socialise with individuals suffering from a mental illness. Stigma was also specifically associated with being hospitalised for a mental health problem (Tabassum et al., 2000) and seeking help from a psychiatrist (Lawrence et al., 2006).

Izzat/shame. Help-seeking was linked to the concept of izzat in five studies (Bradby et al., 2007; Chew-Graham et al., 2002; Gilbert et al., 2004; Hussain, 2006; Pilkington et al., 2012). Chew-Graham et al. (2002) defined izzat as, “family or personal honour/respect, or as status or prestige in the eyes of the community” (p.342). This was reported to play a powerful role in Asian family life and was closely linked with the fear of bringing shame to the family (Gilbert et al., 2004; Pilkington et al., 2012).

Chew-Graham et al. (2002) carried out focus groups with women, some of whom had attempted suicide and/or self-harmed. Participants reported that izzat could be misused to pressure women into remaining silent about their problems. Their behaviour was also monitored by a ‘community grapevine’ which served to spread ‘gossip’ if women were seen to be behaving inappropriately. Participants were concerned that if they discussed any personal issues or were even seen help-seeking, this might get back to their families or others in their community. Being ‘found out’ for seeking help was also a concern discussed in other focus groups. One participant linked izzat to limiting free expression, “Izzat is almost like a veil, and having good mental health promotes people as being able to talk about their feelings openly and honestly. So the two don’t really go hand in hand” (Gilbert et al., 2004, p. 122).

Discussing ‘madness’ openly was considered to reflect a lack of honour, and sharing family problems with ‘outside people’ was considered shameful (Bradby et al., 2007). GP referrals to mental health services were perceived as a threat to the family’s izzat and were met with resistance (Hussain, 2006). Perhaps unsurprisingly, Pilkington et al. (2012) found that higher levels of shame/izzat were associated with less intention to access help for mental health difficulties. However, when the data were separated for first and second generation South Asians, shame/izzat was only a significant predictor for individuals who had migrated to Britain. This suggests that generational differences may be important to consider in attitudes to help-seeking.

Explanatory models of distress. The way in which mental health problems were explained or thought to be caused influenced whose help was sought. Sheikh and Furnham (2000) found that causal attributions of mental distress were significant predictors of attitude to seeking professional help for British Asians. More specifically, Pilkington et al. (2012) found that Muslims holding more biological-based beliefs about the cause of mental health problems were less likely to access psychological services.

Four concepts were central to Hussain’s (2006) first generation Pakistani Muslim participants’ beliefs regarding health and distress: izzat (discussed above), kismet, sabr and purdah. Kismet can be translated as destiny. Participants believed that all events are predetermined by God including distress and cannot be changed unless God changes one’s kismet. To complain about kismet or take control of it by seeing a medical professional could be interpreted as a sin and make things worse. Participants believed enduring distress without complaint can entice God to ameliorate distress and change kismet, which is referred to as sabr. Purdah refers to gender roles and the behavioural expectations of men and women. In accordance with this, talking about problems must be restricted to certain family members or not done at all. Some participants believed that GPs could only offer symptom suppression

because they addressed material not spiritual matters. Instead, religious healers were approached, and distress was discussed using a shared language where emotions were not openly shared, as that could be a violation of purdah (Hussain, 2006).

In other studies, some Pakistani Muslims believed mental health problems could have a supernatural cause and might partly be due to a lack of faith and failure to pray regularly. Consequently, participants believed prayer or religious healers would be the treatment of choice (Cinneralla & Loewenthal, 1999; Tabassum et al., 2000). However, among the younger Indian Hindu and Pakistani Muslim participants, some responses suggested there were generational differences. The younger generation felt that older members of the community might adopt more religious explanations of mental illness and prefer religious coping strategies compared with themselves (Cinnerella & Loewenthal, 1999; Tabassum et al., 2000).

Confidentiality. Concerns that confidentiality would be broken was a barrier to help-seeking from mainstream services. Health professionals including GPs were thought to be a potential source of gossip and were not trusted with personal issues (Hussain, 2006). There was also mistrust of Asian staff from participants' communities working as receptionists in the services they might access as, "not everyone sticks to the ethics" (Bradby et al., 2007, p. 2417). Others had experiences of their confidentiality being breached (Chew-Graham et al., 2002) particularly by Asian GPs (Gilbert et al., 2004) making them unlikely to trust services again.

Blame. Fear of being blamed for their own or their children's mental health problems was reported by Asian women to be a barrier to using mental health services. This was related to being blamed for 'spoiling izzat' (Chew-Graham et al., 2002) or for bringing 'madness' into their husband's family (Bradby et al., 2007). Concerns about the response

they might receive if they did seek help was shared by one participant during a focus group, “you won’t seek help because you are afraid it might get out and people, they ain’t going to sympathise with you and they are going to think it’s your fault” (Gilbert et al., 2004, p.125).

Cultural insensitivity. There was a sense from participants that professionals from European or White British backgrounds were not aware of Asian cultural values and may not be able to understand their difficulties fully, such as the implications of disclosing emotional problems or the consequences of help-seeking (Chew-Graham et al., 2002; Hussain, 2006). However, there were also concerns from female participants that Asian male GPs may also not understand their particular difficulties and be judgemental (Gilbert et al., 2004). Some participants felt that professionals could be discriminatory or hold negative attitudes about the Asian community and were therefore reluctant to seek help from them (Bradby et al., 2007; Chew-Graham et al., 2002; Tabassum et al., 2000).

Knowledge of mental health problems and services. Some studies highlighted a lack of awareness of available services among participants (Gilbert et al., 2004; Hackett et al., 2006; Neale et al., 2009). Other participants had limited knowledge of mental health problems (Bradby et al., 2007; Hackett et al., 2006). Taylor et al. (2013) presented Indian and White British women with a vignette of a woman exhibiting symptoms of depression and asked them to evaluate the difficulties they felt the vignette character was experiencing. In comparison with the White British women, Indians reported that they had less understanding of the character’s difficulties. However, when the data from first and second generation Indians were analysed separately, second generation Indians felt the character’s difficulties were having more of an impact on her emotionally and were more likely to indicate that the character should seek help from her GP. This further suggests that there may be generational differences in understanding of Western conceptualisations of mental health problems.

Being unable to speak English was also cited as a barrier to accessing services or relevant information about where to seek help from (Chew-Graham et al., 2002; Gilbert et al., 2004; Tabassum et al., 2000). This was not addressed through the use of interpreters, as women felt uncomfortable talking about personal problems with them. They were also concerned about breaches of confidentiality if interpreters were from the same community as them (Chew-Graham et al., 2002). Participants were unclear about the role of counsellors and how GPs might facilitate access to treatment for mental health problems (Lawrence et al., 2006).

Coping independently. Some participants believed that trying to resolve difficulties independently before turning to friends and family was important in coping with difficulties (Chew-Graham et al., 2002; Lawrence et al., 2006; Neale et al., 2009). Randhawa and Stein (2007) explored attitudes to mental health and mental health services in South Asian adolescents and found participants were reluctant to speak to strangers about their personal problems. Similarly, South Asian older adults felt it was inappropriate to talk about personal problems with strangers (Lawrence et al., 2006).

Attitude to counselling. Soorkia et al. (2006) examined the associations between attitudes to seeking professional psychological help, adherence to Asian values, cultural mistrust and salience of ethnic identity in South Asian university students. They found that South Asians generally reported negative attitudes to seeking psychological help. However, Indian participants had significantly more positive attitudes to seeking help than Pakistani participants suggesting intra group differences among South Asians. Greater ethnic identification and cultural mistrust was associated with more negative attitudes towards help seeking. The authors suggest that participants who were mistrustful of 'Whites' held more negative attitudes to help-seeking. Also, greater adherence to traditional Asian values were negatively associated with attitudes towards psychological help-seeking.

Syed et al. (2012) found that first generation Indians living in the UK had more favourable attitudes to counselling compared to both Indians living in India and White British participants. However, British Indians reported that they would seek help from friends and family before a counsellor.

Facilitators to Help-seeking

Whilst the literature mainly focussed on attitudes and beliefs which prevent help-seeking, four studies also explored facilitators to seeking psychological help. Increased advertising was the most common suggestion to facilitate greater access to services, particularly in places where the Asian community meet. Adolescents suggested advertising services in schools and professionals having a greater community presence so trust could be developed (Neale et al., 2009; Randhawa & Stein, 2007). Some participants wanted information about mental health problems and the support services could offer (Chew-Graham et al., 2002; Hackett et al., 2006) particularly in Asian languages (Chew-Graham., 2002).

Bhugra and Hicks (2004) pilot tested the effect of an educational pamphlet on help-seeking attitudes for depression and suicidality among British South Asian women. Participants were asked to complete a questionnaire before reading the pamphlet, immediately after reading the pamphlet and four to six weeks later. Following this intervention, authors concluded that the pamphlet “increased women’s willingness to report depression and suicidality to general practitioners” (Bhugra & Hicks, 2004, p.828) which was maintained at follow-up. This suggests increasing awareness of services and available treatments for depression may change help-seeking attitudes. The pamphlet was translated into several Asian languages but the effectiveness of the translated versions has yet to be evaluated.

A shared cultural understanding and a preference for speaking to professionals from the same ethnic background and/or religion was highlighted by participants in three studies (Chew-Graham et al., 2002; Cinnerella & Loewenthal, 1999; Randhawa & Stein, 2007). Following the concerns regarding confidentiality, participants felt it would be helpful to emphasise the confidential nature of seeking help from services (Cinnerella & Loewenthal, 1999; Randhawa & Stein, 2007). ‘Word of mouth’ and knowing that other people they knew had received effective help from services may positively influence adolescents’ beliefs about help-seeking (Neale et al., 2009).

Discussion

The quantitative and qualitative studies reviewed provide some valuable insight into the attitudes and beliefs that prevent and facilitate South Asians in the UK seeking psychological help. This section summarises some of the key findings and methodological issues identified in this review. This is followed by a discussion of the clinical and research implications.

Overview of Findings

Much of the help-seeking research has focussed on the perspectives of South Asian female adults. Some studies interviewed adolescents jointly with their parents (Bradby et al., 2007; Tabassum et al., 2000) or included some adolescents in their sample (Bhugra & Hicks, 2004; Chew-Graham et al., 2002; Gilbert et al., 2004; Neale et al., 2009). However, only two studies employed separate adolescent samples (Hackett et al., 2006; Randhawa & Stein, 2007).

The findings of this review provide support for the Cultural Determinants of Help-seeking Model (Saint Arnault, 2009). The results highlight that the meanings attributed to the experience of distress, and how distress might be perceived by others, influences whose help

is sought, or whether help is sought at all. The stigma of seeking help for mental health problems was one of the most common barriers identified in the review. Participants were concerned about being ostracised, and the impact seeking help might have on their family's reputation and marriage prospects. This is consistent with Goffman's (1963) notion of the 'spoiled identity'. It appears that within South Asian cultures, the identity of the family as well as the individual seeking help may be 'spoiled'. In light of the need to protect one's family reputation, concerns about breaches of confidentiality were also discussed. This was particularly in relation to Asian receptionists and professionals from within participants' communities.

Other factors which appeared to prevent help-seeking included alternative explanatory models of distress, *izzat* and perceived cultural mismatch between participants and professionals. This was mainly in relation to language barriers and a lack of understanding of Asian culture. These factors underline the importance of considering individuals' levels of acculturation when trying to engage minority groups in services. Berry's (2005) model proposed that the non-dominant and dominant group both undergo a process of acculturation when they come into contact. When diversity is an accepted feature of the larger society and is recognised in national policy and law, this acculturation strategy is referred to as 'multiculturalism'. This requires the dominant group to adapt services to better meet the needs of the different cultural groups in society.

The review identified that help-seeking may be facilitated by services providing information about mental health problems and treatments (Bhugra & Hicks, 2004) particularly in Asian languages (Chew-Graham et al., 2002). Other studies highlighted the need to advertise services and increase visibility of professionals in the community (Chew-Graham et al., 2002; Hackett et al., 2006; Neale et al., 2009; Randhawa & Stein, 2007).

Methodological Critique

Whilst two studies focussed on specific populations, such as first generation Pakistani Muslims or Indians (Hussain, 2006; Syed et al., 2012), many of the studies reviewed included a combination of first and second generation Indians, Pakistanis and Bangladeshis and a range of religious groups in their sample. This may have obscured important differences in attitudes and beliefs, particularly as generational differences in help-seeking were identified in four studies (Cinnerella & Loewenthal, 1999; Pilkington et al., 2012; Tabassum et al., 2000; Taylor et al., 2013). Whilst the above populations represent the largest number of South Asians in the UK, the findings may not necessarily generalise to South Asian cultural groups more broadly.

Six of the studies explicitly stated that some of their participants had sought professional help (Bradby et al., 2007; Chew-Graham et al., 2002; Hussain, 2006; Lawrence et al., 2006; Tabassum et al., 2000; Taylor et al., 2013). The remaining studies examined attitudes and beliefs towards seeking help using community samples, and it is possible that intentions elicited using questionnaires or case scenarios may not correspond with actual behaviour. Therefore, Bhugra and Hick's (2004) claim that reading an educational pamphlet increased women's willingness to report depression and suicidality to their GP may reflect changes in what women said they would do rather than what they would actually do, particularly as women were not asked whether they had experienced depression or suicidality.

The quantitative studies included a range of questionnaires to measure attitudes towards seeking psychological help. Three studies employed questionnaires devised by the authors themselves (Bhugra & Hicks, 2004; Randhawa & Stein, 2007; Syed et al., 2012). Whilst Bhugra and Hicks (2004) piloted their questionnaire among South Asians and

Randhawa and Stein (2007) developed their measure from a literature review and discussion, neither provided any information regarding the psychometric properties of their questionnaire. Syed et al. (2012) evaluated their questionnaire using principal component analysis. However, only the reliability of this measure was provided. This makes it difficult to assess the validity of these questionnaires and whether they are measuring what they purport to measure.

Soorkia et al. (2011) included measures that were developed and validated using few or no South Asian participants. The Asian Values Scale employed a predominantly Chinese and Southeast Asian sample (Kim, Atkinson & Yang, 1999) and the Cultural Mistrust Inventory was developed to measure African American mistrust of White Americans based on their specific history (Terrell & Terrell, 1981). The authors adapted this measure so the items referred to South Asians instead of African Americans which perhaps, incorrectly, assumes validity across cultural groups. In addition, it can be argued that the use of questionnaires to examine or explore attitudes towards seeking psychological help reduces findings to the extent to which participants agree with the statements or attitudes presented without considering why these attitudes are held. However, two studies did include open questions (Randhawa & Stein, 2007; Taylor et al., 2013).

The transparency of research methods provided by the qualitative studies was variable. Some studies gave little or no information about their analytic procedure or how themes were developed. This makes it difficult to assess the robustness of their analysis (Chew-Graham et al., 2002; Gilbert et al., 2004; Hackett et al., 2006). Only three papers made explicit reference to researchers comparing coding strategies, emergent themes and discussing findings among the research team (Bradby et al., 2007; Cinnerella & Loewenthal, 1999; Lawrence et al., 2006). Data was triangulated in two studies by carrying out observations and interviews, (Hussain, 2006) and collecting information from community

focus groups and carers with and without experience of accessing CAMHS, (Bradby et al., 2007) strengthening the validity of their findings.

In their discussion, Tabassum et al. (2000) acknowledged that the research interviewer's position as a Pakistani doctor may have resulted in socially desirable responses, particularly in relation to accessing services. However, few authors gave consideration to the ways in which their role and the research process may have influenced the collected data. For example, focus groups were utilised to elicit help-seeking attitudes and beliefs in five studies, two of which recruited women who were known to each other and accessed the same community groups (Chew-Graham et al., 2002; Gilbert et al., 2004). It is possible that existing group dynamics may have influenced who chose to participate and what was disclosed in these focus groups. Additionally, dominant narratives within focus groups may have inhibited voices of difference.

Brief Evaluation of the Reviewed Literature

Overall, the reviewed papers provided some valuable insight into the attitudes and beliefs which prevent and facilitate South Asians in the UK seeking psychological help. However, as highlighted above, these studies varied in quality. Three quantitative studies provided little or no information regarding the psychometric properties of the measure used, and only one study employed measures which were normed and validated on South Asian populations in the UK.

Yardley (2000) suggests that transparency of the analytic process and reflexivity are important characteristics of good qualitative research. Of the nine qualitative studies reviewed, only four discussed the analytic methods used in detail. There was also a lack of reflexivity on the part of the researchers, particularly in terms of how their personal experiences may have shaped the collected data. Future research may benefit from taking these issues into greater consideration.

Research Implications

Although the attitudes and beliefs of South Asians towards help-seeking have been considered as representing the perspectives of one group in this review, it is important to note that this group is very heterogeneous. Variations in religion, country of origin and generational status for example, highlight the need for future research to disaggregate this population in order to better understand and appreciate its diversity.

Much of the help-seeking literature has combined first and second generation South Asians in their samples. However, this review has identified generational differences in attitudes to help-seeking and suggests that second generation South Asians may be less likely to seek help from a traditional healer. This may be related to higher levels of acculturation and greater familiarity with Western conceptualisations of mental health (Pilkington et al., 2012; Taylor et al., 2013). Future research should further explore generational differences in attitudes to help-seeking, particularly among second generation adolescents as much of the existing research has focused on the perspectives of South Asian adults.

Adolescence is a crucial developmental period, particularly in relation to mental health and well-being (Rickwood et al., 2005). Two of the reviewed studies explored the views of adolescents using focus groups. Future research may complement the existing literature by carrying out in-depth interviews with young people regarding their conceptualisation of distress and the meaning of help-seeking. It may also be important to consider how intergenerational differences manifest in relation to help-seeking, as the family play an important role in recognising difficulties and facilitating the help-seeking process for children and adolescents (Costello et al., 1998).

In addition, whilst five of the studies focussed solely on the perspectives of South Asian women, none employed a purely male sample. South Asian men and women have

different behavioural expectations (Bhugra, 2002; Hussain, 2006) particularly, as the responsibility of upholding the family's izzat or honour is placed mainly on the women in the family (Chew-Graham et al., 2002; Gilbert et al., 2004). Therefore, the help-seeking attitudes and beliefs of South Asian men may be different and warrant further exploration.

Clinical Implications

This review has highlighted that South Asians appear to feel that services lack understanding of Asian culture and may offer treatments which are inappropriate or incongruent with their world view. Services have a responsibility to improve the cultural competency of their workforce so they are able to meet service users' needs in a culturally sensitive way. Clinicians also have a responsibility to reflect on their assumptions about other ethnic groups and explore this in supervision. It seems that more investment is needed to build trust between services and Asian communities, possibly by greater use of community outreach work and collaboration with alternative sources of help, such as traditional healers. This may also provide an opportunity to facilitate greater understanding of mental health problems and the support services can offer. However, it is important this approach takes account of individuals' level of acculturation, explanatory models of distress and their worldview to avoid the risk of alienating them further.

Finally, this review highlighted the importance of maintaining confidentiality, particularly as seeking psychological help may impact on an individual's social standing and sense of acceptance within their community. Whilst breaking confidentiality may not be common practice, instances when this did occur were understandably felt by participants to undermine trust in services. It is essential for staff to make the boundaries of confidentiality explicit and uphold their professional, ethical and legal responsibility to maintain client confidentiality, especially when they are part of the communities they are serving.

Conclusion

Research has suggested that South Asians under-utilise mental health services. This paper reviewed published research examining the attitudes and beliefs that prevent or facilitate seeking psychological help among this population. The review identified that alternative explanatory models of distress, social consequences of seeking help, and perceived cultural mismatch between participants and professionals appeared to influence help-seeking. Services have a responsibility to improve the cultural competency of their staff and adapt ways of working to meet the needs of this group. Future research should take account of the diversity of this population, perhaps starting by further exploring generational differences in attitudes to help-seeking.

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Section B

Second-generation South Asian adolescents'
experiences and management of psychological distress

Word count: 8000 (594)

For submission to Mental Health, Religion and Culture

Abstract

Culture can often influence how psychological distress is experienced and where help is sought. South Asians are the largest ethnic minority group in the United Kingdom (UK). This paper aimed to explore how second-generation South Asian adolescents make sense of their experiences of psychological distress and the meanings attributed to help-seeking. Semi-structured interviews were carried out with nine second-generation adolescents aged 13-19 years. Interpretative Phenomenological Analysis was employed. Five superordinate themes emerged from the analysis: overwhelmed by strong emotions, negative impact of family and cultural ideals on the self, connectedness to others, perception of help-seeking outside the family and intergenerational differences in help-seeking. The results indicated that help is sought from families when participants perceive their families are able to relate to the source of distress. However, when there is a lack of understanding of distress, participants sought this from external sources of help. Professional help-seeking appeared influenced by the interplay between not meeting family ideals, intergenerational differences in understanding of distress and the stigma of mental health problems. Clinical and research implications are discussed.

Keywords: Help-seeking, South Asians, adolescents, psychological distress

Introduction

Cultural and religious beliefs can often influence the way in which psychological distress is experienced and where help is sought. Therefore, the consideration of these beliefs in mental health service provision is essential to meet the needs of an increasingly multicultural and multi-faith society (Department of Health, 2005). South Asians are the largest ethnic minority group in the UK (Office of National Statistics, 2011). In this paper, South Asians (hereafter referred to as Asians) includes those of Indian, Pakistani, Bangladeshi, or Sri Lankan origin.

Much of the existing literature regarding the mental health of Asians and their utilisation of mental health services has focused on the perspectives of adults (Ineichen, 2012). Consequently, the voices of Asian adolescents have largely been overlooked (Malek, 2011). Research has suggested that the rate of attempted suicide among Asian women aged 16-24 is higher than that of their White female and Asian male counterparts (Bhugra, Desai, & Baldwin, 1999; Merrill & Owens, 1986). Furthermore, a systematic review of child and adolescent mental health differences indicated more disordered eating attitudes in Asian female adolescents, and a greater unmet need for mental health services in male and female Pakistani and Bangladeshi adolescents (Goodman, Patel, & Leon, 2008).

The higher incidence of attempted suicide among young Asian women has led to the suggestion that these adolescents may experience specific cultural pressures in addition to the demands faced by all adolescents (Thompson & Bhugra, 2000). These pressures may be particularly salient for second-generation Asians, as they are exposed to the collectivist values of their first-generation parents and the individualistic orientation of Western culture (Ghuman, 1999). Acculturation refers to the cultural and psychological changes that occur following contact between two or more cultural groups (Berry, 2005). Berry's (2005) model outlined four acculturation strategies which vary in accordance with the individual's

preference to maintain their heritage and culture, or interact with the dominant cultural group, and adopt some of their norms and values. Within Western cultures, adolescence is a crucial developmental period, particularly in relation to mental health and well-being (Rickwood, Deane, Wilson, & Ciarrochi, 2005). It is typically characterised as the transition between childhood and adulthood, and developing greater autonomy is encouraged.

This process may be more complex for second-generation Asian adolescents given the emphasis on interdependency and conformity within Asian cultures (Gupta, 2007). Dugsin (2001) interviewed second-generation male and female Indian adults about their experiences of growing up in North America. Participants described experiencing many conflicts as a result of trying to meet the expectations of two different value systems. Specific cultural pressures included parental control, different behavioural expectations of young men and women, and the need to excel academically. Furthermore, Farver, Narang and Bhadha (2002) found that Indian adolescents reported greater anxiety and family conflict when their parents' acculturation style differed from their own.

Despite the potential risk factors highlighted and the evidence indicating the need for mental health service provision, several studies have drawn attention to the underrepresentation of young Asians in services (Goodman et al., 2008; Hackett, Theodosiou, & Patel, 2006; Minnis et al., 2003). The low uptake of services among Asian adults has been explained by the somatisation of emotional distress (Ineichen, 1990), the use of alternative sources of help such as, traditional healers or family members (Ineichen, 2012), and culturally incongruent interventions (Hussain, 2006).

Some studies have suggested that there are generational differences in attitudes to help-seeking and where help should be sought. Second-generation Asians may be less likely to seek help from a traditional healer due to higher levels of acculturation and greater familiarity with Western conceptualisations of mental health (Cinnirella & Loewenthal, 1999;

Pilkington, Msetfi, & Watson, 2012; Taylor, Brown, & Weinman, 2013; Tabassum, Makaskill, & Ahmad, 2000). As this research pertains to Asian adults, a greater understanding of help-seeking among Asian adolescents is needed to help services to better engage and support this population. This seems particularly timely given the children and young people's improving access to psychological therapies programme is currently being embedded in Child and Adolescent Mental Health Services (CAMHS) across the UK.

Help-seeking has been defined as, "attempts to maximize wellness or to ameliorate, mitigate, or eliminate distress" (Saint Arnault, 2009, p.260). Sources of help can include friends, family, health professionals and religious figures. Help is also increasingly being sought via the internet (Rickwood et al., 2005). Many theoretical models have been proposed to understand the processes involved in help-seeking. The most influential and relevant theories are discussed briefly below.

Andersen's socio-behavioural model attempted to identify characteristics of users and non-users of health services (Andersen, 1968). However, the overly deterministic focus of this model led to the development of dynamic approaches such as the Network Episode Model (NEM), which conceptualises help-seeking as a social process (Pescosolido, 1992). In recognition of the specific influence of culture on the help-seeking process, Saint Arnault (2009) proposed the Cultural Determinants of Help-Seeking theoretical model which provides a framework for understanding help-seeking across different cultures. This model incorporates the meanings attributed to symptoms of distress. It also acknowledges the importance different cultures place on the group versus the individual by considering the costs of seeking help. Given the collectivist orientation of Asian culture, individuals may be concerned about the consequences their distress may have on the family and their izzat. Izzat refers to family honour and status in the community, and plays a powerful role in Asian

family life (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002). This may influence where help is sought or whether distress is kept hidden.

Whilst the models presented above may contribute to our understanding of help-seeking among adolescents, they were developed in relation to adult help-seeking. Costello, Pescosolido, Angold and Burns (1998) highlighted the differences in power adults and young people have over access to health care. Consequently, the NEM was revised (NEM-R) to include family and schools, as they play an important part in recognising problems and facilitating the help-seeking process. More recently, Biddle, Donovan, Sharp and Gunnell (2007) developed the Cycle of Avoidance model. This model suggests that seeking help converts 'normal' distress into 'real' distress. Strategies such as 'normalisation' of symptoms can be used to avoid a diagnosis of 'real' distress as this is associated with stigma.

Goffman (1963) described stigma as a process by which individuals are labelled with an attribute that is socially discrediting. The perceived negative reaction of others to an attribute such as 'mental illness' may deter people from seeking help. Goffman (1963) suggested that the negative reaction of others to discrediting attributes 'spoils' normal identity. Research examining help-seeking among South Asians has suggested that seeking help may not only 'spoil' the identity of the help-seeker, but also that of their family.

Bradby et al. (2007) interviewed parents and young people about their experiences of using CAMHS. Parents were particularly concerned about the impact seeking help might have on their family's social standing as a result of gossip in their communities. Those who had sought help attempted to minimise stigma by describing their child's difficulties as 'naughtiness' and not 'mental illness'. As parents and young people were interviewed together about their experiences, it was difficult to ascertain the views of the young people from the analysis and whether this differed from their parent. Kurtz and Street (2006) carried out focus groups with young people from minority ethnic backgrounds and also found that

stigma was a barrier to seeking help. One Asian participant thought they would be perceived as a 'freak' in the wider Asian community and decided to keep quiet about their difficulties. Another Asian participant stated that young Asians may not be able to talk to their parents about psychological distress, as there was a lack of understanding of these issues.

Neale, Worrell and Randhawa (2009) carried out focus groups with Asian adolescents and found that young people attempted to manage their difficulties independently before seeking help from friends and family. Similarly, Randhawa and Stein (2007) found Asian adolescents were reluctant to speak to strangers about their personal problems. However, concerns about confidentiality, lack of awareness of mental health services and lack of confidence in themselves to approach these services, also prevented young people from seeking professional help (Hackett et al., 2006; Neale et al., 2009). Research suggests that help-seeking and coping are learned behaviours. Adolescents may internalise their parents' coping strategies, and their help-seeking may be influenced by the circumstances in which their parents tend to seek help (Barker, 2007). Therefore, it is also important to consider how intergenerational differences manifest in relation to help-seeking, as the family plays an important role in facilitating help-seeking for children and adolescents (Costello et al., 1998).

Summary

Despite evidence of a need for mental health service provision for Asian adolescents, they are underrepresented in services. Previous research has indicated that the stigma of mental health problems may prevent adolescents and their families from seeking help. Given the specific pressures experienced by second-generation Asians, this study builds on the small number of published qualitative studies to date. This study aimed to focus in more depth on how second-generation Asian adolescents make sense of their experiences of psychological distress, and the meanings they attribute to help-seeking. It is hoped that

exploring this within a non-clinical sample may help services to better engage and support this group.

Research Questions

1. How do second-generation Asian adolescents understand and express psychological distress? And where do they seek help?
2. How does the family influence second-generation Asian adolescents' help-seeking?

Method

Design

A qualitative methodology using in-depth semi-structured interviews was employed. This enabled participants to provide rich accounts of their understanding and experiences of distress which was analysed using interpretative phenomenological analysis (IPA, Smith, Flowers & Larkin, 2009). This idiographic approach was selected to explore how participants made sense of their lived experiences of distress, and the meanings attributed to seeking help.

IPA is interested in participants' subjective experiences of the world rather than an 'objective' reality, and assumes that participants' accounts reveal aspects of their private thoughts and feelings. Epistemological positions commonly adopted in qualitative research in psychology range from radical relativist to naïve realist (Madill, Jordon, & Shirley, 2000). IPA sits between these ends of the continuum, and acknowledges that whilst the experiences relayed by participants are 'real', the data collected does provide direct access to this reality (Willig, 2008). IPA involves a 'double hermeneutic', access to participants' experiences is through interpretation of their accounts. Therefore, the findings can be considered as a co-construction between participants and the researcher (Smith, 1995).

Participants

Nine participants were recruited via purposive sampling. All participants were from two-parent families. See Table 1 for participant characteristics (names have been changed to preserve anonymity). Inclusion criteria required participants to identify themselves as a second-generation South Asian and be aged between 13-19 years. Although this study did not seek to recruit a clinical sample, having a diagnosis of a mental health problem did not preclude adolescents from participating.

Participants were recruited in several ways as the study aimed to access a very specific population. Recruitment posters (Appendix A) were displayed at two sixth-form colleges and a classical Indian dance school. Interested participants were asked to contact the researcher via email for further information. One of the colleges allowed the researcher on-site, and 45 potential participants were approached about the project. Thirty-nine of which met inclusion criteria and requested the information sheet (Appendix B). Seven participants were recruited from these three sites. A further two participants were recruited through social contacts via word of mouth. A sample size of nine was chosen to enable a detailed analysis of each interview in line with recommended guidelines for IPA studies (Smith et al., 2009).

The study was also advertised via posters in two secondary schools and six community organisations throughout London. A member of staff at one of these secondary schools identified ten students from a South Asian background. A jointly drafted letter was sent to the parents of these young people informing them of the study and inviting their child to participate (Appendix C). However, no one contacted the researcher from these sites.

Table 1
Participant characteristics

Name	Age	Gender	Ethnic Background	Religion	Previous contact with services
Janan	13	Male	Sri Lankan (Tamil)	Hindu	No
Christine	14	Female	Sri Lankan (Tamil)	Christian	No
Meera	15	Female	Sri Lankan (Tamil)	Hindu	Sought support from school counsellor
Kajal	16	Female	Indian (Gujarati)	Hindu	GP diagnosed depression. Sought support from school counsellor.
Rohan	16	Male	Sri Lankan (Tamil)	Hindu	No
Abdul	16	Male	Bangladeshi	Muslim	No
Priya	17	Female	Indian (Gujarati)	Hindu	No
Ayesha	18	Female	Pakistani	Muslim	No
Luxmy	19	Female	Sri Lankan (Tamil)	Hindu	No

Ethics

Ethical approval was granted by the Canterbury Christ Church Research Ethics Committee, and the study was carried out in accordance with the code of ethics and conduct (British Psychological Society, 2009). Those expressing interest in the study were given the information sheet and the opportunity to ask questions. If they agreed to take part and demonstrated that they understood what their participation would involve, a date for the interview was arranged. Participants were asked to sign a consent form prior to the interview taking place (Appendix D). For participants under 16 years, a parent was also asked to read

the information sheet and indicate that they had understood what the study entailed before signing the consent form for their child to participate. Participants and parents were reminded that they could withdraw consent at any time. Prior to the interview, participants and parents for those under 16 years were informed that the interview would include questions about personal distress. Issues of risk and the limits of confidentiality were discussed in accordance with this. Participants were given a £10 Amazon voucher for their time.

Interviews

A semi-structured interview schedule (Appendix E) was developed in consultation with research supervisors, one of whom was experienced in working in CAMHS. However, the interview schedule was used as a guide and the course of the interviews was informed by participants' responses. Open questions aimed to elicit participants' experience and understanding of distress and help-seeking behaviour. Interviews took place in a private room in participants' homes, public libraries or community centres and lasted between 52 and 66 minutes. They were audio-recorded and later transcribed.

Data analysis

Data analysis followed the steps suggested by Smith et al. (2009). Firstly, transcripts were read and re-read, then initial reactions, descriptive, linguistic and conceptual comments were recorded. Next, emergent themes were identified by focussing on discrete portions of the transcripts and looking for connections between initial exploratory notes and comments. Themes reflected both the participants' words and the researcher's interpretations.

Connections across emergent themes were identified through abstraction, by clustering similar themes together and developing overarching superordinate themes from this process.

Superordinate themes and their corresponding subordinate themes were then brought together in a table (see Appendix F for an example of a coded transcript and superordinate themes). As IPA is an idiographic approach, these steps were followed for each transcript

which helped to bracket ideas emerging from previous transcripts. The final step involved looking for patterns across cases leading to some renaming and reorganisation of themes. This process produced a master table of superordinate and subordinate themes for the group (Appendix G). In line with Smith et al. (2009) superordinate themes were classified as recurrent if they were present in over half the sample.

Quality assurance

A number of measures were taken to increase the validity of the study. The researcher's position as a second-generation Indo-Mauritian provided an insider's perspective on a version of an Asian family. A bracketing interview was carried out with a colleague prior to data collection to reflect on the researcher's relationship with the topic. This helped bring to light some of the researcher's assumptions about the subject area and consider how they might influence the research process. A research diary was also kept throughout the project to continue recording these reflections (Appendix H). In addition, three coded transcripts were reviewed by the researcher's supervisor who was satisfied that the emergent themes were credible. The aim of this was not to reach consensus but to check that the interpretations made were grounded in the data.

Results

Five superordinate themes emerged from the analysis: overwhelmed by strong emotions, negative impact of family and cultural ideals on the self, connectedness to others, perception of seeking help outside of the family and intergenerational differences in help-seeking. Each of these superordinate themes and their corresponding subthemes are presented in Table 2.

Table 2

Superordinate themes and their corresponding subthemes

Superordinate theme	Subtheme	Participants contributing to this theme
Overwhelmed by strong emotions	Manifestation of distress	All participants contributed to both subthemes
	Coping independently	
Negative impact of family and cultural ideals on the self	No one wants to get below A	Rohan, Abdul, Priya, Christine
	Social comparison	Abdul, Luxmy, Christine, Rohan, Kajal
Connectedness to others	Relationships with friends and family	All participants
	Finding alternative ways to connect with others	Kajal, Ayesha
Perception of seeking help outside of the family	The need to feel understood	Kajal, Meera, Ayesha, Luxmy, Rohan, Priya
	The meanings of seeking professional psychological help	Christine, Abdul, Priya, Janan, Kajal, Luxmy
Intergenerational differences in help-seeking	Awareness of mental health problems and services	Christine, Abdul, Priya, Janan, Kajal, Luxmy, Meera
	Differences in the value of talking as a coping strategy	Kajal, Abdul, Christine

Overwhelmed by Strong Emotions

Participants were asked to describe their understanding and experiences of distress, and the ways it had affected them. Six participants described discrete periods of distress in relation to academic performance, whereas others described experiencing more pervasive

difficulties. As illustrated below, participants used the terms stress and distress interchangeably in their accounts.

Manifestation of distress. Distress was understood as a negative emotional experience which manifested in different ways. Three participants described distress as feeling ‘under pressure’.

Feeling distressed is like when you have lots on your shoulders and you feel really under pressure and just can’t cope... You get stressed out so much that you get to a point where you don’t want to do anything anymore and just give up really (Abdul).

Abdul’s description suggested that this ‘pressure’ could get so intense it was experienced as a crushing weight he was no longer able to ‘shoulder’. Similarly, Luxmy described stress as a ‘pressure on your head’, echoing the feeling of heaviness. This appeared related to participants’ sense of responsibility to uphold family and cultural expectations, which is explored in more depth throughout the analysis.

Kajal described experiencing ‘mood swings’ for several years which contributed to her being expelled from school.

A lot of the time I couldn’t control myself. I felt really sad for like long periods of time. I felt really apathetic towards life and I couldn’t explain the way I was behaving (Kajal).

I felt so ashamed at myself that I was doing this. I was being a massive douche (obnoxious person) to everyone, I was swearing at my mum, I was swearing at teachers (Kajal).

Kajal’s distress and shame appeared linked to her powerlessness to ‘control’ herself. Despite referring to her behaviour as ‘mood swings’, she appeared to lack a framework to make sense

of her experiences. In Ayesha's case, beginning to question her family's religious beliefs in early adolescence seemed to create a hole in her life, and left her feeling lost and without purpose.

I was questioning why are we here? My parents used to tell me to go to the mosque and do these kind of things and I was just going because they were telling me. I didn't believe in God so I just didn't erm know why exactly I was continuing (Ayesha).

Both Kajal and Ayesha felt these experiences set them apart from their family and peers. Looking around them, they were unable to find others experiencing similar struggles, which compounded their distress.

Participants connected their distress with changes in their behaviour. Many talked about withdrawing from family and/or friends, and isolating themselves as a result of their 'negative mood'. However, for most participants these behavioural changes were short-lived. Christine described herself as very active and sociable but felt there was a marked difference in her demeanour when she was stressed about schoolwork.

At school, I would just like not talk to anyone, and to my family, I would just not talk. I would just sit in my room and just like sit there and do nothing (Christine).

The youngest participant, Janan, described losing interest in things he enjoyed, and Rohan felt he became irritable.

I always ask my brother to play with me if I'm going outside, but if I'm feeling stressed I just like some time on my own (Janan).

I got annoyed easily when I was stressed out, normally I wouldn't let it get that far under my skin (Rohan).

The absence of physical symptoms in participants' descriptions of distress may indicate their level of acculturation and subscription to the western mind-body dichotomy of health. Although their experiences of distress varied in severity, their descriptions were consistent with aspects of low mood. The conceptualisation of distress in emotional terms suggest these young people may share a similar understanding to mainstream services.

Coping independently. Participants employed a range of strategies to cope with their distress independently, such as crying or listening to music. Surprisingly, five participants described going to sleep when feeling overwhelmed by their academic and/or extracurricular demands. For some, this appeared to provide a way to temporarily escape or 'forget' about distressing feelings.

Sometimes it's really bad, I'll just get too tired and worn out, then I'll just not do some work and just like sleep so much (Christine).

In addition to these relatively innocuous strategies, two participants had experimented with more harmful ways of coping. Meera began self-harming after being cyber-bullied. She appeared to normalise this as 'just' another way to 'release' her emotions, and its novelty seemed to appeal to her. However, it left her feeling disappointed and ashamed that her attempts to manage her distress privately were now permanently visible to herself and others. Kajal also self-harmed in response to her distress. Her account suggests that this may have been an attempt to cope with her feelings of guilt and shame about her 'mood swings'.

If you cannot cope, you just think that oh here's self-harming, it's just a way that you can release your emotions, let me try it, it's something new...it wasn't that good...it doesn't make me feel like it's a good thing that I have scars, it makes me feel ashamed (Meera).

I had very unhealthy ways of coping with it (mood swings)...back then I would deliberately hurt myself... I just wanted a way to punish myself for it I suppose (Kajal).

Adolescence is a crucial developmental period in western cultures. Trying to cope independently with their distress, may indicate participants' attempts to develop greater autonomy during this transitional stage. However, for some participants, coping independently may also indicate how difficult it can be to ask for help, particularly when their distress highlighted how different they felt to those around them.

Negative Impact of Family and Cultural Ideals on the Self

Participants suggested that there were certain family and cultural pressures associated with growing up as a second-generation Asian in Britain. Six participants spoke about the importance Asian families place on education and pursuing professional careers.

No one wants to get below 'A'. Participants' accounts indicated that the pressure to achieve stemmed from both family expectations and dominant cultural narratives regarding education.

Within the Asian community or the Bengali community like education means everything, like without education you can't get anywhere in life (Abdul).

Therefore, a common source of distress for these young people was their academic performance, and the need not only to do well, but to 'excel'. Whether or not they met these expectations was often determined by their exam results, and as Abdul quipped, 'no one wants to get below (grade) A'. Rohan was hoping to pursue a career in medicine and sat his first GCSE exam aged 13 years. He recalled how he felt before taking this exam and appeared tortured by the fear of failing to meet these ideals.

It was just at the front of my head what happens if this happens (he fails exam), what am I going to do next? Actually sometimes when I was thinking about it I couldn't get to sleep... like a voice in my head just kept on asking questions, the same kind of questions and I couldn't get to sleep (Rohan).

This 'voice's' relentless interrogation which was at the 'front' of his mind indicates Rohan's preoccupation with this fear and the intensity with which it was experienced. Excelling academically appeared linked to maintaining self-esteem and achieving status in the wider Asian community. Abdul spoke of his sense of responsibility to uphold the 'family pride'.

To keep the family pride, it's basically like to keep the standards high so other (Asian) people don't think low of your family...so like if you don't do good it reflects bad on your family as a whole (Abdul).

Abdul and Rohan described feeling 'relieved' after receiving their exam results. Achieving 12 GCSEs at grade A or above affirmed Abdul's self-worth and identity as a high achiever, and served as 'proof' that he could meet parental and cultural expectations. He spoke of his father's elation when he 'called everyone and told everyone' his results. However, for those who were unable to achieve such success there was an absence of celebration for their achievements.

There could be someone who's doing an apprenticeship thing and does really well but you never hear about them. It's kind of worrying. I think like especially in the South Asian community you find that people who do well and go to university and get a really good degree they kind of like, people look up to them more (Rohan).

The need to get a 'good degree' was also shared by Priya, even if this meant sacrificing her social life. Given the cultural value placed on academic achievement and its link to respect, it is, perhaps, unsurprising that many were consumed by the drive to achieve.

I think I can give that up (social life) if I can get a good degree at the end of it (Priya).

Social comparison. Participants felt the pressure they were under became more apparent when they compared themselves with their non-Asian peers. They felt their peers enjoyed greater freedoms regarding their education and choosing an identity other than a high-achiever.

Some of my white friends, they won't get stressed because they don't have the pressure...like they don't really mind what they get for GCSEs...for every homework I think I have to do well in this, I have to do well in this but they just don't have that mind set, which is good (Christine).

Participants also ranked themselves against their Asian peers. This served to highlight how close or far they were from meeting cultural ideals. Whilst Christine felt she worked harder than her non-Asian peers, she felt academically inferior to her cousins, and questioned if she was falling short of these ideals.

I feel like sometimes like that maybe I am lower than them (her cousins) because I didn't get into a grammar school, I didn't do 11+... maybe like I'm not fulfilling my role as like an Asian (Christine).

However, Christine reconciled this by telling herself, 'as long as I know that I'm doing well then it's fine'. Whilst these participants identified family expectations as a specific stressor, their academic achievements suggested that they were able to meet these expectations. This seemed to protect their self-esteem and, perhaps, explained the discreteness of their distress.

In contrast, Kajal's account revealed how different she felt from the 'ideal Asian girl' as a result of her expulsion from school, and mood swings which 'came on without much

warning'. The extracts below indicate the impact these experiences appeared to have on her sense of self.

I would act really polite and like a good student but then something random happened, I don't even know what it was, I can't even explain it, that I would turn around, yell at students, yell at teachers, and I don't even know what was going through my head at the time, it just felt like a blur when I look back at it but then I would go back to being myself (Kajal).

Kajal describes several selves, one that acts 'polite and like a good student', another that cannot be understood or controlled, and 'myself'. There appeared to be a tension between wanting to improve her self-regard by trying to be like the 'ideal' Asian girls she appraised herself against, and the need to rebel and break the mould she did not 'fit into'.

I'm not your ideal Asian girl. There's always this ideal of how you should look in the Asian community, especially being a girl. That girl certainly doesn't get kicked out of school, that girl certainly doesn't have any piercings, or swears, or has a loud mouth and talks about absolutely everything, and I didn't feel like I fit into that...I constantly compared myself to those girls who were the ideal and it just made me feel really insecure and hate myself (Kajal).

Connectedness to Others

Participants' relationships and connectedness with their families and friends appeared to influence whether they felt able to confide in them when they were distressed. Seven participants described close relationships with friends, siblings, and at least one parent. However, two participants described a lack of connectedness to others.

Relationships with friends and family. Five participants identified family expectations regarding education as a specific stressor. However, most of these participants

also described their parents as supportive. When confronted with academic-related distress, these parents were experienced as comforting and reassuring. Janan's account suggested that immediate and extended family have a responsibility to 'make' distressed family members 'happy'. The amelioration of distress was linked to feeling included and connected to others.

If you're like a cousin or brother you should try and make them (cousin/sibling) happy and include that person in whatever they're doing and make them have fun as well (Janan).

Four participants described their relationship with their parents as reciprocal. Two older participants spoke about providing emotional support to their mothers when they were distressed. Their accounts indicated that they employed aspects of western psychological interventions, such as changing thought patterns, when providing support.

Me and my mum are really close so she'll talk to me about it (distress) and...I'll give positive comments, try to change the way she thinks (Priya).

Participants also felt that doing well academically provided a way to give back to their parents. In Luxmy's case, this would allow her to look after her parents and further indicated the interdependence of family members.

I'm really concerned that I need my degree and to get a good job because I've got so many dreams for the future and what I should do for them (parents), because of what they've done for me (Luxmy).

In contrast, Ayesha described a lack of closeness with her parents and her peers. Despite feeling that she did not have 'anyone' to talk to, her account did reveal an attempt to share her difficulties with her mother. However, the 'shocking' nature of her distress deterred her from pursuing this, as her mother's refusal to consider a worldview other than her own was silencing.

Once I said to my mum, “what if I didn’t believe in Islam?” and she said “what are you going to be then, a Hindu? A Christian?” I said “no no” and we were laughing. I said to her “what if I didn’t believe in a God?” and my mum was just like “what are you saying?” And then I didn’t further that conversation because she didn’t even consider that, she was so shocked when I said that (Ayesha).

As the only Asian girl in her year group, Ayesha also felt that cultural differences set her apart from her peers, and further contributed to her feelings of isolation.

I would tell her (best friend) that I wasn’t allowed to go out and she wouldn’t understand, she would think I didn’t like her and we would have those arguments that you have during teenage years where you just don’t talk to each other... all of my friends were like that and they just didn’t understand why my dad was being like that and why I couldn’t hang around with guys (Ayesha).

Kajal also felt very alone. She described a hostile family environment, where no attempts were made to understand or validate her distress.

I was sitting up in my room crying, my dad walked up and told me I should stop crying because it makes me look stupid which is the wrong approach, but that made me feel even more distressed, made me feel like I had to shove things down (Kajal).

Kajal’s assertion that this was the ‘wrong approach’ suggested that that her attempt to seek comfort was, instead, met with rejection.

Finding alternative ways to connect with others. Both Kajal and Ayesha described feeling alienated from their family and friends, and rejected by their wider Asian communities for becoming a ‘failure’ and for ‘trying to be White’ respectively. Seeking support online provided them with an alternative way to connect with others anonymously.

They appeared to increase their connectedness by developing relationships in a virtual community where perhaps they felt more accepted.

I have this one internet friend where I talk to her about anything that's going wrong in my life and she's so unjudgemental because she hardly knows me she can't tell other people, she can't judge me, she's just there to listen to me (Kajal).

I made friends through that (online forum) and after I started messaging them privately through that website then I guess then I started talking to them about my life and then they talked to me about their life (Ayesha).

Perception of Seeking Help Outside of the Family

All participants spoke about their attitudes and beliefs regarding seeking help outside of the family. Three participants described their experiences of seeking help and others discussed the meanings of this act.

The need to feel understood. Whilst most participants confined help-seeking to their friends and family, three participants sought help from other sources. In her despair, Ayesha researched the 'quickest way to end things' and came across some religious websites offering support. She contacted an Imam online and felt her distress was finally understood, which gave her hope and prompted her to look at 'different ways of life'. This seemed very important in helping Ayesha find her purpose, and reconnected her with her family's beliefs.

I looked at every way of life and came to believe that there is a God because I never believed there was a God...I went on the internet did loads of research and I'm Muslim now and I'm happy (Ayesha).

Meera and Kajal sought help from a school counsellor and described the experience as cathartic. Meera appreciated being able to ‘rant on and on’ and Kajal found it helpful to share her distress rather than ‘shove things down’. Seeking help from strangers alleviated their concerns about being ‘judged’. They both felt that their counsellor had helped them feel understood in a way that other people in their lives could not. Interestingly, Meera’s counsellor’s disclosure that she had also self-harmed as a teenager provided Meera with hope.

She (counsellor) said she had also been through it and she knows how I feel...so like it kind of made me feel like, ok she’s gone through it, she’s helped lots of other girls, so why not try and help me. So I went to her and yeah it worked (Meera).

In contrast, three other participants felt strangers would not understand or take seriously their difficulties, as they were removed from their context. Luxmy felt professionals ‘would try and help’ but would be unable to understand her difficulties in the way that those who knew her well would, especially given the ‘tens of hundreds of people coming along with their problems as well’ (Rohan).

I don’t know how they (professionals) would take it, they would try and help but they wouldn’t understand what I’m going through (Luxmy).

The meanings of seeking professional psychological help. Despite concerns about not feeling understood, participants without experience of seeking help outside the family thought professional help would be helpful. However, this was in relation to young people without family and friends to support them or their non-Asian peers. Christine identified mental health services as the ‘only other choice’ for these young people. Implicit in her account was the idea that families should have the resources to contain distress. Similarly, Abdul’s account suggested that seeking help outside of the family indicated a lack of closeness which was atypical of Asian families.

If I was by myself and I didn't have anyone to guide me then I would definitely consider going to one of them (mental health service) because I think they can help you a lot, like that's the only other choice really if you don't have support from your family (Christine).

In general, they're (non-Asians) not as close as Asian families are so they'd rather talk to someone about it they don't know who can offer them advice (Abdul).

Priya felt that 'issues' took on greater significance and became 'larger' when professional help is sought. In response to this, problems were downplayed or normalised, possibly in an attempt to avoid or negate the need to seek professional help.

I never saw an issue as being a serious thing, it's just like with my family, you just deal with it and carry on, it's nothing, you don't feel it as if it's a proper issue and that can be good and that can be bad as well, yeah. It's just the way my parents have always been, ok it will be better next time, it will be better later, like there could be worse situations and that downplays the seriousness of your issue and that would mean that I wouldn't go looking for like a service to help me (Priya).

Therefore, emphasis is placed on coping independently by waiting for things to improve or considering that there could be 'worse situations'. This makes it difficult to ascertain what constitutes a 'proper' issue warranting intervention. The stigma of mental health problems highlighted in participants' accounts may have contributed to downplaying the seriousness of issues. Janan felt having a mental health problem would be 'worse than a disability'.

I'd rather feel happy and have a disability because even though you can't do much stuff, you can still feel happy and proud of yourself, but if you have mental health problems you might think something bad about yourself even though you can probably do more stuff (Janan).

Janan describes physical and mental health as dichotomous. He equates mental health problems with the permanence of a disability, and suggests they are unremitting and associated with shame. Kajal spoke about the stigma of mental health problems in the Asian community. She was initially reluctant to seek help as this meant acknowledging that there was ‘something wrong’ with her.

I didn’t want to go counselling for that reason because it had this whole stigma on it that people would know that there was something wrong with you (Kajal).

Priya felt this would prevent families from speaking openly about seeking help as they would not want to ‘be seen negative to the rest of the (wider) family’. Therefore, families were described as ‘private’ and participants regularly stated that problems were kept between close and trusted family members and not ‘exposed’ to those outside of this circle. Luxmy’s account suggested these measures were necessary to avoid scandal.

If there was a small thing that leaked out of a family it will just turn into a massive story from what I know (Luxmy).

The need for families to protect their reputation and present themselves in a positive light, emphasised keeping the circle tight to prevent anything ‘leaking’ out to the wider family or community.

Intergenerational Differences in Help-seeking

Seven participants described intergenerational differences in awareness of mental health services, coping strategies used or help-seeking behaviours.

Awareness of mental health problems and services. None of the participants felt that their parents would initiate seeking professional help as this would mean stepping outside of established ways of coping. This was partly attributed to a lack of awareness of mental health services and many felt this could be addressed through advertising. Priya’s account suggests

that Asians may be more receptive to learning about services from people they know and trust via word of mouth.

It's like if you know more about it (mental health services), you can help other people that are around you, erm I think South Asians listen a lot to friends (Priya).

Three participants felt their parent's limited awareness of services may be related to these not being widely available in their countries of origin. Janan indicated that mental health problems were afforded more attention in England compared to Sri Lanka. His account suggested that this may have influenced whether his parents felt mental health problems were 'serious' enough to warrant seeking help.

They (in Sri Lanka) might not take it (mental health problems) as seriously as they do in England because it's not that rich there, they won't have that many doctors to help them out, so I think in England they would pay more attention to that (Janan)

Meera and Kajal suggested that intergenerational differences in the understanding of their distress contributed to them seeking help outside the family. When Meera eventually told her mother about her self-harming, she felt this was met with scorn as her mother did not understand the impact being called 'fat' and 'ugly' had on her self-esteem. She was also 'unfamiliar' with self-harm as a coping strategy.

Her view (mother) is that if someone insults you, erm she doesn't see the point in self-harming, she doesn't see the point in that, why would you do that, and she looks down on it (Meera).

Differences in the value of talking as a coping strategy. Whilst all participants indicated that their parents would eventually seek help from each other or close family members if they were experiencing distress, some felt their parents placed different value on talking about distress compared to themselves. In Kajal's case, this was related to her parents'

belief that, 'it's not good to get out your emotions'. This led to an avoidance of talking about her distress when they learned of her self-harm.

I think they've (parents) actually forgotten (about her self-harm). My parents forget things sometimes or they just block it out (Kajal)

Kajal's account suggested that 'forgetting' about her self-harm allowed her parents to protect their community image as an 'ideal family where nothing is going wrong', perhaps in the hope that these difficulties would resolve themselves. Two participants spoke about the value their parents placed on private prayer as a coping strategy. Unlike his parents, Abdul felt he had been socialised to the idea of talking about his feelings to those outside of his family by his teachers at school.

They've (parents) got that way of life where they think that God will make everything ok. I do believe that but then at the same time I wasn't raised in the way that I think just talking to God will help. I think talking to an actual person about it will help as well (Abdul).

The utility of private prayer was also shared by Christine, who described her parents as 'strict' Catholics. Christine's account suggested that her parents associated talking about their difficulties with bringing 'bad onto others' which could in turn make their distress worse.

They'll (parents) feel like if bring my bad onto others that erm I will, it's like karma kind of that I'll get bad myself... I know it's good to like talk to others as well which is what I do normally but I think for them it's just easier just to keep it within themselves (Christine).

Discussion

The present study aimed to understand second-generation Asian adolescents' experiences of psychological distress, and the meanings attributed to help-seeking. This section will discuss each of the research questions in light of previous findings and conclude by considering research and clinical implications.

1. How do second-generation Asian adolescents understand and express psychological distress? And where do they seek help?

Distress was understood as a negative emotional experience and associated with behavioural changes. These included participants isolating themselves, losing interest in things they enjoyed and becoming irritable. For most participants, these changes were short lived; however for some, they were more enduring. Whilst it was not the aim to pathologize participants' distress, in many ways these 'symptoms' were consistent with those included within the Western construct of depression (American Psychiatric Association, 2013). Unlike previous research suggesting that Asian adults somatise emotional distress, none of the participants included physical symptoms in their descriptions of distress. This difference may be explained by their level of acculturation, as they were born and educated in the UK. Consequently, they may subscribe to the Western mind-body dichotomy, and share a similar conceptualisation of distress.

A common source of distress for participants was their academic performance. 'No one wants to get below A' emerged as an important subtheme. This revealed participants' sense of responsibility to uphold the 'family pride' by excelling academically. Failure to meet cultural ideals or share family beliefs appeared to have a profound effect on sense of self. As the concept of izzat is closely linked with the fear of bringing shame to the family, this may also have contributed to the 'pressure' experienced by participants. The need to excel academically was consistent with the stressors described by Dugsin (2001). This appeared to

provide a way to gain approval from families and the wider Asian community. In line with Neale et al. (2009) and Randhawa and Stein (2007) participants attempted to manage their distress independently as well as seek help from their friends and family. The ‘connectedness to others’ theme highlighted close and interdependent relationships between most participants and their families. Whilst family expectations were commonly cited as a source of distress, for participants invested in meeting these expectations, families were also described as a great source of help and comfort. Conceptualising distress in emotional terms and seeking help from family members, may reflect participants’ attempt to integrate both the norms and values of their families and the dominant western culture.

2. How does the family influence second-generation Asian adolescents’ help-seeking?

Parental level of acculturation and appraisal of their adolescent’s distress appeared to influence help-seeking. Distress related to academic performance appeared familiar and understandable to parents. However, participants describing difficulties typically seen in CAMHS, such as self-harm, felt this was not understood or acknowledged by their parents. This was consistent with Kurtz and Street’s (2006) finding that young Asians may feel unable to talk about certain psychological problems with their parents. In these circumstances, participants sought help online or from a school counsellor. The experience of feeling understood appeared to provide young people who were self-harming or contemplating suicide with hope. In line with the NEM-R (Costello et al., 1998), the findings emphasise the role of schools in recognising distress and facilitating help-seeking, particularly when families may not understand nor are familiar with adolescents’ difficulties.

‘Perception of seeking help outside the family’ emerged as a key theme. Participants who confined help-seeking to within the family believed seeking professional help would be helpful for those without family to support them. Implicit in participants’ accounts was the assumption that families should have the resources to manage distress. Unlike the adult help-

seeking literature which identified traditional healers as a common source of help, none of the participants were aware of their parents seeking help outside of the family. Therefore, participants with close relationships with their parents may have internalised the primacy of the family as the container for distress. However, it is important to recognise the differences in severity of participants' experiences of distress, and that in most cases, confining help-seeking to within the family seemed appropriate.

The 'meanings of seeking professional help' subtheme highlighted the stigma associated with mental health problems, and the impact seeking help may have on a family's social standing. This is consistent with the findings reported by Bradby et al. (2007). The need for families to protect their reputation and present themselves in a positive light may explain their reluctance to be labelled with a socially discrediting attribute such as 'mental illness'. Consistent with Goffman's (1963) theory of social stigma, participants appeared concerned that this may 'spoil' their identity. Minimising problems appeared to be a strategy to negate the need to seek professional help. This was also described in the Cycle of Avoidance (Biddle et al., 2007), and allowed participants to avoid the risk of being diagnosed with 'real' distress. The results suggest that professional help-seeking is influenced by the interplay between several factors: not meeting family ideals, intergenerational differences in understanding of distress, and the stigma of mental health difficulties.

Overall, the findings support the existing adult help-seeking literature highlighting the family as a primary source of help (Ineichen, 2012). However, this paper extends our current understanding of adolescent help-seeking by illuminating the complexities of seeking help from the family, and the conditions under which this may or may not occur.

Limitations

The sample included adolescents from different South Asian cultural and religious groups which implies homogeneity, and overlooks inter-group differences in experiences. However, given the difficulties in recruiting this specific population and the importance of including their voices in the literature, it was felt to be a necessary compromise. The sample was also self-selected and it is difficult to know how these adolescents may differ from those who chose not to participate.

In addition, the researcher's position as a second-generation Asian trainee clinical psychologist may have elicited more positive responses to seeking help from services. It is also possible that participants may have assumed the researcher possessed 'insider' knowledge, and withheld certain aspects of their experience. Finally, despite attempts to bracket and record assumptions during the research process, the researcher's experiences may have led to some interpretations being privileged over others, such as her awareness of the stigma of mental health difficulties within her own community.

Clinical Implications

The findings highlighted that intergenerational differences in levels of acculturation may result in a lack of understanding of adolescents' distress. Therefore, schools have an important role in recognising difficulties, providing support and facilitating a dialogue between the different perspectives of parents and adolescents. This may involve greater liaison and consultation with CAMHS, including working jointly with teachers to provide groups or support sessions in schools. Given the cultural pressure to excel academically, these sessions may also provide an opportunity to gain peer support. Participants suggested providing more information about services in Asian communities. However, given the impact seeking help may have on a family's social standing, increasing awareness alone is unlikely

to improve engagement. Parents are often the gatekeepers to services, particularly for younger adolescents. Increasing links with first-generation parents via community outreach, and collaborating with existing sources of help, such as religious and community leaders, may facilitate greater understanding of child and adolescent mental health problems and opportunities to address stigma. Gardner and Davis (2014) refer to today's youth as the 'app generation', and highlight the pervasiveness of digital media in adolescent life. In keeping with the advances made in digital communication, the findings also suggest that the provision of online services may be an effective way to engage young people, and perhaps offer a less stigmatising way for adolescents to access help.

Future Research

The findings highlighted that the Asian community has a powerful influence on the lives of Asian adolescents. Future research could explore meanings attributed to help-seeking in adolescents raised in less diverse areas without a wider Asian community. It is also important to disaggregate this population and explore inter-group differences in understanding of distress and meanings of help-seeking. In addition, engagement with services may be improved by investigating facilitators to seeking help with adolescents who are accessing mental health services.

Conclusion

This study aimed to understand second-generation Asian adolescents' experiences of psychological distress, and the meanings attributed to help-seeking. Whilst a common source of distress for these adolescents was family expectations, the findings also highlighted the primacy of the family as a source of help to those invested in pursuing culturally prescribed goals. However, those experiencing difficulties their families did not understand, such as self-harm, sought help from alternative sources. Professional help-seeking appeared to be influenced by the interplay between not meeting family ideals, intergenerational differences in understanding of distress and the stigma of mental health problems. Increased links with first-generation parents and the wider Asian community are important in providing an understanding of mental health problems and addressing stigma.

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Section C

Appendices of Supporting Material

Are you from a South Asian background?
Are you aged 13-19?

If YES, my name is Vanessa
and I would really like to
hear your views about stress
and coping.

What will it involve?

- ❖ Meeting with me **once** in London for 45-60 minutes.
- ❖ Getting up to **£10** for your travel expenses.
- ❖ And a **£10**  voucher for taking part.
- ❖ That's it!



If you would like to take part or find out more
information, please contact me on
v.gunpath51@canterbury.ac.uk



Participant Information Sheet

Understanding stress in South Asian young people

Hello. My name is Vanessa Gunpath and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. If you would like further information or if anything is unclear then please contact me.

What is the purpose of the study?

I am interested in exploring how young people from South Asian backgrounds think about stress and coping. I am particularly interested in the views of second generation young people, whose parents were born and raised outside of Britain. This information may help child and adolescent mental health services support young people from South Asian backgrounds.

Who is organising and conducting the research?

The research is being overseen by Dr Helen Caird, Clinical Psychologist and Dr Nidhi Dholakia, Clinical Psychologist. The study is being carried out by myself, Vanessa Gunpath, a Trainee Clinical Psychologist at Canterbury Christ Church University.

Why have I been invited?

I am inviting South Asian young people to take part in this study. It is up to you to decide whether or not you want to take part. If you do want to be involved then I will ask you to sign a consent form so that I have a record of your agreement to take part. However, you would be free to withdraw at any time without giving a reason.

If you are under 16, I will ask your parent/ guardian if they are happy for you to take part, and to also sign the consent form. If you are aged 16-18, I will ask if you have understood the information sheet and ask you to sign the consent form. I will not inform your parent/guardian of your involvement in the study. However, I would encourage you to talk to your parent/ guardian before deciding to take part.

What do I have to do if I decide to take part?

As part of this study, I would like to interview young people about their thoughts about stress. If you decide to participate you will meet with me to take part in a single interview which will last for up to one hour. The meeting will be arranged to take place at a time that is mutually convenient. The sort of questions you may be asked about include what you might

do to show you were feeling stressed. There are no right and wrong answers, and you are free not to answer any question you feel unhappy with.

With your consent, the interview will be audio recorded and only the researcher (Vanessa Gunpath) will be allowed to listen to recordings. The recording will only be used for the purposes of this research and will be destroyed after the interview is transcribed. Some of your comments may be quoted when the research is written up; however, each comment will be completely anonymised.

Expenses and payments

Taking part is voluntary and you will not be paid for agreeing to take part. I can however, provide £10 for your travel expenses.

Are there any risks or concerns associated with taking part?

There are no direct risks from taking part. However, I do understand that some young people might feel nervous about meeting with a new person and talking about their views. You will not have to answer any questions you do not want to. If you feel uncomfortable at any time, you can take a break or decide to stop the interview at any time.

What are the possible benefits of taking part?

I hope the information I collect will help services to better support and engage South Asian young people accessing child and adolescent mental health services.

What will happen to the results of the study?

The results of the study will be written up as part of a Doctorate in Clinical Psychology. Anonymised quotes from your interview may be used in the final report to help explain the key findings. The research may also be published in a research journal. However, any information that is made public will be completely anonymous and will not include anything that could be used to identify you. All information that is collected and stored about you will be kept confidential and anonymised.

Who has reviewed this study?

All research carried out by students of Canterbury Christ Church University is looked at by independent group of people, called a Research Ethics Committee, to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by Canterbury Christ Church University Research Ethics Committee.

What if there is a problem?

If you have any concerns with any aspect of the study, then please speak to me. If you would prefer not to speak to me, you can as an alternative contact Helen Caird, Research supervisor. We will do our best to answer your questions. I can be contacted on v.gunpath51@canterbury.ac.uk and Helen can be contacted on helen.caird@canterbury.ac.uk

If you remain unhappy and wish to complain formally, you can do this through Salomons, Canterbury Christ Church University. Details can be obtained from Deborah Chadwick on deborah.chadwick@canterbury.ac.uk.

If you are distressed by taking part in the study, then please contact me or Helen Caird to talk through any concerns or queries you have about the study.

If completing the study brings up wider issues, then we would suggest that you contact your GP.

Contact details for researchers

If you have any questions or concerns about the study, please get in touch using the contact details below.

Vanessa Gunpath
Trainee Clinical Psychologist
Email: v.gunpath51@canterbury.ac.uk

Dr Helen Caird
Research Supervisor
Email: helen.caird@canterbury.ac.uk

Appendix C: Invitation letter to parents at one recruitment site

Dear Parent's name

I am writing to introduce myself. My name is Vanessa and I'm an Asian Trainee Clinical Psychologist. As part of my training, I am doing some research looking at how South Asian young people think about stress and coping. I have approached [REDACTED] School and asked whether I can interview South Asian young people at the school about their views, and they have agreed for me to contact you with some information about the project so you can decide whether you would like your child to take part.

The interview will involve your child meeting with me once for approximately 45 minutes at [REDACTED] School and discussing their thoughts and experiences about stress and coping. There are no right or wrong answers - I'm really interested in young people's views. I am hoping that the information I collect will help mental health services better understand and support South Asian young people and their families.

As your child is from a South Asian background, I am writing to ask whether you would like your child to take part in this project. If you would like your child to take part, please can you email me by Wednesday 10th December 2014 on: v.gunpath51@canterbury.ac.uk

The interviews will be taking place at [REDACTED] School on Monday 15th December. The interviews are confidential and will not be shared with anyone else. Quotes from your child's interview may be used when the research is written up but these will be completely anonymised. I have enclosed my information sheet with further information about the project.

Please contact me on v.gunpath51@canterbury.ac.uk if you have any questions.

I look forward to hearing from you.

Best wishes

Vanessa Gunpath
Trainee Clinical Psychologist

Appendix D: Consent form



Participant Consent Form

Understanding stress in South Asian young people

Please initial box

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information and ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason.

3. I understand that my interview will be recorded

4. I agree that anonymous quotes from my interview may be used in published reports of the study's findings.

5. I agree to take part in the above study.

Name of Participant

Signature of Participant

Date

Name of Parent/Guardian

Date

Signature

Appendix E: Interview schedule

1. Could you start by you telling me a little bit about yourself?

Prompts: hobbies, interests, subjects at school

2. What do you understand by the term feeling distressed?

3. Can you describe a time when you felt really distressed?

Prompts: What happened? What did you do? How did you feel?

4. What do you do when you're feeling distressed?

Prompts: What do your family do? What do your friends do?

5. If you were having a really hard time, where would you go first for help?

Prompts: Where would your family go first? Where would your friends go?

6. What is your understanding of mental health services?

Prompt: What do you think is your family's understanding of mental health services?

7. What do you think is important for mental health professionals working with South

Asian young people like yourself to know?

Appendix F: Superordinate themes from a coded transcript

Manifestation of distress

Anxiety
Hopelessness
Despair
Anger
Difficulty expressing herself
Feeling lost
Crying

Social connectedness

Feeling alone
Feeling different to others
Being visibly different to others
Different parental expectations to peers
Alone with distress
Isolated self
Distant relationship with parents
Boundaries with others
Connecting with people online
Developed relationships online
Feeling less alone
Others are rejecting
Others are bad
Withdrew from others
Lack of family communication
Distant relationship with dad
Lack of closeness with parents
Does not confide in sister
Alienated from family
Complex family dynamics
Distant relationship with mum
Rejected by Asian community

Poor sense of self

Lack of sense of self
Feeling defective
Low self-confidence
Critical of self
Something wrong with me
Feeling abnormal
Experimenting with self-expression
Dad communicates with family via insults

Seeking help

Looking for answers

Finding a sense of purpose

A place of understanding

Can't trust sister with her feelings

Looking for a psychologist

Not feeling heard

Seeking help from an Imam

Trust is key

Fear of judgement

Lack of privacy

Mum wouldn't understand her distress

Intergenerational differences in help-seeking

Parents cope using private prayer

Dad keeps to himself

Mum confides in sister

Dad only trusts family

Appendix G: Master table of themes for the group

Overwhelmed by Strong Emotions

Manifestation of distress

Abdul: You feel really under pressure and just can't cope.

Luxmy: Pressure on your head

Rohan: Feeling stressed is like feeling under pressure

Janan: I might just be in my room for the whole day or just walk around the house not talking to people that much

Priya: Distress is when you try to get it (revision notes) done but it's not working and it's like negative thoughts that you have, I can't do this.

Ayesha: I didn't believe in God so I just didn't erm know why exactly I was continuing

Kajal: I couldn't control myself. I felt really sad for like long periods of time.

Meera: There was a long period when I didn't talk to any of my family members. I didn't even tell them my problems, I didn't even go down to get dinner, I would take my plate up to my room.

Christine: I would just not talk. I would just sit in my room and just like sit there and do nothing

Coping independently

Priya: When I'm in that state you can't actually think about anything like if you think about trying to do one thing you just realise oh I've got this other thing to do as well so once I've slept I can think about what I need to do and then I'm like I can get this done.

Abdul: I think sleep's the best way, it just helps you get rid of everything, just sleep yeah sleep all day

Janan: I feel more relaxed and stuff when I get up, it (sleep) makes me feel a bit better

Rohan: I'll just go to sleep and forget about everything

Christine: Sometimes it's really bad, I'll just get too tired and worn out, then I'll just not do some work and just like sleep so much

Ayesha: I cried, yeah that's basically what I did

Kajal: I had very unhealthy ways of coping with it (mood swings)...back then I would deliberately hurt myself

Meera: If you cannot cope, you just think that oh here's self-harming, it's just a way that you can release your emotions, let me try it

Luxmy: I literally just cry

Negative Impact of Family and Cultural Ideals on the Self

No one wants to get below A

Rohan: I was scared what would happen if I would fail

Abdul: I was afraid I was going to fail, just fail everything like it was mostly like I'd be a disappointment to my family and stuff like I'd look bad.

Priya: I think I can give that up (social life) if I can get a good degree at the end of it

Christine: Some people got chosen for AS RE, so it's like A-level RE and erm I don't know why I accepted to do it but like we got an essay and I was crying for ages over it because I couldn't like work myself up to do it like I just didn't know what to do for like ages

Social comparison

Abdul: I don't think they (non-Asian peers) would be as stressed as us in this situation... most of my non-Asian friends didn't really care about exams, not not care but they didn't care if they got C's and B's and stuff whereas all of us Asians wanted to get A's and A*'s, like straight A's.

Luxmy: Well education isn't a pressure for them, it's like they do what they like to do, they learn like the (degree) course they want to do and they're more individual the non-Asians.

Christine: Some of my white friends they won't get stressed because they don't have the pressure...like they don't really mind what they get for GCSEs.

Rohan: They (Asian friends) say my mum knows this guy who got this many A*s, did this work experience.

Abdul: I've got loads of peers in my age group that my family know and just family friends, cousins and stuff that are all the same age, we all did GCSEs at the same time so I felt like I had to do better than all of them.

Kajal: I constantly compared myself to those girls who were the ideal and it just made me feel really insecure and hate myself.

Christine: I feel like sometimes like that maybe I am lower than them (her cousins) because I didn't get into a grammar school.

Connectedness to Others

Relationships with friends and family

Janan: If you're like a cousin or brother you should try and make them (cousin/sibling) happy

Meera: I open up to like my mum, I open up to dance teacher a lot because I've known dance teacher since I was six so I open up to her quite a lot, she's like a second mother to me and my best friends.

Christine: I just get like support from everyone in my family really in different ways erm so yeah I just like talk to my mum for ages and be like I just can't do this.

Rohan: I kind of feel responsible to do well (academically) for my parents, they spend a lot of money on me. I want to study as well, but I know that I'm going to make my parents happy and proud at the same time

Abdul: I felt like I had to get really really good grades to actually make my dad happy that he spent the money on me (for private school).

Luxmy: If it was to do with finance problems (her mother's distress) then I would try and get a loan or if I've got money from my student loan I would obviously help them or talk to the bank myself. If it was just like other problems I would try and look at the positives.

Priya: Me and my mum are really close so she'll talk to me about it (her mother's distress) and...I'll give positive comments, try to change the way she thinks.

Ayesha: I didn't have anyone in my family to talk to and I didn't have anyone outside of the family to talk to.

Kajal: I still have this paranoia in the back of my head that my friends don't actually like me so I didn't usually go and talk to them.

Finding alternative ways to connect with others

Ayesha: I made friends through that (online forum).

Kajal: I have this one internet friend where I talk to her about anything that's going wrong in my life

Perception of Seeking Help Outside of the Family

The need to feel understood

Kajal: She's (counsellor) not judgemental and she understands me

Meera: She (counsellor) said she had also been through it and she knows how I feel

Ayesha: So I contacted them (Imam) and said I'm feeling this way and I'm doing this and they responded to me and gave me articles and stuff

Luxmy: I don't know how they (professionals) would take it, they would try and help but they wouldn't understand what I'm going through

Rohan: If I had a problem and I told my mum she would take it seriously whereas if I told someone at a service they've probably seen loads of other people as well, they might not think it's as serious.

Priya: I don't think the person (professional) would understand, yeah they wouldn't understand.

The meanings of seeking professional psychological help

Christine: Like that's the only other choice really if you don't have support from your family.

Abdul: They're (non-Asians) not as close as Asian families are, so they'd rather talk to someone about it they don't know.

Priya: Talking to friends is minor, when you go to a doctor you view it as larger.

Janan: Mental health problems are a bit worse than having a disability

Kajal: I didn't want to go counselling for that reason because it had this whole stigma on it that people would know that there was something wrong with you

Luxmy: It will just turn into a massive story from what I know

Intergenerational Differences in Help-seeking

Awareness of mental health problems and services

Janan: They (in Sri Lanka) might not take it (mental health problems) as seriously as they do in England because it's not that rich there.

Christine: Because how they (parents) grew up, it (services) wasn't an option there (Sri Lanka) so it's not an option here either.

Priya: They don't know it's there, (mental health services) if they know about it they know about what they can do

Abdul: As my mum and dad didn't grow up in this country, I don't think they have a full understanding of mental health services and how they could take advantage of it.

Luxmy: They (parents) wouldn't be aware of what they (services) can do for you.

Meera: She (mother) came here (England) when she was 16, so she is very modern compared to most Tamils, but she didn't know anything like self-harm. She didn't see the point in hurting yourself when other people are just calling you fat and ugly.

Kajal: I feel like British children could talk to their parents because they parents have grown up in the same country and experienced the same sort of issues.

Differences in the value of talking as a coping strategy

Kajal: Getting out your emotions is actually really healthy and I wish they (parents) would do that more.

Abdul: They've (parents) got that way of life where they think that God will make everything ok.

Christine: The first person she'll (mother) got to is definitely God and she'll just pray for hours in her room.

Appendix H: Abridged research diary

June 2014

Contacted so many schools, colleges and community organisations but rarely managed to persuade the receptionist to give me the contact details of the appropriate person to speak to about my project. I am beginning to worry that I underestimated how hard recruitment would be. One college agreed to display my poster but would not let me on site to talk to young people about the project. I finally got a call back from a large Asian community service I have contacted several times now. The project leader told me that they are bombarded with research requests but she decided to call me back because I'm Asian, and the young people had experienced feeling 'othered' by previous researchers. Being a 'cultural insider' seemed to facilitate greater access and she agreed to circulate my poster and information sheet to the young people at the service but would not let me meet with them to discuss the project. There seemed to be a need to keep researchers at a certain distance as a result of negative previous experiences.

July 2014

I met with another trainee for a bracketing interview. I found this helpful in thinking about how my project brought together my interest in child and adolescent mental health and the impact of culture on the experience of distress. I reflected on discussions within my wider family about mental health and my attempts to challenge the dominant narratives of stigma and 'madness'. I became aware that I was expecting to hear lots of stories of stigma and made a note to monitor this.

Sept 2014

Had my first interview today and felt quite nervous. He seemed to be a very motivated and high achieving adolescent, and appeared to have lots of resources to maintain his well-being. He talked about taking his first GCSE exam and his fear of failing in relation to his experience of distress which left me disappointed at first, as I couldn't help thinking that feeling stressed about exams was not an unusual response and perhaps was less clinically interesting to me. However, after transcribing the interview and discussing my thoughts in supervision, I reflected on the cultural value placed on doing well academically and its link to respect indicated during the interview. I wondered if I had underestimated his distress. At the time of our interview his status as a high achiever had been established by attaining very high GCSE results. However, I wondered what would have happened if his fear was confirmed and he 'failed' that exam. I was left curious about the meanings he attributed to failing and not doing well, and the impact this might have had on his self-esteem. If he had failed this exam, would he have shared this with me?

Oct 2014

I did my third interview today, this felt very different from my two previous interviews which were focused on experiences of distress in relation to education. When she spoke of the nature of her distress in her early adolescence and her complex family dynamics, the challenge for services to reach such young people were brought home to me. I was impressed by her resilience and attempts to seek help from different sources, particularly as she seemed to have entered a different phase of her life and be in a much better place psychologically at the time of the interview.

Nov 2014

My fifth interviewee was very open about some of her difficulties and talked about failing to meet cultural expectations. Prior to the start of the interview, she talked about having an interest in psychology but said her parents referred to this as a 'dummy' subject unlike medicine. During the interview, she talked about constantly comparing herself to other Asian girls who were the 'ideal' which left her feeling 'insecure'. I wondered how she perceived me. I wondered whether she felt that I too had fallen short of cultural ideals by pursuing psychology and therefore felt less intimidated and able to relate her difficulties more freely?

Jan 2015

I've completed eight interviews now and many young people have spoken about family pressure to excel academically but also feeling their families are supportive. Participants describing poor relationships with their families seemed to have also described more severe experiences of distress including self-harm. Some of the young people asked me if I was Asian or said, 'you know how Asians are', suggesting they thought I possessed inside knowledge and might have had similar experiences to them. I wondered how this might have influenced what they told me - whether they had held back parts of their experience assuming I already had knowledge about these issues. Participants without experience of seeking help outside of the family spoke positively about mental health services and I wondered whether my position as an Asian trainee clinical psychologist had elicited more positive responses about mental health and help-seeking.

Appendix I: Ethical approval

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Appendix J: Completion of study

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Appendix K: Submission guidelines for Mental Health, Religion and Culture

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