

**How Do People from the Indian Gujarati Community
Make Sense of Help-Seeking for Mental Health Problems**

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A thesis submitted in partial fulfilment of the requirements of the
University of East London for the degree of Doctor of Clinical
Psychology

May 2016

ABSTRACT

Background: Ensuring equal access and good quality care for minority ethnic groups has been a long standing concern for mental health services in the UK. The South Asian community are a minority group who are significantly under-represented in mental health services. Various factors have been suggested to account for their limited help-seeking. However, the existing research concerning South Asian communities has homogenised this group, this is problematic as it does not allow for the heterogeneity between South Asian subgroups to be attended to. Little is known about how individual South Asian subgroups, make sense of help-seeking for mental health problems. The objectives of this study were to explore how the Indian Gujarati community, a specific South Asian subgroup, understand mental health, where they go to seek help for mental health problems and the factors that facilitate or hinder them in seeking help.

Method: Semi-structured interviews were conducted with nine Indian Gujarati people recruited from the community. Transcripts were analysed employing thematic analysis underpinned by a critical realist epistemology.

Results: Five main themes emerged from the analysis: 'Constructions and causes of mental health problems'; 'Religion: An integral role'; 'Family: Honour and reputation'; 'Community: A means of support & safety and 'Professional services: Challenges and vision'.

Conclusions: Participants' reported family and community to be the sources from which they would seek help from for mental health problems. Religion was viewed as being fundamental in both understanding and managing distress. A number of barriers were identified as impeding help-seeking from the statutory services in this community. Integration of community groups and statutory services was highlighted as being vital in improving access and appropriateness of services. The implications of the findings at clinical, service and research level are discussed.

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ACKNOWLEDGEMENTS

A special thank you to the nine participants' who agreed to take part in this study, without sharing your experiences with me this study would not have been possible. I hope that I have captured and presented your accounts in a meaningful way.

I would also like to thank the following people:

- Dr Maria Castro Romero (Senior Lecturer & Academic Tutor in Clinical Psychology at the University of East London) my research supervisor, for her invaluable guidance, encouragement and reassurance at every stage of the research process.
- My UEL peers for containing my anxieties when they got the better of me, and providing me with much needed entertainment and laughter.
- Avni, Neha, Shinal, Reema, Iva and Roshni for critiquing, proof reading, correcting my grammar and supporting me with various aspects of the recruitment process.
- The NCO's (in particular Ripal) and my fellow NSDT leads for their untiring support for the duration of my studies. I deeply appreciate you all taking on my share of the responsibilities, so that I could have time and space to complete this research.
- Both my parents, for their trust, patience and constant faith in seeing this process to fruition. Without your practical, moral and emotional support I really could not have completed this project.
- Finally, to my Guru to whom I forever owe my greatest debt of gratitude to, he has been my constant source of motivation and inspiration.

CHAPTER ONE: INTRODUCTION

1.1 Literature Search Strategy

A literature search was conducted across the following databases: PsycArticles, PsychInfo, CINHALL, SCOPUS and ScienceDirect. These databases were considered to be the most appropriate for psychological research. The specific search terms used were: 'Gujarati', 'Gujerati', 'Indian', 'South Asian', 'Help seeking' and 'Mental Health'. As the body of literature in this area was expected to be relatively small, the inclusion criterion was not too stringent. Specific date ranges were not implemented and there were no methodological limitations; studies could be both qualitative and quantitative. Only articles published in English were accepted and the keywords were required to be present in the title or abstract of articles. In addition, the reference sections of journal articles were used to gather relevant literature as well as, accessing 'grey' literature (e.g. Google scholar). It is important to note that research on South Asian (SA) communities and mental health has largely been conducted in the USA. The USA has a very different context with respect to public health services compared to the UK therefore, where possible UK literature has been discussed.

1.2 Improving Access to Mental Health Services for Black and Minority Ethnic Communities (BME)

There is a growing concern about the access and quality of mental health care for Black and Minority Ethnic (BME) groups in the UK. Inequalities in mental health services continue to prevail, despite the implementation of legislation, including the Human Rights Act (1998) and the Race Relations (Amendment) Act (2000), which place responsibility on health services to protect against discriminatory procedures and practices. The experience of coercive treatments and adverse experiences faced by BME service users in the mental health system has been well documented (Keating, Robertson,

McCulloch & Francis, 2002; Singh, Greenwood, White & Churchill, 2007). However, the inequitable variation in the use of mental health services by BME communities has received less attention (Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003; Cochrane & Sashidharan, 1996).

Ensuring equal access and good quality care has been a long standing concern for policy makers, service users and mental health professionals (Department of Health, 2011; Sashidharan, 2003; Department of Health, 2000; Acheson, 1998). In light of these concerns, several policies and service initiatives have been developed to help reduce disparities in access and service experience for people from a BME background with the aim of creating an equitable mental health system. Most significantly, in 2005, the Department of Health produced a policy document titled *Delivering Race Equality (DRE) in Mental Health Care*, which highlights the inequalities in the mental health system and outlines a five year plan to reduce these inequalities in twelve key areas (see Appendix A for the all twelve areas). To date, it remains the only national policy specific to BME mental health. To support the DRE programme, the *Count Me in Census* (Care Quality Commission, 2010) operated between 2005 and 2010. It served to collect data regarding the ethnicity of patients in mental health services.

Despite such efforts over this five year period, inequalities in the mental health system remain entrenched and have worsened in every area earmarked for improvement (Sewell, 2009). A review of the DRE programme (Department of Health, 2009) fails to acknowledge any failures and, instead, describes the limited improvement in certain areas as a result of the "higher rates of mental illness in some BME groups" (p22). There is no reference to account for the impact of social inequities in explaining the higher rates of mental illness in this group. Furthermore, the *Count Me in Census* highlights no change over time in the disparities between BME and white groups, which mean services, are inevitably failing in providing BME communities an accessible and equitable service. Since the ending of the DRE programme, although there have been policies and service development within mainstream mental health to improve access to mental health services for the population as a whole, Improving Access to Psychological Therapies (IAPT) is a key example of this,

the 'ethnicity agenda' has become marginalised. This could partly be explained because previous attempts at addressing the BME community's needs have been fragmented or selective. Currently, there is no national strategy or policy to specifically address access, quality of care or treatment for BME groups.

Research has consistently demonstrated that people from BME backgrounds experience greater levels of ill health and disability yet have poor access to health services compared to white groups (Hwang, Myers, Abe-Kim, & Ting, 2008). It is unclear in the literature whether the underrepresentation of BME groups in mental services is due to differences in help-seeking behaviours, inaccessible services, or other factors. Suggestions as to why inequalities in accessing mental services for BME groups remain, point to the failure of policies and services in both, addressing cultural conceptualisations of 'illness' and taking into consideration the context in which 'illness' is experienced (Morgan, Hutchinson & Leff, 2004).

One particular BME group consistently underrepresented in mental health services is the South Asian (SA) community (Sheikh & Furnham, 2000). The interest in understanding SA communities' mental health has grown, however, the majority of the research concerning SA's has homogenised this group by amalgamating different SA subgroups (i.e. Bangladeshi, Pakistani & Indian). This is problematic in research as it does not allow for heterogeneity between subgroups to be attended to (Gerrish, 2000). As a result, a number of researchers have argued for the need to examine the experience of mental health in individual communities (Gerrish 2000; Patel & Shaw, 2009; Nazroo, Fenton, Karlsen & O'Connor, 2002; Parveen, Morrison & Robinson, 2011). In light of this argument, this study seeks to explore help-seeking ideas for mental health problems of one particular SA subgroup, Indian Gujarati'. The Indian Gujarati community is under-represented in mental health statistics, and, very little knowledge exists regarding their mental health experiences (Patel et.al, 2009).

Whilst it is acknowledged that there are problems in homogenising SA sub-groups in research (See section 1.4 for further discussion), due to the scarcity of research specifically concerning the Indian and/or the Gujarati community, this chapter reviews the literature relating to mental health and help-seeking applied to the broader category of 'South Asians', in order to provide context for this study. Where research concerning the Indian and/or Gujarati community is available this is discussed.

1.3 South Asian Communities, Mental Health & Help-Seeking

1.3.1 The Mental Health Status of South Asians in the UK

People whose cultural and familial backgrounds originate from India, Pakistan, Bangladesh or, Sri Lanka are referred to as 'South Asian' (Marshal & Yazdani, 2000). They make up approximately 2.3 million of the UK population according to the 2011 Census (Office of National Statistics, 2011). To develop a better understanding of how the SA community makes sense of help-seeking and the low access rate to mental health services, it is important not only to consider the status of their mental health but also the factors which may have a salient impact on their mental health.

1.3.1.1 Prevalence of Mental Health Difficulties

The mental health status of the SA community has been of significant interest to researchers as a result of the mass migration of this community to the UK (Pilkington, Msetfi, & Watson, 2012). Early epidemiological studies stated this group experience better psychological well-being, and as result are less likely to need to access services (Cochrane & Stopes-Roe, 1977; 1981; Raleigh, 1995). However, over the years the picture has changed considerably, the evidence now suggests higher rates of mental health problems in this group compared to the general population (King, Coker, Leavey, Hoare & Johnson-Sabine, 1994; Nazroo, 2001; Fazil & Cochrane, 2003; Sonuga-Barke & Mistry, 2000; Weich, Nazroo, Sproston, Mcmanus, Blanchard, Erens & Tyrer, 2004). In particular, the mental health of SA women is concerning. Evidence from large and small scale studies has shown young South Asian women have the highest rate of suicides compared to any other group (Ineichen, 2008; Bhui &

McKenzie & 2008). Research suggests SA women experience the highest rate of any common mental health disorder (Brugha, McManus, Meltzer, Smith, Scott, Purdon & Bankart, 2009). A systematic review of the literature concerning the mental health of SA women in the UK found a high prevalence of depression, suicide, parasuicide, deliberate self-harm and eating disorders (Anand & Cochrane, 2005). Whilst studies have shown a higher prevalence of mental health difficulties in this group, the evidence should be interpreted with caution. It is difficult to establish “true” prevalence rates because, firstly, factors such as socio-economic status, religion and education are all likely to have an influence on the prevalence of mental health difficulties and, secondly, prevalence rates are determined by western diagnostic tools based on Eurocentric conceptualisations of mental health, as a result are likely to over- or underestimate distress (Anand et.al, 2005).

Acculturation, migration, socio-economic deprivation and racism impact on wellbeing and are common experiences faced by SA communities. There is a significant relationship between these factors and mental health.

1.3.1.2 Acculturation

Berry (1995: 458) defines psychological acculturation as a “phenomena which results when groups of individuals from different cultures come into continuous first hand contact with subsequent changes in the original culture patterns of either one or both groups”. The level of acculturation varies significantly between SA groups (Palmer, Macfarlane, Afzal, Esmail, Silman, & Lun, 2007). Indian Gujaratis’ are thought to be ‘well assimilated’ amongst all the SA sub-groups (Ramji, 2006; Poros, 2011; Berry, 1980). ‘Acculturative stress’ refers to the stress associated with adapting to a new environment. Examples of acculturative stressors include negotiating language barriers, managing the pressure to conform to the dominant culture and intergenerational difficulties, all of which are seen to increase the risk of developing mental health difficulties (Hwang et al., 2008). For example, confusion with cultural identity and difficulties with acculturation in immigrants has been found to lead to psychological difficulties, especially in second generation immigrants (Bhui, Stansfeld, Head, Haines, Hillier, Taylor & Booy,

2005). Furthermore, cultural confusion and “shock” may impede the process of developing a stable cultural identity, resulting in higher incidence of mental health difficulties in young Asian adults (Bhugra, Leff, Mallett, Der, Corridan & Rudge, 1997). The relationship between acculturation and help-seeking has been well documented. For example, a study by Hammid, Simmonds and Bowles (2009) found SA individuals with higher levels of acculturation were more willing to access professional help. In another study, Furnham and Malik (1994) found that older SA women had very different ideas about mental health compared to White British women, but also significantly different views to younger SA women (whose ideas corresponded those of the British women). The authors concluded that acculturation is likely to play a significant role in help-seeking preferences.

1.3.1.3 Migration

The migratory process has three stages (Bhugra, 2004), first is the pre-migration stage, where the decision to migrate is taken. The second stage is the process of transition itself, moving from one place to another. During this stage, an individual may experience loss of support networks, bereavement, and stress, and as a result may be vulnerable to psychological difficulties. The third stage is post-migration, where individuals have to deal with the social and cultural frameworks of a new society. During this stage the experience of racism, low ethnic density, social isolation, unemployment, culture ‘shock’, culture conflict and discrepancy in aspiration/achievement may lead to psychological distress. However, at this stage distress may be mediated by social support networks, positive cultural identity, socio-economic advantage and high levels of self-esteem. Bhugra (2004) argues that one must consider the heterogeneity of the migration process, for example, migration must be reviewed from the viewpoint of different generations, the younger generation may face problems as a result of adjusting to two different cultures, whereas in the first generation stress may be associated with economic difficulties. This three stage model of migration focuses on voluntary migration. It is important to note migration for members of the SA community has often been forced, therefore, this context will leave individuals facing very different psychological stressors compared to voluntary migration. Whether voluntary or forced,

migration is a traumatic life event resulting in disruption of attachment and external stability (Falicov, 1995). The impact of migration and the related stressors is multifaceted and will have an influence on individuals at a biological, social and psychological level (Bhugra, 2004).

Research has highlighted that migration has a significant impact on mental health. For example, Nevo, Sharaga, Petrovsky & Borodenko (2006) found SA migrants faced poorer mental health due to racism and prejudice from the majority population. However, others have argued that the strong founded assumption that migrants will inevitably experience poorer mental health compared to the native populations is oversimplified (Cochrane & Bal, 1989). Poor mental health is commonly associated with migration because it results in the breaking of family ties, adapting to a new culture and facing rejection from the host country. Interestingly, in the case of Indians, migration stressors seem to have not impacted them in the same way as other communities. For example, a report seeking to assess the mental health needs of BME communities in Leicester (Leicestershire and Rutland report ,2008) hypothesised that as the City had one of the largest migration of Indian immigrants, most arriving as refugees from East Africa in 1970, it would be expected that this group would experience higher levels of mental health difficulties. However, looking at the incident reports produced by Leicester City Primary Care Trust (2007) this does not appear to be the case. It is possible however, that this group are underrepresented in the incident report as a result of the lower rates of help-seeking in this community, along with other factors that might mediate psychological distress such as family support and strong community ties.

1.3.1.4 Racism

Racism has been cited in the literature concerning SA communities, as being a significant contributor to mental health problems. Experiences of racism and discrimination have a damaging impact on BME communities, as it results in the erosion of emotional, spiritual and intellectual resources which are essential to psychological wellbeing, leaving people vulnerable to mental health difficulties (van OS, 2012). In the UK, one in eight people from a BME

background report the experience of some form of racial harassment or discrimination; these experiences have a devastating impact on self-esteem and social functioning (Modood, Berthoud, Lakey, Nazroo, Smith, Virdee, Beishon, 1997). Curer (1984) interviewed 50 SA women in the UK, who reported that experiences of direct and indirect racism contributed significantly to their depression, and resulted in social isolation, abuse, socio-economic disadvantage and a lack of opportunities. In another study, Fenton and Sadiq (1990) found that SA's reported the impact of racism to be a causal factor in the development of anxiety.

1.3.1.5 Socio-Economic Deprivation

There are marked differences in the economic inequalities faced by SA sub-groups for example, 90% of Bangladeshi people are in the bottom third of household incomes compared to 45% of Indian people (Nazroo & Williams, 2005). Socio-economic factors play a key role in determining mental health and wellbeing (Rogers & Pilgrim, 2002; Williams, 1999). Despite the wealth of research reporting higher levels of poverty, unemployment, poorer housing and educational opportunities in BME communities, there is little focus in the literature on social-economic inequalities as a causal factor for the higher prevalence of mental health difficulties in this group. Socio-economic inequalities are often considered to be a result of having mental health problems as opposed to the cause (Jarvis, 2007). Critics have argued that the failure to recognise the relationship between 'ethnicity' and mental health as a consequence of social disadvantage allows for the higher rate of mental health problems to be attributed to genetic and cultural factors (Sashidharan, 1993). One study found increased risk of psychosis and mental distress in people from BME backgrounds living in run down, overcrowded, inner city environments with poor housing (King et al., 1994).

The arguably increased prevalence of mental health problems in the SA community together with, the impact of acculturation, migration, racism and social-economic deprivation on mental health would lead one to hypothesise that this community would have an increased need to access mental health services.

1.3.2 Factors Influencing Help-Seeking In South Asians

In spite of increased social stressors, research has consistently shown SA under-utilise formal mental health services compared to the general population (Fazil et al., 2003; Furnham et.al, 1994; Kleinman, 1987). Furthermore, demographic data from mental health services reveal this group is significantly less likely to seek help from services compared to any other ethnic minority group (Sheikh et al., 2000; Koffman, Fulop, Pashley & Coleman, 1997). This group appears to utilise generic services such as GP and welfare support more than (Modood, Berthoud, Lakey & Nazroo, 1998), specialist services such as psychiatry and learning disability services (Raghavan & Waseem 2007).

To increase access to services and understand the reasons for this under-utilisation, it is important to understand factors which influence help-seeking (Mo & Mak, 2009) with respect to the SA community.

1.3.2.1 Conceptualisation of distress

The expression of psychological distress and beliefs about the causes of mental distress have a pervasive influence on help-seeking, use of mental health services and mental health treatment (Kleinman, 1978; Helman, 1994). The western view of 'mental illness' is based on the Cartesian concept established by Descartes as a strict division between the mind and body (Gold, 1985); an 'illness of the mind' is seen as a medical problem caused by factors internal to an individual, such as genetics, physiological or biochemical factors. This has become the hallmark of western thinking and continues to inform mainstream mental health practice. Western conceptualisations of 'mental distress' are at stark odds with Eastern thinking. There is no dichotomy between the mind-body, instead, the mind-body-spirit are seen as united entities (Fernando & Keating, 2008). Broadly speaking, in Eastern thinking integration, harmony and balance within oneself, family and community are seen as essential aspects of mental health, in contrast to self sufficiency, personal autonomy and efficacy prioritised in the West (Fernando et al., 2008).

There are two widespread assumptions made about SA communities' understanding of mental health. Firstly, they are thought to somatise their distress as physical discomfort and, as a result, are more likely to have their symptoms misinterpreted as physical health problems (Wilson & MacCarthy, 1994). This is supported by findings demonstrating the failure of GPs to detect mental health difficulties in SA patients and referral to mental health services (Raliegh & Almond, 1995). The second assumption is that SA's do not recognise psychological distress or perceive it as an 'illness' (Raliegh et al., 1995). For example, a summary article by Ineichen (1990) suggested that SA's poorly understand the psychological causation of illness. This suggests there can only be one dominant possibility for understanding mental health. Both assumptions are often incorrectly used to explain the statistical underrepresentation of those seeking help for mental health difficulties and allows for this group to be viewed as lacking psychological mindedness (Patel et al., 2009).

However, critics have argued it is not that this group fail to recognise psychological distress, rather the Eurocentric model of mental health is incapable of attending to 'language' and cultural idioms of distress (Nazroo et al., 2002). A number of studies have looked at the cultural expression of distress in SA (Malik, 2000; Krause, 1989). Krauser's (1989) study on how the Punjabi community conceptualises distress found that they expressed distress as a "sinking heart" (*dil ghirda hai*), which refers to the experience of a particular physical symptom in the body. In another study Fenton & Sadiq (1993) found that in their native language women could easily express feelings and identify difficulties in psychological terms. These findings contradict the idea SA somatise psychological difficulties, instead, it highlights an elaborate use of language to express distress which may not be akin to the vocabulary of the West (Lin & Cheung, 1999).

1.3.2.2 The Influence of Religious Beliefs

Conceptualisations of mental health are embedded in religious, holistic and relational belief systems, and therefore, influence help-seeking (Kleinman, 1987). One of the major religions of South Asia is Hinduism and many SA in

the UK continue to have strong religious roots even after migration (Coward, Hinnells & Williams, 2012).

In Hinduism, two particular concepts are noteworthy in relation to suffering. Firstly, one of the basic tenants of Hinduism is the principle of *karma*. Karma means 'action' or 'deed', the law of karma is a self-governing system of justice which creates future experiences. In other words, 'what we sow, we shall reap'. However, unlike the judicial justice system which only punishes for wrongdoings, karma punishes for misdeeds and rewards good deeds carried out knowingly or unknowingly (Fowler, 1997). Therefore, mental or physical suffering is seen as a consequence of karma (Whitman, 2007). The second concept is "God's will", in which an individual submits suffering as a result of God's will. Hussain and Cochran (2003) found for SA women belief in one's mental health as a result of "God's will" and destiny (kismet) is important in making sense of one's mental health problems. They argue that such conceptualisations of mental health within a religious belief system may explain why religious healers are sought over formal help. Furthermore, supernatural beliefs are frequently attributed to causes and cures for mental health difficulties (Cinnirella and Loewenthal, 1999). For example in Pakistani or Bangladeshi cultures the cause of mental health problems is attributed to *jinn* possession (Lim, Hoek & Blom, 2015). In Gujarati communities' *najar* (evil eye) and *bhut* (ghost affliction) are identified as the causes of physical and mental health problems; these beliefs are aligned to the Hindu ideas of the soul and reincarnation (Spiro, 2005).

1.3.2.3 Familial Support

Family plays a central role for SA communities; great value is placed on the family as a unit. One study illustrated family life to be highly valued for Indians and is characterised by closeness and mutual assistance in times of need (Medora, Larson, & Dave 2000). It is thought the close familial ties in SA families act as a protective factor against psychological difficulties and, as a result, account for the low rates of mental health difficulties in this group. Furthermore, if difficulties arise, it is likely that help is sought from within the family (Furnham et al., 1994). A number of studies have highlighted familial

support to be a protective factor for mental health problems in SA (Sonuga-Barke et al., 2000; Chase-Lansdale, Brooks-Gunn, & Zamsky, 1994). Hackett and Hackett (1993) attributed the greater psychological well-being of SA children to be a result of the protective and nurturing role of families. In Furnham et al's (1994) study they found that SA women preferred to talk to family about their depression instead of friends.

In stark contrast to the overall positive effect of families, some authors have argued that SA families may act as a risk factor for mental health difficulties. For example, a study by Hicks and Bhugra (2003) identified unhappy family situations as a common causal factor in suicidal behaviour among SA women. Nonetheless, the general perception so far, including stereotypical views among health professionals, is that the practical, social and emotional needs of South Asians are well met within the context of the family (Willis, therefore, they do not require support from services (Okuyiga, 1998). This cultural stereotyping could result in a gap in service provision for this community. Furthermore, Katbamna, Bhakta, Parker and Ahmad (2004) argued that whilst SA families in the UK may have kinship ties and extended families that could provide support from within, this belief must be reconsidered in the current context. For example, Holmes and Holmes (1995) state economic instability, acculturation and migration can all change family functioning and structures, which is likely to have an impact on the type and availability of support offered informally in families. In light of the evidence, it may be that close family relationships act as a buffer for psychological difficulties and make help-seeking from within the family more likely. However, it still remains possible that such intimate relationships are a cause of distress and as a result, make informal help seeking from within the family less likely.

1.3.2.4 Role of community

SA cultures are typically characterised by strong community support systems, research evidence supports the notion that community support is beneficial to mental health (McKenzie, Whitley & Weich, 2002). For example, Stansfeld and Sproston (2002) demonstrated that being integrated within social networks and receiving a high level of social support is associated with higher

levels of well-being. Community support systems act to reduce the risk of mental health difficulties (Raleigh, 1995). Research has postulated two pathways to explain the protective effects of community support on health: 'direct' and 'buffering' effects. The direct pathway suggests that well-being is improved as a result of high levels of community support and social contacts, which enhances an individual's self-appraisal and self-esteem resulting in a positive influence on mental health (Cohen, 1988). The buffering pathway states that community support only has an influence on mental health in the context of exposure to acute or chronic stressors (Alloway & Bebbington, 1987). In these situations, community support acts to help individuals reappraise the threat posed by the stressor or to cope with the consequences of the stressor by providing material and/or emotional support.

Some authors have suggested that the low rates of mental health difficulties found in the SA community in the UK is a result of the extended community support systems found in this group, which may be protective of mental health despite the stressors of migration and social disadvantages they face (Stansfeld et al., 2002; Cochrane et al., 1989). Research has illustrated that for Indians living in the UK, a sense of community is highly valued, as it allows them to maintain a close connection with their home country by participating and contributing to their culture (Bacon, 1996). Close knit communities provide opportunities to participate in facets of life important to them (e.g. cultural and religious life) and, therefore, protect against factors such as isolation, prejudice and alienation, which have deleterious effects on mental health (Cochrane, 1983). It is likely that if individuals' psychological, social and emotional needs are met from within the community, then formal help is unlikely to be sought (Cauce, Domenech-Rodríguez, Paradise, Cochran, Shea, Srebnik & Baydar, 2002).

Others have criticised the stereotypical view of SA communities being close knit and supportive (Hatfield, Mohamed, Rahim & Tanweer, 1996). It is important to remain mindful of the fact that whilst close community networks may be supportive, there remains a possibility that they can be a source of distress too. This means it would be unreasonable to say close community

networks in SA communities protect or reduce the risk of mental health in this group (Patel et al., 2009). Furthermore, the idea that SA communities cope with mental health problems using their own resources should be viewed with caution. It is very much likely to depend on the kind of problem for which an individual is seeking help (e.g., practical, social or psychological); if the problem is associated with a high level of shame and stigma, or threatens traditional values, there may be a serious barrier in seeking help internally.

1.3.2.5 The Role of religion

As discussed earlier the conceptualisation of mental health is often linked to religious belief systems, therefore, this may influence the type of help sought. Sheikh et al., (2000) argue that in SA cultures treatment for any difficulty has traditionally been pluralistic, and SA individuals might consider seeking help from a religious leader over professional help. For example, Healey and Aslam (1990) found that traditional healing was frequently sought over professional help by SA. Hussain et al., (2003) found that for SA women, visiting religious healers who work with their conceptualisations of distress was a more favourable help seeking option. In another study, Dein and Sembhi (2001) found that SA patients resorted to a traditional healer for their mental health difficulties. Some have suggested that the SA community turns to their religious community for help as a result of dissatisfaction with formal services, which are seen to be culturally insensitive (Incayawar, Wintrob, Bouchard, & Bartocci, 2009).

Not only does religion influence help-seeking, but also coping practices which may also effect use of services. Cinnirella et al., (1999) found that Pakistani-Muslim people reported religion to be a way of coping with mental health problems; prayer was seen to be an effective way to manage symptoms of depression and schizophrenia. In another study, SA women experiencing depression used religion and prayer as coping strategies (Hussain & Cochrane 2003). Research has shown that Indians continue to maintain religious and cultural practices, despite migration to the UK, and report it to be the most important aspect of life (Singh, 2006). Furthermore, the Office of National Statistics (2006) reported that for Indians their religion remains an

important marker for their identity (ONS, 2006). Therefore, we could hypothesise that the role of religion might be particularly pertinent in the management of mental health difficulties for the Indian community

1.3.2.6 Stigma and Shame

Issues relating to shame and stigma appear to be more pronounced in the SA community in the UK, compared to other ethnic minority groups (Bradby Varyani, Oglethorpe, Raine, White & Helen, 2007; Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak, 2005), and may act as a systemic barrier to help-seeking (Bowl, 2007). It has been argued that as a result of traditional SA cultural values, individuals may be less tolerant of the stigma associated with mental health difficulties and, therefore, are less likely to seek help (Atkinson & Gim, 1989; Soorkia, Snelgar & Swami, 2011).

One particular cultural value specific to SA communities that may impede help-seeking is known as *izzat*. *Izzat* can be defined as “honour”, “self-respect” or “prestige” (Takhar, 2005, p. 186). Whilst the construct of *izzat* is complex and multifaceted, in simple terms *izzat* involves taking every measure to preserve one’s family honour even at the cost of sacrificing one’s own desires (Takhar, 2005). Gilbert, Gilbert and Sanghera’s (2004) study was based on a focus group discussion with SA women exploring their meanings, beliefs and views about *izzat*, *shame*, subordination and entrapment. The research found *izzat* or family shame had a significant impact on women’s lives and influenced help-seeking and uptake of services. In another study, Pilkington et al., (2012) found that shame and *izzat* were associated with less intent to access psychological services in a group of British Muslims of South Asian origin. MacKenzie (2006) found that in their sample of South Asians the stigma associated with having a family member with mental health difficulties would jeopardise important life events such as marriage prospects, therefore, there was pressure not to disclose concerns and seek help. Whilst it is evident stigma and shame influence help-seeking in the South Asian community, some have argued that this cultural stereotype absolves services of the responsibility to consider other dimensions of mental health care (Shah,

Lindesay & Nnatu, 2005), such as cultural sensitivity or working in frameworks that are less Eurocentric.

1.4 The Category of 'South Asian' as Problematic in Health Research

The use of 'ethnic' categories in health research has been widely agreed to be unsatisfactory both theoretically and practically (Bhopal, Kohli & Rankin, 1997). The category 'South Asian' is argued to be too wide and misleading to be useful in health research (Nazroo, Fenton, Karlsen & O'Connor, 2002), as they are conceptualised to be a homogenous group with generalisations made about them as a whole ethnic group, therefore, masking the heterogeneity that exists within each sub-group (Bhopal 1998; Nazroo 1998; 2003). For example, most of the research presented in this chapter has amalgamated different SA subgroups (i.e. Indian, Pakistani and Bangladeshi) into the group of 'South Asian'. However, there are vast regional, cultural, linguistic, religious and political differences between different SA communities (Gunaratnam, 1993). Therefore, research under the broad category of 'South Asian', renders these communities invisible (Kalathil, 2008). Gerrish (2000) argues that research which does not account for the heterogeneity within SA sub-groups could be viewed as unrepresentative or meaningless. Patel et al., (2009:13) states that "very little knowledge exists regarding the mental health experiences of individual communities, such as the Gujarati community" therefore, more research is necessary. Different regions of South Asia have varied cultures, as a result, it is likely that their understanding of mental health and how they make sense of help-seeking will vary largely.

1.5 Current Study

Given the problems with homogenising South Asians, the current study has chosen to focus on a specific SA cultural-linguistic group, Indian Gujaratis. Focusing on one individual community allows for a more accurate understanding of how this group makes sense of help-seeking for mental health problems and a better understanding of the influence of complex social, economic and cultural matrices specific to this group.

1.5.1 Indian Communities in the UK

In the following section, a brief overview of Indian and Indian Gujarati Communities will be provided to highlight the vast heterogeneity that exists within this community but also to help readers consider the social, historical, cultural and personal contexts of Indian Gujaratis' which may be relevant to the findings of this research. Indian refers to an individual whose ancestral roots trace back to India. Like any other group, the Indian community has its own languages, religions and cultures (Das, 2013). Indian communities are composed of a diverse group including Punjabis, Gujaratis, Bengalis, Tamils and Parsis. The main intra group differences are linguistic, religious and cultural however, others differences also exist (Ballard, 1994) . Poros (2011) highlights that as a result of the heterogeneity in Indian groups they are worthy of study for this reason alone.

According to the most recent census data for England and Wales, the SA community constitutes 6.9% of the total UK population (Office for National Statistics, 2011) making it the largest ethnic minority group in the UK. The Indian community is made up of just over 1.4 million people making it the largest SA subgroup in both London and the UK (Office for National Statistics, 2011). Most of the Indian population in the UK is made of two communities namely the Punjabis and Gujaratis. The majority of Indians practice either Hinduism or Sikhism (Hiro, 1967). The migration history of Indians to the UK is noteworthy, it is unique in many ways because of the two countries' colonial connection, which spans over two centuries. Whilst migration from India to the UK can be traced back to the 18th Century, the most significant mass immigration took place in the 1950s and 1960s, (Desia, 1963; Singh & Tatla, 2006). Immigration from India to the UK is now very restricted and growth among the population has mainly been as a result the growth of second and third generation families of early migrants (Das, 2013). Many Indian migrants faced hostile environments in the UK and intended to leave after achieving financial security (Hiro, 1967). Indians were subject to increasing hostility and discrimination in the 1950s/1960s, with violent attacks ever imminent (Reitz, 1988). Despite the adverse effects of discrimination and disadvantage this group have shown and continue to show great resilience and success. For

example, Indians have good educational achievements and are the lowest users of income support benefits (Platt, 2007).

1.5.2 Indian Gujaratis

Indian Gujaratis are a community of people who share a common language and cultural heritage (Shah et al., 1998). They make up the second largest Indian subgroup in the UK (ONS, 2011), they originate from the Indian state of Gujarat and speak Gujarati (Ballard, 1994). The majority of Gujaratis are Hindus (Hiro, 1967). Many Gujaratis in the UK are 'twice migrants', originally migrating from India to East Africa and then to the UK, others moved directly from India to the UK in the 1950s (Crewe & Kothari, 1998). In East Africa, most Gujaratis enjoyed a middle-class lifestyle, where they owned businesses and trade (Poros, 2011). However, in the 1970s East African Asian communities, particularly Gujaratis were forcibly exiled from East Africa by President Amin, with many having to leave behind their livelihoods and migrate to the UK (Cohen, 1997).

When the community arrived in the UK they typically had to take up unskilled jobs with poor working conditions and low pay, forced down the social class ladder. In addition, they faced social exclusion and racial discrimination as highlighted by the dominant discourse of the 1970s 'keep Britain white' (Patel et al., 2009). The Indian Gujarati community who have now been in the UK for three or more generations are considered to have 'assimilated well', with respect to education status, employment, retaining cultural norms and identities compared to other minority groups (Ramji, 2006; Poros, 2011; Berry, 1980).

1.5.3 Indian Gujaratis and Mental Health

The literature search did not identify any specific studies on help-seeking in the Gujarati community, however, there are a limited number of studies considering Gujaratis and mental health. In a qualitative study, Dogra, Vostanis, Abuateya and Jewson (2005), explore how Gujarati young people and their parents understand mental health and mental 'illness', there was

found to be no clear distinction between the terms mental health and mental 'illness'; both concepts were viewed similarly and interchangeably, the majority of parents defined it as a brain deficiency or dysfunction. Parents believed the causes of mental health difficulties were attributed to loneliness, which was thought to be exacerbated by a culture of silence in the Gujarati community, alongside isolation and economic difficulty. They felt isolation was also related to immigration and leaving behind social networks. Young people identified causes of mental health difficulties to be related to low self-esteem, school related stress, intergenerational difficulties, and conflict between the culture of origin and the host culture. Finally, the majority of participants were reluctant to discuss mental health issues outside of their close circle of families and friends. In a further study by Dogra, Vostanis, Abuateya and Jewson (2007), which looks at Gujarati families' perspectives of service provision for mental health problems, highlighted that parents reported mental health professionals, friends, family, support centres and temples to be sources of help for mental health problems.

Two quantitative studies investigating the rate of psychological difficulties in Gujarati children and white children found a lower rate of psychological difficulty amongst the former. The researchers explained cultural factors, cohesive family structures, encouragement of sharing, together with a stricter parenting style protected Gujarati children from psychological difficulty (Hackett, Hackett & Taylor, 1991; Hackett & Hackett, 1994).

A study by Lindsay, Jagger, Hibbett, Peet and Moledina (1997) investigating the factors which influence uptake of health and social services in Gujarati and White British elders found that there was a poor uptake of services by Gujarati elders despite experiencing greater levels of ill health. Gujarati elders were found to have a greater availability of support and alternative sources of help compared to White British elders. The authors conclude that the lower uptake of services by Gujarati elders is not a result of assumed better health but could be explained by greater familial support and a lack of knowledge and dissatisfaction with the available services. A further report exploring the experiences and views of Gujarati speaking elders' on mental health & mental

health services conducted by Harrow Mind (Joshi, Parmar & Smith, 2008) found that many of the elders used a religious explanation known as *karma* to make sense of mental suffering. Furthermore, family relationships were seen as a great source of support but could also exacerbate mental health problems. In relation to their experiences of mental health services, both language difficulties and the lack of specific provision were identified as areas of dissatisfaction.

A more recent paper by Patel et al., (2009) discussed explanations for the underrepresentation of the Gujarati community in mental health statistics and services in the UK. Three factors were highlighted, including firstly, whether the supposedly better psychological health of South Asians could account for underrepresentation. They argued, however, that the evidence for this hypothesis is debatable given more recent evidence demonstrating higher rates of psychological difficulties in South Asians. Secondly, they considered factors that could influence help-seeking behaviours such as stigma, alternative constructions of mental health, somatisation of distress, and lack of knowledge about services as being possible explanations. Lastly, failure to detect mental health difficulties in SA people by GPs is also considered a hypothesis. Although explanations have been put forward for the lower rates of help-seeking in the Gujarati community, to the researcher's knowledge, there have been no studies to date exploring how the Gujarati community make sense of help-seeking for mental health difficulties.

The present study aims to explore how the Indian Gujarati community makes sense of help-seeking for mental health problems. Developing a better understanding of how this community makes sense of help-seeking for mental health difficulties will allow mental health services to ensure that they are both accessible and appropriate for the communities they serve.

1.6 Research Questions

In summary, the present study sets out to explore the following questions:

- How do the Indian Gujarati community understand mental health?
- Where do the Indian Gujarati community go to seek help for mental health problems and, why?
- What factors facilitate or hinder the Indian Gujarati community in seeking help?

CHAPTER 2: METHODOLOGY

2.1 Overview

This chapter discusses the rationale for adopting a qualitative methodology and the epistemological position chosen to address the over-arching research questions. Details of the research procedure, including data collection and analysis will be described.

2.2 Qualitative Methodology

A qualitative methodology was adopted in favour of a quantitative methodology for several reasons. Firstly, quantitative approaches are primarily concerned with testing hypothesis generated from theories, establishing causal relationships, investigating prevalence or quantification (Harper & Thompson, 2011). Secondly, the theoretical ideas regarding the nature of knowledge (epistemology), centrality of language and the importance of reflexivity, which underpin qualitative research, better reflect the aims of the present study and the researcher's own assumptions about what can be known and how (Willig, 2008). A qualitative methodology will also allow for the development of a rich and extensive understanding of participants understandings, perspectives and realities (Snape & Spencer, 2003) making it a more appropriate approach for this research given the limited literature on this topic.

2.3 Epistemology

Epistemology is concerned with the 'study of knowledge and methods of obtaining it' (Burr, 2003: 202). Clinical psychology has established itself on a positivist epistemological position. Positivism rests on the premise that knowledge is objective and value free and through the application of scientific methods this can be obtained (Miller, 1999). In other words, the assumption is that there exists "truths" we can know about in the world, and the researcher

brings no bias to the interpretation or discovery of these. This position has historically been privileged within the discipline of psychology. However, qualitative methodologies have shifted the focus of research from objectivity to subjectivity (Parker, 2005). The idea that the researcher and researchee cannot be separated therefore, our position is not value-free, is acknowledged by epistemological positions linked to qualitative methodologies.

2.3.1 Critical Realism

This study adopted a critical realist epistemological position. A critical realist position lies between realism, which assumes that material reality can be directly observed and social constructionism, which suggests that knowledge is a social reality and is dependent on individual interpretation (Harper, 2011). Critical realism shares in common with social constructionism the premise that scientific and technical concepts, need to be examined in the context of the socio-historical conditions which allowed them to emerge (Bentall & Pilgrim, 1999). However, unlike a social constructionist approach, critical realism does not propose that the study of psychopathology is dispensable in favour of studying discursive practises alone. Instead the study of the socio-historical context of concepts is viewed as necessary in replacing misleading concepts with ideas that are more useful both scientifically and clinically (Bentall & Pilgrim, 1999). Critical realist accounts do not deem reality to be socially constructed, but theories of reality and the methods used to investigate it are seen to be shaped and influenced by factors such as race, class, gender and culture. These factors invite forms of critical analysis when one is asked to accept or reject claims about reality (Bentall & Pilgrim, 1999).

The relevance of a critical realist position in relation to the current study is that it assumes that a material reality exists however, participants' accounts will be constructed and recalled in way which represents their own subjective perspectives and interpretations of the world (Harper, 2011). In other words, this stance acknowledges that there are socially constructed discourses influenced by historical, cultural, religious, personal and social factors (Bentall & Pilgrim, 1999) which will shape how the Gujarati community perceive and understand mental health problems and help-seeking. Additionally the critical

realist position does not view the researcher as objective and separate to the research, but as active and interpretive in the process, bringing their own experiences and viewpoints to understand the data, and in turn shaping the final analysis (Willig, 2013). In light of this, the researcher's own context (see section 2.4) is as important as the participants throughout the research process.

2.4 Reflexivity

Reflexivity forms a defining feature of qualitative research (Banister, Burman, Parker, Taylor & Tindall, 1994); the researcher is actively involved in and has an influence on the collection, selection and interpretation of data. Personal reflexivity involves the "process of examining how the researcher and intersubjective elements impact on and transform the research" (Finlay & Gough, 2008: 4). Research is not independent of the researcher, but is a co-constituted product shaped by the participants, researcher and their relationship. Therefore, meanings are co-constructed in particular social contexts, unfolding a particular story which may not be unfolded by another researcher. A researcher must be transparent about their position where one has an existing relationship to the topic area (Willig, 2013) and engage in a critical self-reflection of how their social background, assumptions and behaviour may influence the research (Finlay & Gough, 2008: 9).

2.4.1 Statement Positioning

Banister et al., (1994) propose as the researcher is not objective, one must be mindful of his or her position in the research, as this will have implications for what is spoken of, and not. Therefore, it seems appropriate to mention three contexts relevant to the researcher. Firstly my interest in the subject area comes from my own background of working with Gujarati communities to raise mental health awareness where access to statutory services was limited, this sparked a personal interest in understanding what factors influenced help-seeking. Secondly, my own identity as a young woman who identifies as being a British Indian Gujarati will no doubt have an impact on the research process. For example, it may make it easier for individuals to be interviewed

about sensitive topics by someone from the same ethnic background however, I remain mindful that my similarities may close other avenues of conversation. Finally my role as a trainee clinical psychologist will have an impact on what is asked and not asked. A reflexive journal will help me to reflect on my thoughts, beliefs and assumptions that might implicate the research (see appendix B for an excerpt from the reflexive journal). Although my statement makes clear my position, it is not sufficient in qualifying the analysis and interpretation on its own, as there are numerous factors which will shape the research that cannot be pre-empted, these will be discussed in the discussion.

2.5 Data Collection

There are debates regarding the type of data collection method best suited for qualitative research (Potter & Hepburn, 2005), including a preference for 'naturalistic' styled data collection as opposed to interviews due to the risk of engaging in a 'leading' interview. However, it could be argued 'naturalistic' styled data collection reinforces the idea of objectivity, in that there can be a separation of the researcher and the researched and, as discussed earlier, it is impossible for the researcher not to bring their own position to the research process. Focus groups were considered as a data collection method, however, due to the shame and stigma associated with mental health problems in this community (Dogra et al, 2005), it was thought that one-to-one semi-structured interviews would allow for sensitive topics to be explored more openly than in a group setting. Semi-structured interviews acknowledge the impact of the researcher in the construction of the research and data collection, supporting the idea that knowledge is co-constructed (Banister et al., 1994). Smith's (1995) guidelines on semi-structured interviews were used to construct my questions and ensure the language was accessible to participants.

2.6 Participants

2.6.1 Inclusion Criteria

Participants were able to take part in the study if they met the following criteria:

- Self identified as being Indian Gujarati
- Over the age of eighteen years
- Live in the United Kingdom
- Primary speakers of English (due to loss of meaning of original data and cultural and linguistic difficulties in translating qualitative data (Temple & Young, 2004) non-English speakers were not eligible).

2.6.2 Exclusion Criteria

Individuals who currently and/or previously accessed mental health services were not eligible to take part in the study, as the present study aims to develop an understanding of how the 'lay' community makes sense of help-seeking for mental health problems. It was thought that through interaction with services, individuals who have accessed mental health services may have a different understanding of help-seeking as a result.

2.6.3 Sample Justification

Eight to twelve interviews are suggested to yield enough data for analysis and meet criteria for data saturation (Guest, Bunce & Johnson, 2006).

2.7 Procedure

2.7.1 Recruitment

BME communities have lower participation in health research (Miranda 1996; Hussain-Gambles, Atkin & Leese, 2004) despite making up a significant proportion of the population. A systematic review of the existing research indicates barriers to access for research in minority groups includes: the

perception that despite being involved in research the BME community have seen little benefit as a result (Culley, Hudson & Rapport, 2007), social stigma, cost, language barriers, different explanatory models of illness, lack of trust, religious beliefs and lack of culturally competent researchers (Brown, Marshall, Bower, Woodham & Waheed, 2014). The underrepresentation of BME people in services and their low representation in research has meant they have been termed 'hard-to-reach' as a result (Salway, Barley, Allmark, Gerrish, Higginbottom & Ellison, 2011). However, Johnson (2008) argues BME communities are not 'hard-to-reach' but 'easy-to-ignore'; encouraging participation in research is not difficult but requires innovative recruitment strategies such as engaging with local communities, faith groups and organisations responsible for equal opportunities (Manthorpe, Iliffe, Moriarty, Cornes, Clough, Bright, & Rapaport, 2009).

Research evidence suggests researchers need to go beyond traditional recruitment strategies to gain access to members of minority communities. Therefore, this study employed multiple and innovative recruitment strategies (Mohammadi, Jones & Evans, 2008) including 'snowballing' and 'opportunistic' sampling by attending events and engaging and building relationships with local communities and faith groups in London.

2.7.1.1 Engaging With Local Community Groups

To maximise recruitment, and gauge interest in the research several Gujarati community groups in London were contacted, via email. Out of the 12 groups contacted 5 community groups responded with interest. Increasing research participation requires building relationships with the community and ensuring community leaders are fully aware of the research and its aims, as they are likely to act as gatekeepers to potential participants (Sheikh et al., 2009; Douglas et al 2011). Between July and September 2015 several visits were made to the five community groups in order to begin building relationships, which was key in the recruitment process. Three of the community groups offered to advertise the research (see Appendix C for recruitment advertisement) in their monthly newsletter, and weekly email shots and provided me with the opportunity to deliver a small presentation on the

research and its aims at community events. Additionally, one community group organised a large health fair with over 1000 attendees from the Gujarati community, with the aim of raising awareness and providing screening for physical health conditions effecting South Asian Communities (e.g. diabetes, cardiovascular disease, cancer etc). I was provided with a stall at this event to recruit potential participants. Overall, this recruitment method yielded the most participation, as trusted members of the community were onboard with the research, which meant people were more likely to participate (Rooney et al., 2011).

2.7.1.2 Visiting Places of Worship

Two Hindu temples with mostly Gujarati followers agreed to advertise the research and also invited me to join their Temple events, where I had the opportunity to discuss the research with the community members. Visiting temples on several occasions allowed me to witness the activities that went on in the temple and build familiarity with the temple community and faith leaders, both of which were important in encouraging participation.

2.7.1.3 Snowballing

Recruitment through snowballing can be a useful method for “hard-to-reach” populations or when the research topic is stigmatising (Magnani, Sabin, Saidel & Heckathorn, 2005; Sadler, Lee, Lim & Fullerton, 2010). Snowballing was adopted in the present study as a recruitment method to increase participation rate. Participants did pass on the details of the study to friends and family members, however, this method did not attract many potential participants. Forming links with the community proved to be more effective.

2.7.2 Description of the Sample

In total 9 participants took part in this study. The table below (Table 1) provides a summary of the participants and demographic information.

Name *	Gender	Age in Years	Country of Birth	Migration Route	Occupation
Sahaj-Priya	Male	40	UK	-	Hindu Monk
Bharti	Female	60	India	India-East Africa-UK	Retired
Manoj	Male	65	India	India-East Africa-UK	Retired Pharmacist
Mansi	Female	24	India	India-UK	Dyslexia Trainer
Sejal	Female	25	UK	-	Student
Dhara	Female	32	UK	-	Accountant
Tarun	Male	39	UK	-	Biomedical Scientist
Rajesh	Male	30	UK	-	Researcher
Meena	Female	50	East Africa	East Africa-UK	Teacher

Table 1: Participant Demographics

**All participant names have been changed to ensure confidentiality*

2.7.3 Data Collection and Analysis

2.7.3.1 *Semi-Structured Interviews*

Nine individual semi-structured interviews lasting between 40-90 minutes were conducted in several locations including: temples, community centres and participants' homes. The interview schedule comprised of a list of pre-defined questions (see Appendix D for interview schedule), however, the interview was flexible depending on what the participant discussed. All interviews were audio-recorded.

2.7.3.2 *Transcription*

Interviews were transcribed verbatim, Malson's (1998) transcription convention was adopted for transcribing. The convention is outlined in Appendix E. Due to the methodology selected, detailed aspects of the recordings were not necessary (i.e. non verbal utterances, pauses, tone).

2.7.4 Thematic Analysis

As there is a dearth of research available (Breakwell, Smith & Wright, 2012) on how the Gujarati community make-sense of help-seeking for mental health difficulties, thematic analysis (TA) was selected as the method to analyse the

data. Due to TA's theoretical 'flexibility' (Joffe, 2011), a critical realist approach to interpretation was taken to explore the data, both in terms of the ways in which individuals understand help-seeking and the broader socio-cultural context imposed on meanings (Braun & Clarke, 2006). Furthermore, TA has been highlighted as being a suitable method for informing service provision, which is relevant to the present study (Braun & Clarke, 2006). In TA themes can be identified through either adopting a 'bottom up' inductive approach or a 'top down' deductive approach (Braun & Clarke, 2006). An inductive TA aims to make sense of themes which are grounded in data rather than prescribed by a theoretical framework (Willig, 2013). The present study adopted an inductive approach, however, as the literature review was conducted prior to data collection, this will have influenced how the data was interpreted, as a result the approach was also deductive in this sense (Joffe, 2011).

Braun and Clarke's (2006) six phase approach was adopted to guide the process of analysis. Phase one involved familiarisation with the data which was achieved during transcription and through active reading and re-reading of the transcripts, as well as noting down any initial observations or points of interest. During phase two initial codes were generated (see Appendix F for list of initial codes) to help organise the data into meaningful groups. Codes were noted in the margins of all the transcripts (see Appendix G for an example of an annotated transcript).

In phases three and four, the process of searching for and reviewing themes was undertaken. This initially involved collating codes and related data extracts (see Appendix H example of a coded data extract). Subsequently, codes were printed, cut and organised visually into meaningful clusters (see Appendix I), where a central or unifying feature was observed (Braun & Clarke, 2012). Clusters of codes were organised in proximity to each other where there was seen to be a relationship. This process fostered a sense of coherence to be developed across the data and, allowed for decisions regarding where the boundaries between themes exist, to be made. An initial thematic map was produced following this process, (see Appendix J) which was then redefined to produce a final thematic map (see Appendix K). Phase

five involved defining and naming themes, in this stage there was an emphasis on reviewing the coherence, quality and boundaries of themes. Reviewing involved comparing themes with excerpts from the original, to ensure firstly, that the themes captured the essence of what was said and secondly, the quality of the themes in relation to the research question. Finally, phase six involved the write-up of the analysis which provides a concise and coherent account of the data both within and across themes.

2.8 Materials

A digital audio recorder, a password protected computer, transcription equipment and an interview schedule were required to conduct the study.

2.8.1 Construction of Interview Schedule

The semi-structured interview schedule was constructed by identifying salient topics that emerged in the existing literature. Open ended questions were then developed to reflect these broad topic areas. It was important to ensure the questions were not leading in anyway (Smith, 1995). The researcher used the interview questions as a guide only and was not used in a prescriptive manner. A pilot draft interview schedule was conducted with colleagues to ascertain clarity and structure of the questions. The interview schedule was evolved after gaining feedback from participants and the researcher's experience with each interview.

2.9 Ethics

2.9.1 Ethical Approval

Ethical approval for this research was granted by The University of East London (see Appendix L). As the participants' were recruited from a community sample, NHS ethical approval was not required.

2.9.2 Consent

Prospective participants were provided with an information sheet (see Appendix M) highlighting the aims of the research, what the study involves

and information about anonymity and withdrawal. This allowed individuals to make an informed decision whether or not to take part. Participants who agreed to be interviewed were again asked to read the information sheet and sign a consent form (see Appendix N). After the interview was completed participants were debriefed and given the opportunity to raise any questions or concerns. In the event participants became distressed, they were informed that they would be signposted to appropriate support services.

2.9.3 Confidentiality

Only the researcher and supervisor had access to the audio recordings. Pseudonyms were used during transcription and all identifiable information was removed to ensure anonymity of participants. The recordings and all information related to the study were held electronically on a password protected computer. Audio recordings will be deleted at the end of the research and transcripts will be destroyed after five years, in line with the Data Protection Act (1999).

CHAPTER THREE: ANALYSIS

This chapter will examine in detail the themes derived from the data analysis by providing extracts from participants' interviews. A total of five main themes were constructed (each with sub-themes, see Table 1), titled: 'Constructions and causes of mental health problems', 'Religion: An integral role', 'Community: A means of support and safety', 'Family: Honour and reputation' and 'Professional services: Challenges and vision'. The themes reflect aspects of the participants' accounts to varying degrees. Descriptive terms such as 'all', 'most, and 'some' will be used to indicate level of participant response. To protect the anonymity of participants, pseudonyms have been given to each one. The letter 'I' is used to refer to the interviewer. Minor changes have been made to the presentation of interview excerpts to improve readability. The omission of words to shorten quotes is indicated by a dotted line in enclosed brackets (...). The addition of text to provide explanation to the reader is denoted by square brackets [text]. Repetitions or filler words (e.g. 'like') and hesitations (e.g. 'errmm') have been omitted from excerpts for the purposes of clarity.

Table 1: Themes and Sub-Themes

MAIN THEME	SUB-THEMES
Constructions and Causes of Mental Health Problems	<ul style="list-style-type: none">▪ Unity of mind & body▪ An illness caused by biological factors
Religion: An Integral Role	<ul style="list-style-type: none">▪ The Will of God▪ Central to managing difficulties
Family: Honour and Reputation	
Community: A Means of Support & Safety	<ul style="list-style-type: none">▪ A self-sustained system▪ The community context
Professional Services: Challenges and Vision	<ul style="list-style-type: none">▪ Barriers to help-seeking▪ Integration of services

3.1 Constructions and Causes of Mental Health Problems

The first theme sets the context for the proceeding themes, as it seeks to explore how participants conceptualise mental health paying particular attention to the influences on their understandings. This theme will be explored in relation to two sub-themes: ‘unity of mind and body’ and ‘an illness caused by biological factors’.

3.1.1 Unity of Mind and Body

This sub-theme reflects participants' construction of the mind and the body as being integrated rather than distinct entities. Most participants described the

mind to be a facet of the body. In the excerpt below, Dhara describes the mind to be almost like an extension of the body:

And I think also the mind (...). In the sense the mind is another part of the body. But I look at it again, that even though it's mental health, it's also a physical part of your body (Dhara: 742-744).

Some participants' referred to their understanding of the link between the mind (mental) and body (physical) as being derived from religious beliefs. For example, Sahaj-Priya describes how mental health and physical health are integral to each other by drawing on his knowledge of the Hindu scriptures as an influence on his understanding. He describes the fusion of the physical body and the mind to form a "functioning machine" through which one experiences the world. He uses an example to illustrate how difficulties in one's mental health may have impact on physical health. The integration of the mind-body should be viewed as being part of one's "holistic health" from a Hindu perspective. Furthermore, Sejal raises the issue of professionals not attending to alternative constructions of mental health as being a barrier in accessing professional services for the Indian Gujarati community:

If we go back to Hindu *Shastras* [religious scriptures] and my understanding of it, I think mental health and physical health have been very integral to each other (...). The *Shashtras* [religious scriptures] talk about the body as a combination of not just the physical elements but also the subtle elements. And it's those subtle elements that comprise the mind – the word they use in Sanskrit is the *antakaran* (...). And it's interesting how the physical body and the subtle body [the mind] all come together to make this a functioning machine, so to speak, which then the soul enlivens and allows us to actually know, feel and do. Even in our *Shastras* we talk about how if someone has grave mental health difficulties it will have an effect on the body. For example, they'll have a fever or pain somewhere else. So it's vice versa, the Hindu idea of a body is a composite body, it's not just the physical; flesh, bones, muscles and blood, it's much beyond that. So, from a Hindu perspective it seems quite natural to accept that as a part of your holistic health (Sahaj-Priya: 105-110)

Because being a Hindu, we believe that the mind and the body are linked. That the two entities that are linked, so that's one of the reasons why they [the Gujarati Community] wouldn't go to a [mental health] professional. Because I feel a

professional, would not touch on these types of beliefs or these kinds of thoughts, and the principles that are attached to that (Sejal: 222-228).

A few participants emphasised the need for Western medicine to appreciate the integration of the physical and mental. Meena points out that it is “old fashioned” to think of physical and mental health as being separate, as both have an effect on each another. Like Sejal, Meena also highlights the constraints on professional knowledge regarding the integration of the mind and body. She expresses the dominant construction of health in the West maintains a divide between the mental and physical, and this being something that needs challenging:

It's old fashioned to be honest, to think that physical and mental are different. Because what is happening physically in your body, is affecting your mind, so no they are not two separate things. So I think doctors need to be mindful of that. The Western medicine needs to change, accepting that all the things are linked (Meena: 575-580).

3.1.2 An Illness Caused By Biological Factors

As illustrated in the sub-theme above, the majority of participants were influenced by an Eastern understanding of the relationship between mind-body. However, in discussing the causal factors for mental health problems, there appeared to be somewhat of a paradox in the participants' accounts. Many of the participants attributed the causes of mental health to be linked to biological factors such as genetics and hormones, as articulated in the following extracts:

Ok I think the first reason is genetic (...). Yeah, I think causes are basically, either genetic but it can be linked to depression is genetic at times (...). You get a lot of people, if it was in their family, or you know hand it down (Meena: 72-91).

The causes of mental health issues in my opinion, I mean again it's a lot to do with – there have been studies on biological and genetic predisposition (Mansi: 146).

Many participants drew on a medical model of mental health to explain the causes of distress. For instance, in the extract below Manoj describes mental health as an “illness” which has observable symptoms and for which one needs “help”; he likens mental health to physical health difficulties and infers

that the absence of symptoms is suggestive of normality. Thus, suggesting that there is merit in explaining mental health as a set of symptoms:

Yes there is an illness that needs help, (...) yes the clinical symptoms are this, like you have clinical symptoms of cancer, of heart disease and everything else. It might be clinical symptoms for – and then you can convince people that look this is the symptoms; your normal brain should be like that normally. (...) (Manoj: 320-327).

It also could be hormonal related. So if your hormones are imbalanced due to dietary reasons or physical exercise, or not looking after yourself well enough, you're unhappy or you've got this negative pattern of thinking that changes the chemistry in your body. That affects the function of the brain, and that can drive you into anxiety and depression (...). (Dhara: 755-762).

Rajesh describes how in the Gujarati community mental health problems are viewed as being an “illness”, however he does not position himself as holding this view. He compares the more compassionate attitude towards mental health in the West to the Gujarati community, where it would be “stereotypical” for one to be ostracised and isolated as a result of having a mental health problems. It seems Rajesh is alluding to there needing to be a shift in the way the Gujarati community view mental health.

Well Gujarati people, tend to think it's an illness. And it's something that either you get out of bed and just deal with or forget it. And you're a lost case. Whereas I think, the western attitude is a lot more embracing. Saying that look you've got an issue, we want to help you. You know you can get out of this, don't think that's the end of it. In the Gujarati community, you tend to get shunned (...). It's a very stereotypical thing. And that's the reason I think, why Gujarati people tend to lack that support. (Rajesh: 115-120).

Mental health problems as an illness is further reflected in Sejal's comment. She concurs with Rajesh's view about the dominance of the illness construction of mental health in the Gujarati community. However, she is the only participant to refer to the supernatural beliefs held in Hinduism such as najar (evil eye) and bhut (ghost affliction) as having a role in explaining the causes of mental health problems. In her perspective supernatural beliefs are

viewed to be the initial explanation adopted by the community followed by biological factors.

Yeah someone that's lost their mind, or somebody who's mental health is not doing well. Obviously and his illness is related to that (...). Biological reasons, I think a lot of times are attributed [to mental health difficulties]. Especially within the culture I come from, we don't really tend to look at other factors. We don't tend to look at social factors, it's more of you know, probably like if it's not *najar* [evil eye], if it's not *bhooth* [ghost affliction] or *karma* [reincarnation], then they would probably say it's you know internal biological factor, than any kind of social issues (Sejal: 44-49).

3.2 Religion: An Integral Role

The second main theme explores how participants drew on one particular religious concept to make sense of the difficulties they face and the integral role religion plays in the management of mental health difficulties. This theme will be explored in relation to two subthemes: 'The Will of God' and 'Central to managing difficulties'.

3.2.1 The Will of God

This sub-theme considers how participants used the Will of God, a key a religious concept in Hinduism, to make sense of why people experience distress. All nine participants talked about distress as being "the Will of God", in some shape or form; inferring that a religious understanding is central in the participants' construction of mental health.

In the extract below, Rajesh makes reference to a quote from the Hindu scriptures to emphasize his view that whatever happens in life is a result of God's will. Not only does he view difficult times in life at the hands of God, he also views positive phases in one's life to be the grace of God. He reiterates twice that one must have this understanding, implying this is an important context, which he uses to make sense of things:

God says [quoting from the Hindu scriptures], "you could be sitting on an elephant one day, and the next day you're sitting on a donkey, but at the same time you must understand that that is through the will of God". You know whatever happens in life,

whether you're given honour or you're insulted, whether you go through a high phase or a low phase one must have that understanding that this is all through the will of God (Rajesh: 198-203).

Like Rajesh, both Sejal and Tarun also highlight very explicitly that whatever happens in their life is due to God. They firmly position God to be the controller or decider of the things that happen in their life, for them it appears to be his wish that dictates what may or may not happen. This is reflected in their use of the words: “you know it is because God's pretty much wanting that to happen” (Sejal: 91-93) and “you know, God has done it” (Tarun: 343). From the quotes it is possible to infer that ‘God’s will’ is symbolic in how the trajectory of the life is understood. Participants do not refer to any other factors in making sense of why they may experience distress:

Having that stamina, that whatever happens, happens for a reason. And you know it is because *Bhagwaan's* [God], God's pretty much wanting that to happen in your life” (Sejal: 91-93).

Whatever happens it's for the best or *Bhagwaanu karyu chhe* [by the will of God]. You know, God has done it whatever way or form (Tarun: 342-343).

A few participants described how they would use the concept of ‘God’s will’ as a way of offering support and guidance to other members of the community to cope with difficulties. ‘God’s will’ seemed to be used as a way of helping people to be at peace with whatever is happening in the present. In this extract Sahaj-Priya describes God’s will to always be for one’s betterment, even if this cannot be understood by the person in the context of the difficulty they are experiencing:

I: What kind of advice or guidance would you give to [other] members of the community to cope or manage such [mental health] difficulties?

Again, realigning their thought patterns to ‘whatever happens in the world is only by the will and doing of God’ – what we call *karta pana no vichar* [God as the all doer] and he is the sole doer, the ultimate doer, and whatever he does by his all gracious, all loving and benevolent will is always for my best, even though I cannot understand right now (Sahaj-Priya: 194-199).

There was a tendency for participants to refer to 'God's will' as providing a sense of "solace" amidst difficult times. Belief in this concept is seen to provide strength and hope that one can endure the problem. Although it is not explicitly mentioned, God's will is seen to be a personal resource for coping that can be drawn on to both make sense of what has happened and to manage the difficulty itself:

Whatever happens is meant to happen, it is God's will. So maybe some, as you said, religious influence comes in, because in part of some of the religious scriptures do say that "whatever is meant to happen will happen". So that itself is a big help. And that I think brings a lot of solace and peace of mind. (Manoj: 174-178).

And if you have that if you are going through a really tough time, mentally it gives you strength. And that strength cannot be calculated or, you know, measured. It's a strength that comes through from a divine intervention. And that's what gives you that assurance that you can get through (Rajesh: 203-207).

3.2.2 Central to Managing Difficulties

All nine participants spoke about religion being integral to their day-to-day life and a crucial resource they would draw on to manage mental health difficulties. Religion and faith were used synonymously by participants and constructed to be a protective factor, providing them with strength to bear through difficulties.

A number of participants referred to the magnitude of religion in their life. Participants describe this in the excerpts below, indicating religion to be an essential component they turn to in the face of distress:

I think I do draw on religion, spirituality does see me through the day to be honest. (Meena: 112-113).

Religion is a big part of me. It's quite a big part of my life, so that's definitely something that I would turn to. (Sejal: 83-84).

Yes, as a person who is focused on spiritual praxis the fundamental understanding, theological understanding of an individual and the world around is that belying everything is a spiritual entity (Sahaj-Priya: 100-102).

Some participant's discussed drawing support from the religious community when they are experiencing difficulties. In the excerpt below, Rajesh talks about the religious community as being a place which provides comfort and acts as a "safety net". The connection that people have with each other in the religious community may provide a more welcoming environment for help seeking. As Taurin tentatively states, the embedded connection between people in the religious community could make it easier to seek support within it:

And I think the good thing with *Satsang* [religious community], and using the faith based approach is that it gives people the comfort. So if, for example, there's someone who's going through a low patch in their life, when you have *Satsang* it's more a safety net. It stops that person, spiralling out of control (Rajesh: 138-141).

(...) I would say you know most of the people coming to *Mandir* [temple], have some kind of connection with [each other]. So you would have thought most people would [seek support] go for these things (Tarun: 445-449).

Participants also spoke about religion providing a sense of "protection" and giving them a source of strength:

And that's when religion comes, it's protection and I think I just put it out there, to the vibrations and try and be positive (Meena: 121).

Other participants spoke about how their connection with religion and faith helped them to get through difficulties, as they do not have to bear the weight of the problem alone, either sharing it with God or a spiritual leader:

You don't see it at that point of time, but you have to have that faith. And I think if you don't have that faith [in God], then you feel everything is your responsibility, which is quite overwhelming (Dhara: 326-329).

But I know from my spiritual practice, is that my *Guru* [spiritual leader] will always help me. If I call out to him with a pure heart, and find refuge in him. Then that faith is always going to build. In every circumstance, it is going to show up on me. (Mansi: 318-321).

In the excerpt above a notable aspect of both Dhara and Mansi's talk is their emphasis on how religion and faith helps to remove the individual onus of finding a solution from them onto to a higher power. Furthermore, Mansi uses "always" to refer to the help she would receive from her Guru, indicating the permanency and reliability of this source of support in her in life.

In considering the ways in which religion and spirituality are used to manage mental health, participants spoke about various religious practices they may draw on to support them. Many participants spoke about prayer as being a useful tool in coping with difficulties and how they find solace in using it:

Pray, I would pray because in the religion prayers quite a strong technique to get through the difficulties that people face. And just having faith in God that things will go right (Sejal: 88-90).

I would say I'm a very religious person, so I would pray to God all the time that, you know, I don't want all this. But yeah, I think praying helped me quite a lot [in a low period in her life] (Bharti: 57-58).

Some participants talked about drawing on religious scriptures to gain "inspiration" to get them through hardships. Further, Sahaj-Priya articulates that as a member of the community who provides support to people experiencing distress, he would suggest, they to refer to spiritual readings from the Holy Scriptures. Here he also conveys his knowledge of mental health practise, by referring to a specific kind of psychological therapy in a detailed manner, which he describes as being similar to the "vichars" [spiritual ideas] he might suggest:

The good thing is that you can draw upon the scriptures as well. And in scriptures you can get inspiration. So when you're going through a low patch, sometimes you can read the spiritual books and you can draw inspiration from that, to help you through those tough times (Rajesh: 186-190).

Then depending on, as I said people's receptivity or their spiritual maturity, we would perhaps advise on some readings from the *Shastras* [Hindu Holy Scriptures] where God or the *Gurus* would advise certain patterns of thinking that would help to alleviate certain situations for them. And then as you go forward, as I said these spiritual thoughts what we call the - *vichars*, spiritual ideas (...) not probably that different to what you would call cognitive behavioural therapy. It's a way of countering negative thought patterns and changing mind-sets (Sahaj-Priya: 203-208).

Participants talked about a range of other religious practises they would practically implement into their life to cope with distress including: chanting the holy mantra, turning the rosary, listening to spiritual discourses and visiting the temple:

Doing lots of *malas* [tuning the rosary], listening to *katha* [spiritual discourses], all of these things are hugely important in mental health. This would be ongoing, before any psychiatrists (...). (Mansi: 303-306).

So "*Om Namah Shiva*" [a Hindu mantra], is a very strong, a big burst for me. And you don't have to physically go out and pray, or do anything. If you're just doing your work, you can still chant that in your mind. And I think it gave me a lot support, and strength I think (Bharti: 80-83).

But there are also say other tools that can alleviate mental pain and lead to peace-*shanti*. Things like what the *Shastra's* talk about like when you reminisce about good times with the *Guru* for example, who is above these mental tribulations what we call '*smruti*'. *Smruti* of the *murti's* that can be very very cleansing and pacifying. Even coming to the *Mandir* [temple] itself and just sitting in front of the *murti's* [images of God], the peace that can shower down upon you can be very powerful and therapeutic. And these are the very practical things (Sahaj-Priya: 163-169).

From the excerpts above it seems clear engaging in religious practises is both a powerful tool and a source of strength in alleviating mental pain. Both Bharti and Sahaj-Priya talk about the practicality of drawing on religious practises. Furthermore, Mansi talks about it as being the first thing she would draw on before seeking professional help again, signifying its value and importance.

3.3 Family: Honour and Reputation

Many of the excerpts evidence the family as being the first port of call for seeking support for mental health problems over any other source, as it was seen to be trusted. In the excerpt below, Mansi constructs the mind to be valuable and, therefore, something she would not easily leave at the hands of someone unknown to her. She conveys a sense of fear in seeking help which is not internal to the family. Although, she does not explicitly address what this fear is, she highlights the importance her family place on not seeking help externally, “you should never go to anyone and seek help (Mansi)”. It could be inferred here that there are implications of seeking support outside of the family system.

Mental health is an area, where people only seek help, from people who they trust. It's all built on trust. It's this idea it's my mind and I'm not going to hand over my mind to someone I don't know and trust. When actually my family, who I've known for years, have been saying, you should never go to anyone and seek help. It would look so bad, we'll just sort it out internally. Or that's just the idea that's floating around the house, maybe no one has said it explicitly (Mansi: 712-718).

I think its combination. I think mostly family, because they are the first ones to notice, then friends who they would be able to confide into. And religious, I think number three or four (Manoj: 390-392).

In both Dhara and Meena's quote below they illustrate more explicitly why there is a strong sense of needing to keep mental health problems confined to the family. This highlights the view of mental health problems as perhaps being personal and intimate in nature, therefore, not seeing the benefit in sharing the problem. Both Meena and Dhara comment on not spreading the word outside of the family context, perhaps alluding to the shame it would bring on their families if it was shared. Meena also talks about “keeping it in the family” as being an “old Indian thing”, which alludes to the dominant discourse of mental health problems not only in the Gujarati but, more broadly, in the Indian community:

From my own perspective, I know my husband was the one that sort of rejected all help. Because he feels that “why would you want to wash your dirty laundry in

public?" And then well you're not, you're just telling someone getting help as a family (...) I think it's that old Indian thing "keep it in the family" (Meena: 263-270).

The rest of us were quite enclosed. In the sense all of my aunts, uncles and her parents would keep her business [referring to her aunt's mental health difficulties] to ourselves. We wouldn't spread it. (Dhara: 586-590).

The majority of participants spoke about the significance of protecting family honour and reputation by not discussing mental health difficulties with others. It seems that sharing mental health difficulties is inevitably associated with the loss of family honour:

If they have a family member who's got a mental health issue or if they've got someone close to them, who has got mental health issues. They would like to mask that as much as they can, it's all about the honour thing (Rajesh: 78-81).

Yeah and I think what happens is, people are afraid to talk about it with other people. And they don't want to share it with you know, the family or friends because they're scared as coming across as though they have something wrong with them or losing their honour (Dhara: 44-47).

Meena talks about how her family did not share the fact her daughter experienced mental health difficulties, as they were concerned about the judgment this disclosure would bring on them from the wider Gujarati community as a result. There is a strong sense in her quote that both her and her husband have a duty to protect their daughter from judgement. She makes an overarching statement about the Gujarati community's reluctance to discuss mental health, as it may lead to one's reputation being questioned and have a negative implication on other family members:

I think basically nothing we kept it quiet from all the families, because I didn't want anyone judging her [Meena's daughter]. My husband didn't want anybody to judge, you know within our [community] (...). I think nobody knew. (...). I think people think [referring to the Gujarati community] their reputation is at stake, and it may affect other family members and things like that (Meena: 320-324).

Sejal's quote also speaks clearly to the implications sharing mental health difficulties would have on her family; she discusses it in the context of the

shame and stigma that would be brought on the family. Again, like Meena there was a sense of concern about the wider community finding out. Furthermore, she makes reference to professionals' lack of understanding about these cultural issues:

Because then that would automatically bring stigma, shame to my immediate family. Which I probably wouldn't – which I don't want, obviously. So that's one thing because – yep so that's one drawback in telling people. Once the society or culture knows, that you know you're in a mental health hospital that would be quite damaging. Not just to the person fighting, overall to the family. And I don't think professionals quite understand that (Sejal: 550-553).

Some participants acknowledged generational differences in the importance given to family honour. For example, Tarun's excerpt below raises the point about honour not being a "big thing" in his generation but perhaps a more pertinent issue in the older generation. Although, he alludes to the idea of honour not being as significant in the younger generation, there is still a hint of scepticism in his tone as to whether this is truly the case, also indicated by the use of the words "I don't know"...."I wouldn't think".

I don't know, I mean from my age group, I wouldn't think honour is a big thing. But I would guess in the previous generation, I reckon there probably is a lot. And probably in peers. Looking at peers. There's probably words being said amongst peers. So like my dada's [grandfather's] age group, I'm sure like people would have said something somewhere. You know, between each other or whatever. I'm sure people do (Tarun: 50-55).

Tarun's scepticism was evident in others' accounts; for example, in Bharti's excerpt, although she explicitly states the older generation are probably more concerned with honour, she follows up by saying it "might" be problem in the younger generation too. Mansi too finds it difficult to acknowledge that this would be a significant problem in the younger generation, however, she too is tentative about her conclusion. Both accounts highlight education to be the corollary of the reduced concern regarding family honour and reputation in the younger generation:

I think it's probably the older generation more, than the younger. Young people are educated these days. So they do have an understanding, but I think even in some cases, there might be a problem. People don't want to admit it [mental health difficulties] because of losing their family reputation (Bharti: 517-523).

You know maybe in really traditional Gujarati families, maybe the older generation still have beliefs like that [beliefs about protecting family honour and reputation]. I really highly doubt any educated new generation child, would be concerned. I'm not sure that's something that happens. Of course I could be wrong, it could happen. I just can't see that that would be the case (Mansi: 606-611).

Whilst there seemed to be a strong sense from the participants accounts that family support was sought as the first option in order to protect family honour and reputation, a number of participants highlighted the benefits of seeking familial support over professional help. The most important benefit was seen to be the deeper understanding families have of the person, therefore, allowing for a different kind of support to that offered by professionals, whose knowledge of the person is limited. There was also a sense of dissatisfaction about seeking help from professionals due to the assumptions that may be made about them. Therefore, family support seemed to be privileged over professional help. The excerpt below speaks to this:

The reason why I'd go to my friends and family, is because they would know me better and then they would be know what is right and wrong, for me. And they'd understand why I'm feeling the way I do. It's not a situation that's happened within that speck of time. Isn't it? It's something that probably built up. And so someone will really have to know your history. And I think someone external, unless they're really specialised and I don't think GP's generally are. And so they wouldn't – you'd have to sit there, and explain to them your history. And then they'll try and make a conclusion out of it. And even that is like a hit and miss, so that's why I'd go to friends and family. Because they know me (Dhara: 211-238).

Interestingly, only one participant raised the dilemma of seeking help from the family; referring to the family itself being a possible source of tension and that there may also be judgement made by family members:

But I always think now, I don't want to keep going back to that person, they will suggest things, those things I might not take on board and might do. So I feel judged. People do judge, and even if they don't judge it's their opinion. You may not

agree with what they're saying. I don't think there are options for me, because it's not involving anybody else, family or – because sometimes your feelings are linked to something that has happened in your family, or people that you know (Meena: 780-783).

3.4 Community: A Means of Support and Safety

At surface level, there appears to be somewhat of a contradiction in the participant's accounts in discussing the community as a safe and supportive source of help based on what was discussed by participants in theme three. In the previous theme participants talked about ensuring help is sought from within the family to prevent others in the wider community finding out, as this could have implications on family honour and reputation. However, what appears to be a contradiction at surface level is not, as participants are making a distinction between the wider Gujarati community and the specific communities they belong to. Participants appeared to be drawing on two constructions of community; firstly community as represented by the faith community they belonged to, and secondly, community as a group of people who they had known personally for a long period of time. In the extracts below participants are orientating to this local construction of community when discussing the support they would draw on and why. Whilst there was a sense of fear of people in the wider community finding out, one's own personal community was constructed to be a useful support system to draw on when experiencing difficulties. The community was positioned as having a unique role in providing support and holding a certain type of knowledge, which participants saw as being central in seeking help for mental health difficulties. In addition various aspects of the community context were seen to make help-seeking more comfortable and beneficial.

3.4.1 A Self-Sustained System

This sub-theme explores how the community acts as an internal support system for people experiencing distress. The protective nature of communities along with their unique roles and responsibilities is highlighted.

The majority of participants constructed the community to be a self-sustained system from which they could seek support for mental health difficulties internally:

Yeah, I mean I think within *Mandir* [temple], I think you got a quite a good framework for friends and stuff like that. And particularly like where I am, I think there's a good group of people, who I think could understand because we've grown up together. But everyone will understand. (Tarun: 157-168).

And the good thing with the *Mandir*, with the community feeling we've got here, the support structure it's there. It's not as visible, but it's there (...). So having that support structure within the *Mandir*, makes a big difference (.....) And it might be just talking to a friend within the *Mandir*. It might be talking to a senior volunteer in the *Mandir*, or like I said speaking to a *Sadhu* [monk] in the *Mandir*. And you can get through those tough times, you know that support's there. And I think that helps (Rajesh: 278-281).

In the excerpts above both Tarun and Rajesh highlight the value of the support structure they can draw on in their respective faith communities. Although neither participant refers to community as a self-sustained system it is alluded to in their accounts. For example, for Tarun there is a real oneness reflected in his relationship with the community. Not only does he indicate the intimacy of the relationship he has with his faith community, but also the assurance that others would almost certainly appreciate his context. Similarly, Rajesh also highlights the “big difference” that a support structure within the community makes. He identifies the members of the community he could seek help from internally. Again there is a sense of assurance in his tone that the support will be there undoubtedly and that being key in getting through difficult times.

Other participants described the community to operate in a safeguarding manner; this excerpt speaks to the protective nature of the community:

I think [the community] allow[s] for inclusion. The community allows you to feel included, and I think the community acts a safety net. It kind of draws you back into this safety element, when you're not feeling the best or you're surrounded by lots of negativity that has caused this illness (Sejal: 372-375).

For others, as indicated in Mansi's excerpt below, the community has an important role in supporting all facets of one's wellbeing, emotional, physical and mental development. Mansi refers to community as a "trusted network" and something "we need", indicating the value of the community for her:

So having a trusted network of people, who you know that every week you're going to go see, who you know every week they're going to meet you with a smile is very important. Otherwise you end up – and human beings are not creatures who are supposed to be alone. Which is why we live in communities and families, and we grew up with each other. It's because we need support, we need people, we need – for our all sorts of development mental, physical, and emotional. All the development we go through we need people, we need other people's support, we need people's love and that's what people can give you if you're in a society like that (Mansi: 648-654).

Many participants spoke about the community as having a collective responsibility in supporting one another in times of distress. From the quotes below there is a real sense of unity and strength found in helping one another out. Sejal's and Manoj's excerpts suggest people are not alone in their plight, making reference to not being alone, and implying a shared responsibility, both of them transmit a sense of solidarity:

It definitely brings a sense of oneness, because you're around a lot of people, and a lot of people are fending for you and, you know, looking out for you to some degree (Sejal: 376-378)

If you have a network of people, who are saying to you "we understand that you have a problem, but we are going to do whatever it takes in order to help you". That's when you know that you can get through it, because you're not alone anymore. That vulnerability kind of shifts, because you're not reliant on just yourself to get over it, and you know you have the support of everyone else (Manoj: 632-636).

Although not explicitly stated, Rajesh alludes to the notion that supporting each other is a duty or moral obligation. However, Sahaj-Priya explicitly makes reference to the Hindu scriptures stating very clearly that it is the person's responsibility to seek others out. Implicit in this is the idea that one must be mindful of our connectedness to others and support one another:

We must support one another rather than just saying “this is your problem, this is how we are going to sort it out nice to see you”. (Rajesh: 181-182).

(...) The community plays a huge huge role. The *Shastra's* [Hindu scriptures] very clearly explain (...) we are part of a community and you cannot isolate yourself (...). So, no man is an island you are living in a public place you are interacting with people all the time so learning to grow from that .(Sahaj-Priya: 420-423).

3.4.2 The Community Context

As stated above, seeking help for mental health difficulties from the community was preferred amongst the majority of participants; various factors were described as providing a context which facilitates help-seeking from the community.

A sense of trust was seen as a crucial factor that enabled people to seek help from the community. Both Sejal and Mansi perceive the community as being a “trusting network” and source of support and comfort, which is achieved through spending time with the people in community and knowing them over a long period of time, and by the sense of a knowledge of their life's contexts (including the religious context), which perhaps professionals can never fully understand:

I have a better relationship with my spiritual base, like I definitely have a better relationship with my spiritual leader, with the religion I'm with and with the people that come here as opposed to my GP (...). You're around people you know, and the people that understand your factors, there's that element of trust. You trust these people, because you know they understand you and they know you. In a community, you know these people, you see them, you spend time with them. So that trust is definitely felt. (Sejal: 111-113).

Having a trusting a network of people, is so important for a person, because they really can help you get through whatever that thing is. Whenever someone goes through a mental health issue, generally they tend to feel very alone, they feel very vulnerable, and they feel very alone and segregated (Mansi: 627-631).

In relation to trust, a few commented on the discrete nature of help found in their faith communities:

And that second thing with that [referring to community support] it's discreet, that helps a lot because *sadhus* [monks] have a personal obligation and a duty, to keep that person's confidential matters confidential. And they will (Bharti: 165-168).

In addition to trust and the discrete help offered in the community context, some participants talked about how community members offer a more tailored approach to managing distress. For example, Rajesh talks about monks offering a “special perspective” in understanding someone’s needs. It is possible here that by “special perspective”, Rajesh is referring to the religious, cultural and philosophical understanding a monk might have and this would be integrated into the approach he provides, which may be more suited to the person seeking help. Sejal explicitly mentions how other factors important to person seeking help would be integrated into the support provided by the community and this potentially being something that is not adopted by other sources of support:

In the same way, a monk, a sadhu, has that understanding of life. Be it from a special perspective, but a special perspective is sometimes better, in understanding someone's needs and their wants (Rajesh: 161-164).

I think coming to the temple, and seeking – if there was something like this set up, they would also be mindful of the type of person you are, and what kind of principle, or religion, or spirituality. Like they're a lot more aware of those thoughts. So they'd integrate that into in inverted commas, the treatment (.....). Whereas somebody who doesn't understand that, wouldn't be able to integrate these things. So would probably ask you to do things, which are completely different which are quite alien to me (Sejal: 423-433).

A few participants talked about tapping into the knowledge and experiences of others in the community and this being a helpful aspect of the community context. In the excerpt below, Sahaj-Priya constructs the community as an extension of the family and people who work together to support each other. In reflecting on his experiences of offering support to members of the faith community in his pastoral role, he attributes drawing on other people’s

experiences and wisdom as being an important tool that has supported people in hard times:

Consulting other people [in the community] who have been through what you have, or who are more experienced or have your interest heart. I think that is a huge source of help, reassurance and wisdom that people can tap into. And people have and that's been a very important part of people coming out of very dire situations [speaking from his experience offering support in the temple]. Whether it's at home, with family, having that support system, the matrix of resources at people's disposal has been very helpful to many people. That's a very powerful part of communities and fellowships. People coming in, feeling at home as an extended family with one purpose where people will not be judging them, accepting them for who they are, working together for a higher purpose. That sense of community is deeply invigorating and deeply satisfying (Sahaj- Priya: 366-380).

Many participants referred to the environment provided by the community as being an easier place to seek help compared to professional services. For example, Tarun illustrates how people may not go to the GP, as they might feel daunted, while seeking support from the community might be easier as its people with who you already have a rapport with and in a place which feels more familiar and welcoming. In line with this, Bharti also talks about the sense of belonging the community environment provides and this being an enabler for help-seeking:

They are people that you see week in week out. So it's not like you're going to see someone specially and it's something that is very – so if I was a person reluctant to go to a GP or anyone (...). You can speak to your friends, or you can speak to someone you know about whatever you need to speak to them about. Whereas like going to a professional, might be a bit of a daunting then going to the *Mandir* [temple]. And it's a less of a what's the word? Less of a – well it's more of a welcoming environment. Yeah. You feel less strayed, should we say to let it out what you want to talk about. And again it's with people you know. (Tarun: 380-393).

I: In your opinion what makes it more comfortable, seeking help from the community rather than going to professional services?

Because they see the community group as their own. There's a sense of belonging. (Bharti: 474-475).

Both Rajesh and Sejal also commented on the warm and friendly environment of the community as being conducive to seeking help compared to the environment found in professional services. In talking about his view of the professional system as “black and white”, Rajesh might be referring to the dominance of diagnosis that pervades mental health services whereas this is not the focus in the community:

In terms of atmosphere, it's an environment that is conducive to that [help-seeking]. You've got a very supportive, a very friendly, very spiritually focused, very calm peaceful atmosphere. That makes a difference. I think a lot more people are able to talk about their issues, in that sort of environment rather than in a clinical environment, where everything is completely black and white (Rajesh: 275-279).

I think it's a lot more warmer, because it's more of a choice. You're not forced or you're not told, by your GP of what you're required. I think it's definitely a lot more warmer, and you're able to track some of the warmth (Sejal: 416-420).

3.5 Professional Services: Challenges and Vision

This theme focuses on the challenges and dilemmas faced by the Gujarati community in accessing professional support. This was discussed by participants with respect to several barriers. Integration of professional services and communities was viewed to be the vision for mental health care and an enabler to help-seeking.

3.5.1 Barriers to Help-Seeking

In considering the factors that may act as barriers to seeking help from professional services the majority of participants talked about; lack of cultural sensitivity, fear of gossip, damage to marriage prospects, and relationship with professionals, as being a significant barrier in the decision to seek help. Many participants expressed the poor cultural understanding amongst professionals as having an impact on their interaction with professional systems. For example, Meena describes the incapability of professionals to attend to the subtleties of the Gujarati culture in her experience with mental health services. There is a sense of dissatisfaction in her tone regarding the lack of cultural sensitivity, she alludes to being given suggestions that are not

culturally relevant. Therefore, she suggests professionals should seek consultation from other professionals from either the Gujarati community, or wider Asian community, as way of better attending to nuances of culture:

[Mental health professionals] we had didn't understand the dynamics of a Gujarati family, so they were like "why, what's the problem?" They couldn't understand that no, actually, it doesn't happen in our family. The man will not do this, you know the husband will not do this, or the husband would expect the wife to have done this. (...)You have to understand how the dynamics of it in Asian families (...). I think just to have more – like if it's like yourself [referring to the interviewer], you could go and talk to the therapist, or sit in on maybe if there is a family that have these issues, maybe just sit in and guide the issues along. Because the practitioner may suggest something, but that might not be appropriate or right for that family. You, the Gujarati's or the Asians would understand why that doesn't work, and can find another solution (Meena: 467-476).

In a similar manner, Sejal explicitly refers to the ignorance of professionals when it comes to considering the "damaging" consequences a mental health diagnosis may have on the family. She refers to Eastern and South Asian cultures as being collectivist and prioritising shared decision making and this being an aspect neglected by professionals. Connected to theme two, she highlights the importance religion. Again, like Sejal there is a sense of dissatisfaction in her comment, as she feels these aspects are not integrated into the care provided by professional services in this country:

Once the society or culture knows that, you know, you're in a mental health hospital, that would be quite damaging. Not just to the person fighting, overall to the family. And I don't think professionals quite understand that. Like if I told a psychiatrist, not to give me a diagnosis, or to not kind of send me to a mental health centre or a mental health hospital, I don't think they'll quite understand why I'm saying it.

I: So do you think maybe there's like a lack of understanding, from professionals in terms of/...?

Yeah definitely. They don't get cultures, like they don't at all get cultures (.....). I think for them they need to understand, it's not an individualistic thing. Like you're not just working with one person, you're working with all the entities. And within the culture – within an eastern culture (...). Within a South Asian culture, a family is probably the biggest, it's like such a key thing. So much so that, you know, families don't take

decisions, as individuals. You take major decisions together. And I think when it comes down to things like mental health, and diagnosis and things like that, the family would want to be included. And I think when a professional is treating, or is trying to help a person with mental illness, coming from a South Asian community, they have to take in that they do belong to a culture and that they do belong to a religion (.....). And I don't think the system in this country, does that. It's very just about the person. It's not about the entities that make the person (Sejal: 285-293).

Some participants raised the cultural relevance of psychological therapies and offered in services. Dhara illustrates how the intervention offered to her Aunt was not effective in the long run as it did not fit with her cultural needs. She assumes that if it was set up in conjunction with someone of the same cultural background it would not have been an issue. Further, Sejal's excerpt attends to the incompatibility of western psychological therapies with the eastern cultures. She refers to the older generation in her family not being able to conceptualise the western construction of mental health which dominates mental health services:

And then there was – at towards the end of the 6 months, they were struggling to find things that they could do together [referring to a psychological intervention]. So I don't think that would have been an issue, if yeah, if that person was Asian, or Gujarati or anything like that. Or it wouldn't have been much of an issue. And it definitely, would have made my aunt feel more comfortable (Dhara: 1130-1145).

Yeah can you like imagine me telling my grandma, about CBT? She's not going to know what that is. She's not going to know about you know, her feelings and her emotions, and how to regulate the emotions. Like she's not going to know that, or my mum even. My mum's not someone that is born or brought up in this society. You know, she comes from an Eastern society, there's a way they think is very different (Sejal: 350-355).

A number of participants considered how language and the lack of consideration for ethnicity and culture might create difficulties for the Gujarati community. In excerpt below, Tarun refers to the mismatch language between professionals and the community. He states that some words may not be translatable into English and this may result in a misunderstanding on the part of the professional. Rajesh explicitly indicates that the statutory services need

to think carefully about ethnicity and language barriers or else it could result in people receiving an unfair service:

Yeah. Well the older [generation], yeah, like I said with that the other thing, was we might have a problem with the language barrier on some of them. And you know, even if they do go to a GP, they're not sure what to say. And if they do know what to say, they're freely willing to say it. It's just the language, the words. We have the words in our language, but they might not be translatable. You know they might come out harsher or softer, than they're trying to portray. So you would – like you have with any translation, you can't use word for word in most cases. You would have to – you'd have alternatives and it might not be as it's supposed to come out. Or exactly what the person is feeling. (Tarun: 238-267).

(...)So there might need to be something in the statutory services, about being more aware of the person's ethnicity and their language barriers. Because at the moment, for example, I am going to give the Dementia example, and if there's an elderly lady or an elderly man who don't understand the language, then they'll struggle anyway (Rajesh: 355-385).

Many participants raised the fear of gossip as a barrier to help-seeking. This connects to aspects of theme three, where there was a sense of needing to keep mental health within the confinement of the family to avoid judgement from others.

Both Rajesh's and Mansi's quotes speak to the pervasive fear that stops people from seeking help. There is a real sense from both participants that other people finding out that someone was accessing mental health services would be detrimental to the way they are then viewed. There is a sense in Mansi's quote that perhaps this fear is exaggerated as she ridicules the nature of it:

Or "what if..." you know gossip spreads and all of a sudden people think I've got issues (...) There might still be a little bit of a doubt of hesitation in that person's mind that you know "this is a small world I might end up you know, going home and here's – through the great mind of people, people start finding out that you know I am going to speaking to someone" (Rajesh: 312-317).

You know, what would your *kaka* [paternal uncle] say? What would your *mama's* [maternal uncle] son's dog say? What would our neighbours say? If they found out you have a mental health problem. This kind of gossip, this fear of society and fear of what everyone else will say and everyone will be talking about us. It's that kind of fear, that stops people from seeking help. (Mansi: 441-445).

Indeed, in the excerpts below Meena and Dhara reflect on their experiences of being gossiped about and this being directly linked to their decision not to seek help:

You know, it became Chinese whispers, because whatever you say will go to somebody else in a different form. So we just didn't want to talk about it or ask for help (Meena: 656-659).

I have experience at first hand, but I hear that – I hear from friends that it's not... what do you hear? You hear that they're very gossipy about it, so we didn't ask for help (Dhara: 73-75).

Sejal further alludes to the fact that seeking help might have a damaging impact on her parents. Again this might be linked to theme three, where it was seen as important to protect family honour and reputation:

I think again, (...) they'll gossip about me or the words will be spread. And then you know, I don't want someone calling up my parents one day and saying that "oh I heard about your daughter going through something. You know I heard her mental illness is..." (Sejal: 145-149).

Some participants spoke about how seeking help for mental health difficulties could have a negative impact on marriage prospects. Several participants describe how there is stigma attached to seeking help for mental health problems and this stigma may prevent people from accessing services, as it may jeopardise marriage prospects for the members of the family who are unmarried, perhaps pointing to dominance of genetic explanations of mental health problems in this community as highlighted in theme 1:

Then the family itself, if it was a girl who was say 20-year-old girl, daughter suddenly had a problem. They would not want to openly declare, that she had a mental health problems, in case they're worried they could be not find a suitable husband for her

afterwards. Because the word will spread “she's not well”, and whatever and they then would assume she's not well for the rest of her life. So there is that stigma, which would prevent people from initially seeking help, till maybe it was too late or too advanced (Manoj: 483-490).

Just thinking back, from what we're saying what people perceive mental health. I know there was an aunt, and an in-law that had mental health problems. And I remember my mother-in-law, would say “oh yeah, you know, she's got these issues like this”. And so for that reason, nobody would marry the daughter. (...) So that's why they didn't ask for help (Bharti: 298-304).

Many participants discussed the relationship they have with professionals as being an influencing factor in seeking help. The limited time primary care professionals spend with people was seen not be facilitative of building a trusting relationship or getting to know the individual, therefore, making professional help-seeking a last resort. Mental health is constructed as being a complex and intimate problem requiring the value of time. In the excerpt below, Dhara states not having trust in the judgement of GP's, and the discomfort her aunt faced when seeking help. Due to the negative relationship she had with her GP, she states that would be the last place she would seek help from. Sejal echoes similar sentiments in her quote:

The GP was just saying things like “oh, she looks fine to me”. And that just made me think that “yeah, you're just seeing her for like 10 minutes, every few weeks or months. You can't know that person”. And so you don't really trust their judgement sort of on mental health issues. [My aunt] she wasn't made to feel comfortable basically. She was made to feel like “ok, now you're a problem, you have a problem, and there's something not quite right with you”. And that's the last thing you want, when you go and seek any sort of medical help. So I don't really trust certain medical lines. Yeah like it's not something I'd go to. GP's the last place I go to (Dhara: 740-745).

And I think with GP's, it's more the experiences I have had in the past, it's more just going in speaking to them for 10 minutes and that's it. And I don't think these situations are 10 minutes. You know, conversations – I mean these aren't 10 minute conversations you can have with someone. You can't build a trusting relationship in 10 minutes, let alone tell the person what I'm going through. So I think the way GP

systems work, from the experiences I've had, wouldn't allow me to seek help (Sejal: 122-128).

3.5.3 Integration of Services

This subtheme explores what the Gujarati community envision for mental health services both in terms of making them accessible but also relevant to the community.

Many participants stated the need for the NHS to make links with the community and faith groups as way of helping people to not only access services but seek support in a place that is comfortable to them. Rajesh highlights the failure of the statutory services to integrate with faith and community groups. In his ending phrase there is a sense of urgency in building connections with the neglected groups:

I think where the NHS hasn't been able to, historically, tap in to maybe faith and community groups, they've been regular at targeting voluntary groups but they haven't been integrate with faith groups(...) So, if anything, the message from the NHS is "ok, you've been very good talking to charities, you've been very good at talking to public organizations. But now start talking to the faith groups (Rajesh: 508-510).

Tarun also places the onus on the NHS to build links with communities. He too states the NHS need to be "more forthcoming". He alludes to the idea that the integration between the two might make help-seeking easier or more likely, as Indians are generally "reluctant" to go to the GP:

I think Indians in general would be more reluctant to go to a GP, than any other community out there. And I think NHS could probably need more forth coming to them rather than the other way round. Since I think – I don't know if it's a general Asian thing, or it's just a Hindu thing (Tarun: 505-508).

Some participants offered suggestions of what the statutory services could offer community groups if there was collaboration between the two. Bharti suggests professionals could offer seminars and guidance on what to do for certain problems. Importantly, implicit in her vision is the importance of "working together". Although, she does not explicitly state this, she does

allude to collaboration between communities and statutory services not a taking over from them:

I think that's a very good thing if the NHS links up to the community group in some way (Bharti: 425-426).

I: And what might that look like in your view?

/ If – maybe not the community groups as such, but I think at least have a representation at the community groups. You know, once in a while you would do a seminar on mental health, and what problems you would have, what we can do for you. Things like that. I think working together, maybe the NHS and the councils, and the communities. If they can work together in some way then I'm sure there would be some kind of solution. We are doing everything we can, at a level – at a lower level, local level (...). But it's very difficult to get someone to go to a doctor, and admit those kinds of things (Bharti: 430-433).

Further, Sejal suggests professionals could provide the community with training, perhaps skilling up the people that already offer support in the community:

I think well coming to the temple and stuff, the temple is within an area, and I'm sure this particularly geographical area has you know, mental health professionals who work here. It would be great for them to affiliate, or for the community to affiliate with professionals, where professionals can come in and give us a bit training. Or give people here training, on how – not you know how to professionally you know, having professionals coming in and training people on handling risks, assessments and things like that. It would be nice to see a bit more of that integration (Sejal: 443-448).

There is a more reciprocal relationship in Rajesh's excerpt, as there is a clearer discussion about both professionals and communities drawing on each other's skill sets as way forward, there is a sense of privileging the knowledge from both. The integration of the two perspectives would provide a more "dynamic approach". This connects with theme two were participants discussed the important role of religion and spirituality in the management of mental health difficulties:

So I think its interfacing. So you know, where your NHS offers a more clinical skill set. Whereas you faith group, offer a very subtle and much more different approach. But where you can integrate things, where both services can talk to each other in the well-being of someone. Then that would be a great thing. You know, because there are certain things a clinician would know, which a faith side won't and vice versa and that integration doesn't happen, it's never happened and it might be a new dynamic approach. (Rajesh: 521-527).

Building on this idea, Tarun illustrates how integration between faith communities and statutory services would allow for a multi-faceted approach. He highlights “religion” to be a key aspect of the approach that would be offered:

They have firm beliefs in the religion; it has to be a multi-faceted approach. And religion has to be one of those assets. Because I think that would be something that would make it more digestible (Tarun: 465-468).

CHAPTER 4: DISCUSSION

This chapter will explore in detail the main themes derived from the analysis in relation to both the research questions and the existing literature. The chapter provides a critical review and evaluation of the study, concluding with highlighting the implications of the findings at service, clinical and research level.

4.1 Reviewing Research Aims

The central aim of this study was to explore how the Indian Gujarati community makes sense of help-seeking for mental health problems. In the following section, the five themes identified from the analysis will be discussed in relation to existing literature and the original research questions.

4.1.1 Research Question One: How Do The Indian Gujarati Community Understand Mental Health?

The first research question sought to explore how the Indian Gujarati community conceptualises mental health difficulties. This was primarily addressed through two themes:

Theme 1: Constructions and Causes of Mental Health Problems

This theme represents how participants constructed mental health and what they attributed to be the causal factors for mental health problems.

When discussing their construction of mental health, participants viewed the mind and body as being a united entity. Reflecting this view, physical and mental health were also seen to be integral to each other. Participants did not compartmentalise the mind (mental) and body (physical), both were viewed to have a bi-directional relationship with each other. The conceptualisation of mind-body in this way stands in line with the Eastern view of health (Fernando & Keating, 2008). In stark contrast, central to the Western view of mental health is a strict divide between the mind and body. This dominant

construction not only informs mental health practice but also the way in which health services are set up. Mental and physical health services in the NHS remain largely separate. Participants referred to this divide as being unhelpful, as mental health should be considered as part of one's holistic wellbeing. There was a sense of dissatisfaction from participants pertaining to the lack of understanding from professionals about the Eastern conceptualisation of mental health. For example, some participants referred to the ignorance of both professionals and Western medicine regarding the integration of the mind and body. The lack of appreciation for the Eastern integrative view of health was viewed by participants as being barrier to help-seeking and a reason for their underuse of mental health services. This is line with literature that has shown understandings and beliefs about mental health have a significant influence on help-seeking, the use of mental health services and mental health treatment (Kleinman, 1978; Helman, 1994). On this basis, it could be argued that for participants the dominance of Western ideas that pervade mental health services may result in a reluctance to seek help from professional services. Furthermore, in considering the influence on their understanding of the mind-body, and in turn mental health, participants referred to the importance of the unity of mind-body as elucidated in the Hindu scriptures. They discussed how the Hindu scriptures talk about the physical having an effect on the mental and vice versa, therefore, this should be seen as integral to health.

Paradoxically, although participants' construction of the mind-body was in line with Eastern thinking, the causal factors attributed to mental health were surprisingly at stark odds with the Eastern conceptualisation of mental health. Previous literature regarding beliefs about the causes and cures of mental health problems has consistently shown that the SA community attribute the origins of mental health problems to supernatural beliefs such as *najar* (evil eye), *bhut* (ghost affliction) and *jinn* possession (Lim et al.,2015; Spiro, 2005; Cinnirella et al.,1999; Kleinman, 1978;), which is in line with the Eastern the view of mental health (Fernando & Keating, 2008). However, the findings from this study do not support previous literature about illness causation in the SA community. In this study, participants drew on a medical model of mental

health to explain the causal factors. Mental health was referred to as an 'illness' caused by genetic and biological factors. This finding is also inconsistent with previous research, which suggests the SA community fail to recognise psychological distress, poorly understand the causes or fail to perceive it as 'illness' (Raliegh & Almond 1995; Ineichen, 1990). Although not all participants themselves held the view of mental health as an 'illness' caused by biological factors, they described that the dominant discourse about mental health within Indian Gujarati community remains a very medicalised perspective. This finding is of particular interest, firstly, as it challenges the dominant assumptions made about the SA community in the literature, as failing to understand Western constructions of mental health and their inability to recognise psychological distress. Secondly, it highlights how fundamental differences may exist between SA sub-groups, as evidenced by the findings of this study. However, these differences have been marginalised in previous literature, which assumes that the SA community use the same framework to understand mental health problems and have a shared definition of mental health (Kleinman, 1987).

A possible explanation for this paradoxical finding may be a result of acculturation. Research has demonstrated that acculturation has a significant influence on how people understand and make-sense of mental health problems (Hammid et al.,2009). The Indian Gujarati community are viewed as being the most assimilated out of all the SA sub-groups (Ramji, 2006; Poros, 2011; Berry, 1980). They are also the sub-group who have been in the UK for the longest period of time (Poros, 2011). Therefore, it is likely that they will have been more exposed to Western thinking and this would undoubtedly influence how they understand mental health thus, this might explain why participants' drew on both Eastern and Western conceptualisations. For example, Sheikh & Furnham's (2000) study found that British born Asians' beliefs about the causes of mental health problems and treatment options were in line with a Western conceptualisation of mental health. The authors suggest that whilst the SA community in the UK will be influenced by ideas from their home culture, the host society as well as the UK health system is likely to have a greater influence on how mental health understood. In addition

to acculturation, language and education could also explain this paradoxical finding. Furnham and Malik's (1994) study found that SA women who spent their formative years in their respective sub-continent, spoke little English and received a non-western education had a significantly different conceptualisation about the causes of mental health problems compared to SA's born in the UK whose conceptualisation of mental health was in line with Western thinking. All participants' in this study were either born or spent their formative years in the UK, and were educated to university level, therefore this is likely to be significant in explaining why they drew on both Eastern and Western perspectives.

Research suggests that both recognising mental health problems as an 'illness' and higher levels of acculturation are linked to greater willingness to access professional help (Raliegh & Almond, 1995; Hamid, Simmonds, & Bowles, 2009). However, whilst there was a sense from participant accounts that they were 'well assimilated' and there was a clear appreciation of mental health as an 'illness', there was still a reluctance to seek help from professional services. Therefore, as previously assumed it may not be the inability to recognise mental health as 'illness' or lack of psychological mindedness that explains the underrepresentation of SA in the statistics of those seeking help from mental health services. This assumption has too often been easily adopted by the statutory services to explain why this community do not seek help (Patel et al., 2009). However, there is a need to thoroughly consider, other factors that have usually been in periphery that may explain limited help-seeking. This includes help-seeking from non-professional sources (see section 4.1.2 for further discussion) and the relationship the community have with professional services (see section 4.1.3 for further discussion).

Theme 2: Religion: An Integral Role

This second theme considers the important role religion plays in both making sense of suffering and managing mental health difficulties. As discussed in theme 1, participants drew on a predominantly medical framework to describe the causes of mental health problems. However, to make sense of why one is

subject to suffering or mental pain, they referred to a key religious concept in Hinduism known as 'the will of God'. Whether one experiences distress and what the outcome may be was constructed by participants to be ultimately in God's hands. Taking solace in this religious concept gave participants a sense of hope and that the burden was shared. Making sense of suffering to be 'God's will' is consistent with previous research that has demonstrated that it is an important concept used by SA to make sense of mental difficulties (Hussain & Cochrance, 2003; Hatfield et al., 1996). For all the participants, God's will was symbolic in how they understood and managed mental health difficulties; this significance was reflected in the advice and guidance that participants reported they would give other members of the community to help them cope with mental health problems. Interestingly, drawing on this religious concept was viewed by participants as being positive; it acted as a personal resource and strength, it was not perceived as becoming a victim to a higher power or leading to passivity and resignation about one's situation. Belief in the will of God as being a personal resource and source of strength has been illustrated as a strong feature in how many SA communities cope with both physical and mental health problems (Ismail, Wright, Rhodes & Small, 2005; Morjaria & Orford, 2002).

In addition to drawing on a religious framework to understand distress, all participants described religion as being integral in the management of mental health difficulties, and salient in their day to day life. Religion provided participants with a sense of protection, safety and strength to bear through mental pain. There was strong appreciation for using religious practises such as prayer, chanting and reading of the religious texts as tools to cope with mental health difficulties. They were described to lighten the weight of the problem, and a medium which was a reliable and permanent source of support. These findings are consistent with Cinnirella et al's., (1999) study, which found Pakistani-Muslim people reported religion to be a way of coping with mental health problems. As Sheikh and Furnham (2000) note, the conceptualisation of mental health is linked to religious belief systems therefore, influences the type of help sought. Consistent with this, participants spoke about drawing on the religious community for help over professional

help, even though mental health was perceived as an ‘illness’. The significance of religion in the participants’ lives along with various other factors (see section 4.1.2 for further discussion) made help-seeking from the religious community a preferred option. Participants in the sample were of different generations, however, they all referred to the integral role of religion in understanding and managing mental health difficulties. Therefore, it could be concluded that religion plays a significant role over multiple generations in the lives of the Indian Gujarati community. This theme supports the notion that religion and spirituality would have to be integrated into any approach or support offered to this community.

4.1.2 Research Question Two: Where do the Indian Gujarati community go to seek help for mental health difficulties and why?

The second research aim is addressed through themes three and four. Theme three explores why the family is chosen as the first port of call for help-seeking in the Indian Gujarati community. Theme four considers why the community is a preferred source of help over professional services for this community. A discussion regarding why family and community support are chosen will be offered making relationship with the other main themes.

Theme 3: Family: Honour and Reputation

The third theme captures why participants considered seeking help from the family as a first port of call; family support is chosen as the first port of call for both negative and positive reason. The family was described by participants as being a “trusted source” who you can confide in, and also those who hold a deeper understanding of the problem. The mind was considered to be precious, therefore, participants spoke about how they would not easily hand it over to anyone outside of the family. On this basis, it could be argued that families are a highly valued and trusted network, therefore, privileged over professional help. This mirrors previous research, which supports the view that families are highly valued by Indians and are consulted with in times of need (Medora et al., 2000). It is important to note, most of the previous research to date has focused on how the practical, social and emotional needs of SA are well met within the context of the family (Willis, 2010). As a

result, it is assumed SA seek help from the family, therefore, not requiring support from services (Okuyiga, 1998); however, the case may not be that simple. The reasoning behind choosing family support needs to be explored, rather than making a blanket assumption.

In the interviews, none of the participants alluded to their needs being met within the family, or this being the reason why they seek help from within the family. In fact, participants discussed the pressure to keep mental health difficulties confined to the family context to avoid losing one's reputation and honour, and fear of judgement, as the reason why family support was chosen as the first port of call. There was a strong sense of responsibility to protect one's family honour and reputation at any cost; help-seeking from professional services was viewed as potentially jeopardising this honour. This was described by participants as being a dominant discourse in the Gujarati community. This finding is consistent with previous research, which has shown 'family honour or *izzat* to impede on help-seeking and uptake of services (Gilbert et al., 2004; Pilkington et al., 2012).

Although the family is an important source of support, this cultural stereotype has often been used by services to explain the underrepresentation of SA in mental health services and needs to be reconsidered (Katbamna et al., 2004). It was clear from the participants that the pressure of cultural values was seen to leave no option but to seek help from within the family. Some participants raised how professionals were often unaware of these cultural tensions and this resulted in feeling not understood when professional help is accessed. Interestingly, there was also some uncertainty regarding the significance of family honour and reputation across the generations. There was a definite sense that this would act as a barrier to help-seeking for the older generation, however, the case for the younger generation was unclear. Given, the closeness that characterises Indian families (Medora et al., 2000), even if there is difference in the thinking between the generations, the dominant cultural values are still likely to have an influence on ideas about help-seeking.

Theme 4: Community: A Means of Support and Safety

This theme sought to highlight how the community was perceived to be an important source of support for participants when facing mental health problems. In this theme, participants were specifically referring to their faith communities, or people who they had known personally for a long period of time as a 'community'. This local construction of community was described by the participants' to be the place from which they would seek support. Participants differentiated these local communities from the wider Indian Gujarat community, which is the community they wanted to hide their difficulties from. The role and characteristics of these local communities were discussed by participants. They identified various factors unique to the community context that enabled them to seek help. Participants specifically spoke of the differences between seeking help from professional services and the community.

The faith community was described by participants as having an important role in safeguarding all aspects of wellbeing: emotional, mental, physical and spiritual. This protective role of the community against mental health problems is consistent with research that highlights the benefits of community support (Raleigh, 1995; Stansfeld & Sproston, 2002). Many participants referred to it as a self-sustained system from which one's need are met, reducing the need to seek professional support. There was confidence in the participants' tone that everyone would understand each other's context and be there for one another undoubtedly. As a result, the community was viewed to be a reliable and ever available source of support for participants. The collective responsibility to help each other during distress was frequently referred to by participants. This could be considered as a unique feature of communities, as people work together to get through difficult times and the burden lessens as a result. It might be this feature of communities which sets it apart from professional support, as there is a sense of oneness and personal responsibility from community members. In line with previous research by McKenzie, Whitley and Weich (2002), participants reflected the Indian Gujarati community to be characterised by strong community support systems. Research has postulated two pathways to explain the effect of community

support on wellbeing: 'direct' and 'buffering' effects. The direct pathway suggests that community support enhances an individual's self-appraisal and self-esteem (Cohen, 1988). The buffering pathway proposes that community support has an influence on mental health by helping individuals to cope with the consequences of the stressor through emotional, informational or material support (Alloway & Bebbington, 1987). Participants did not explicitly refer to the direct effects of community support, however, the buffering effects of community support were highlighted in the participants' accounts.

Participants shed light on various factors present in the community context that explain why they choose to seek help from the community over professional services. It is important to note, some participants referred to faith communities and others to social communities. The deeper and longstanding relationship people had with their respective communities was considered to play an important role in deciding to seek help. Some participants spoke about how certain members of the community had known them growing up and already had a rapport with them, therefore, a trusting relationship was seen as a crucial factor that facilitated help-seeking. Participants compared the trusting relationship they have with community members and the comfort and warmth provided by them, with the relationship they held with professionals, which was described to be founded on distrust and judgement.

In addition to trust, participants commented on the discrete nature of help, particularly in faith communities, this was seen as enabling people to seek help. It could be inferred from the data derived in theme 3, that discrete help is vital to the Indian Gujarati community as a result of the implication help-seeking can have on family honour and reputation. Another factor described by participants as a reason for why community support is sought, is the ability to draw on the knowledge and experiences of others, this was viewed as being a helpful aspect of seeking help for the community. Again, this links to the earlier point about the emphasis on a collective responsibility to help each other out in times of need. Participants spoke about the community offering a more tailored approach to managing mental health, which is something

professional services were seen to lack. Factors important to the person seeking help such as religion and spirituality are integrated into support provided by the community, however, participants felt that this was largely absent from the support offered by professional services. As a result there was a preference in seeking help from the community. This finding is in line with Incayawar et al's., (2009) study, which found the SA communities turn to their religious community for help as a result of dissatisfaction with formal services' failure to attend to religious and spiritual ideas. As highlighted in theme 2, participants described religion as having an integral role in coping with mental health problems. Therefore, if it is not integrated or attended to in the support provided by the statutory services, it is likely that it will have an influence on help-seeking.

4.1.3 Research Question Three: What factors facilitate or hinder the Indian Gujarati community in seeking help?

The third research aim is addressed through theme five, 'Professional services: challenges and vision'. This theme represents factors which participants described as being barriers or facilitative in seeking help. The majority of the barriers were largely discussed by participants in relation to professional help. Factors described as facilitating help-seeking were spoken about by participants in terms of their vision for mental health services.

A lack of cultural sensitivity was viewed as being a significant barrier in accessing help from professional services. There was a sense of dissatisfaction evidenced in the participants' accounts with respect to professionals being unaware of certain cultural values, such as those illustrated in themes one, two and three. As a result, they considered the support or guidance offered by professionals to be irrelevant as it did not fit their world view. There was sense of disappointment in the participants' accounts that "professionals don't get cultures". This speaks to previous research which supports the notion that cultural insensitivity results in dissatisfaction from services and acts as significant barrier to help-seeking (Incayawar et al.,2009). Furthermore, Shah et al.,(2005) argue it is the responsibility of services to attend to cultural issues and work with frameworks

that are less Eurocentric. This idea was reflected in participants' comments where they questioned the relevance of psychological therapies and interventions offered by services, as they do not attend to cultural or religious beliefs. The incompatibility of Western psychological therapies with the Eastern culture was seen as a challenge in seeking help from professional services particularly for the older generation. This finding is supported by previous research conducted by Harrow Mind (Joshi, Parmar & Smith, 2008) with Gujarati speaking elders which highlighted Eurocentric therapies to be a significant barrier in accessing help but also resulted in dissatisfaction from service users as services were seen to be culturally insensitive.

The fear of gossip from the wider Indian Gujarati community was seen to act as a barrier in accessing help, it is possible the strong sense of community that characterise Indian communities (Cochrane, 1983) may heighten the fear of gossip. The wider community in which one is not personally embedded in may act as a source of distress, as highlighted by some of the participants, hindering one's ability to seek help from professional services for fear of the consequences this may bring. This supports previous findings from the literature, which suggest that communities may hinder help-seeking as people are fearful others may find out (Hatfield et al., 1996).

In relation to the fear of gossip, participants spoke about how seeking professional help could jeopardise marriage prospects. They described how this created a reluctance to access professional help. This finding supports a study by MacKenzie (2006) who found that SA reported the stigma associated with having a family member with mental health difficulties would jeopardise important life events such as marriage prospects, therefore, there was pressure not to disclose concerns and seek help.

Historically, most of the literature concerning barriers in accessing help from professional services has focused on 'shame' and 'stigma' as being factors that impede help-seeking (e.g. Bradby et al., 2007; Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak, 2005; Bowl, 2007). This cultural stereotyping has been argued to absolve services of the responsibility to

consider other dimensions of mental health care which may impede on help-seeking (Shah et al., 2005). 'Shame' and 'stigma' as factors impeding help-seeking were largely absent in participants' accounts. The challenges for the Indian Gujarati community appeared to be related to the fear or gossip and judgement by others, which although share similar dimensions to shame and stigma have different implications on help-seeking. Previous studies have homogenised SA groups, therefore subtleties intrinsic to each sub-group such as the dimensions of shame and stigma are overlooked.

Participants' discussed the relationship they held with professionals (referencing in particular primary care professionals) as impacting on their decision to seek help. Participants discussed how they did not have a trusting relationship with professionals and felt judged this acted as barrier to seeking further help. This is in contrast to the relationship participants described with the community, which was based on trust, warmth and comfort. From the accounts it could be concluded that 'trust' acts as a facilitative factor in help-seeking for this community. Furthermore, some participants' raised the issue of GPs not being able to understand cultural expressions of distress and as a result, they felt misunderstood. This was also seen to act as barrier for help-seeking. Previous research has also demonstrated that interactions with GPs and their tendency to misinterpret communications of distress, act as significant barriers in seeking help for the SA community (Wilson & MacCarthy, 1994).

When discussing factors which would enable the Indian Gujarati community to access help from professional services, participants highlighted the importance for statutory services to collaborate with community groups. It is unsurprising that participants felt there was a need to build connections between the two, given the significant role communities play in supporting people as demonstrated in theme four. Some participants described the NHS as being good at integrating with charities but faith and community groups have been largely neglected. Furthermore, the onus was placed on statutory services to start building a relationship with the community. Participants felt collaboration between communities and statutory services would facilitate

help-seeking, as people would be able to seek help from an environment that was familiar and comfortable to them. Participants suggested raising awareness, delivering talks and training members of the community who already offer support, as ways initial ways of developing a partnership. However, there was a clear message in the participants' accounts that it should be integration between two services, not a taking over of communities by professionals. The community was seen to hold certain knowledge, experience and skills that professionals could draw on, vice versa. All participants discussed how integration of services would allow for a "dynamic approach" (Rajesh) to mental health, as it would allow for the inclusion of religious and spiritual ideas which are seen as integral to coping with mental health difficulties (as discussed in theme two). One participant highlighted that if statutory services integrated with faith communities it would allow for a multi-faceted approach which included aspects important to the person seeking help such as religion, and this would facilitate help-seeking from professional services. It could be inferred here, that drawing on the skills of the community and using them as a base to make connections with people could facilitate help-seeking from professional services. The integration of statutory services with communities is a finding that does not seem to be highlighted in previous literature. It is an area which needs to be explored further.

4.2 Critical Review

In the section below, the limitations and challenges of the study are outlined with respect to the sample, recruitment, method and the role of the researcher.

4.2.1 Limitations

4.2.1.1 *Sample*

The study sample was small and recruited from a specific geographical area in the UK (London). Therefore, the findings may not be representative of members of the Indian Gujarati community outside of London. The findings from the study cannot be generalised, however, this was not the purpose of

the study. Qualitative methodology seeks to develop a deeper understanding of participant's experiences (Snape & Spencer, 2003).

The characteristics of the sample could be viewed as a limitation, as the sample was homogenous in many ways. For example, most participants were either born in the UK or have been living in the UK for over twenty years. Additionally, all participants had been in higher education in the UK. Whilst the sample was varied with respect to age, gender, generation, and migration history, it is likely that the high level of acculturation in this sample is likely to have created a potential bias in the way this group makes sense of mental health problems and help-seeking as their ideas will be heavily influenced by western discourses. Although, the characteristics of the sample can be seen to create potential biases, in many ways the current sample reflects the make-up of the majority of the Gujarati population in the UK, who are described to be 'well assimilated' with respect to education, social status and employment as a result of being in the UK for three or more generations (Ramji, 2006; Poros, 2011; Berry, 1980). In order to ascertain whether there is variation in the understanding of mental health and help-seeking, it would have been useful to recruit recently migrated individuals into the study. However, difficulties with recruitment meant this was not possible in the current study but it would be interesting to consider for future research.

Furthermore, the majority of participants who took part in the study had a relative or friend with a mental health problem and this acted as their motivation to take part. It is likely that having close contact with someone who has previously accessed statutory mental health services will have influenced how this sample understand mental health and help-seeking therefore, creating a potential bias in the research. Again difficulties with recruitment into mental health research in this community meant that those individuals who did not have a personal connection with someone with a mental health problem were reluctant to take part. As a result the findings from this study represent a particular perspective. If the study had adopted a participatory action research design, then it is possible that the views of those who were reluctant

to take part in the study for various reasons could have been included (Maiter, Simich, Jacobson & Wise, 2008).

Only those individuals who could speak English were permitted to take part in the study. As a result, it is likely that the study did not encapsulate the views of a significant proportion of the Indian Gujarati Community. In particular, the voices of those from the older generation, and those who have recently migrated to the UK from India, are likely to have been neglected, as it is more likely that they are not able to speak English (Burholt, 2004). Incorporating the views of non-English speakers would have allowed for a more inclusive picture of how the Gujarati community makes sense of help-seeking for mental health problems. This is an important limitation of the current study which would benefit from further research, as it is possible that there will be a significant difference in how individuals who do not speak English understand mental health and help-seeking.

4.2.1.2 Recruitment

A variety of methods were used to recruit participants into the study, however, finding members of the Indian Gujarati Community who were willing to take part was a difficult task. This is unsurprising given some of the findings from the study, members of the Indian Gujarati Community may be unwilling to talk about mental health even in the context of research. The tendency not to discuss mental health outside of the family due to the repercussions this could bring and the fear of gossip and judgement, that is quite pertinent in the community, may also translate into the context of research. Furthermore, the close knit communities that characterise the Indian Gujarati population may create a sense of wariness in individuals about taking part in research which concerns mental health, as there may be an apprehension of how they will be perceived by others in the community if they discuss mental health. For example, when I was talking to potential participants about the study, many of them raised how they were reluctant to take part in the study, as other members of the community may infer that they have a mental health problem because they have volunteered to take part. Even when the merits of

confidentiality and arranging a location that would be discrete were discussed with potential participants, there was still hesitation to take part.

The nine participants who were willing to take part in the study were particularly interested in mental health either because of their role in the community, their occupation, or because they have had a family member with mental health difficulties. I wondered about the people who were reluctant to take part or for those who viewed it as undesirable. Whilst qualitative research makes no claims about the representativeness of a sample, perhaps the voices of those who are less willing to take part in such research are needed to both better understand how this community makes sense of mental health and influence change in services. As mentioned previously if the current study adopted a participatory action research design, then community leaders could have acted as the researchers which may have allowed for more people to take part as they would be sharing their experiences with a trusted person which may feel more comfortable for members of this community. This design would have allowed for the inclusion of varied perspectives.

4.2.2 Reflexivity : The Role of the Researcher

As highlighted in the methodology chapter, qualitative methodologies shift the focus of research from objectivity to subjectivity (Parker, 2005). As knowledge is seen to be co-constructed, the researcher and those being researched cannot be separated. Therefore, the analysis would be incomplete without accounting for my position and the influence that it may have had on the research process. A reflexive journal was kept throughout the research process to consider the process of reflexivity (see Appendix B for excerpts).

Throughout the research process, I was constantly aware of my position as an Indian Gujarati. Participants often spoke in interviews with an assumed 'shared understanding' based on our ethnicity. For example, participants often used the pronoun "we" as opposed to "I", others made comments such "you know what I mean" or, even more explicitly, "you would understand because you are Gujarati". Researchers have highlighted the benefits of conducting research in the communities they belong to (Benoit, Jansson, Millar & Phillips,

2005; Serrant-Green, 2002; Dwyer & Buckle, 2009). Indeed, I too felt that my similarities may have perhaps afforded me some benefits in the research process. For example, I felt there was a sense of trust and openness with participants. Furthermore, there was a willingness from participants to share their ideas and experiences with me because there was an assumption of a shared understanding, in many ways I was seen to have an insider status. Lastly, my similarities allowed me to more readily access a group who are often labelled 'hard to reach', as I was viewed as belonging to the community, there was a eagerness from the places I recruited from to help me highlight the underrepresentation of this group in mental health services.

Although my perceived similarities afforded me with many benefits to conduct the research, it also is not without limitations; it had the potential to impede on the research process. There were occasions were participants assumed I would have previous knowledge about what they were talking about, therefore, they felt further explanation was not required as a result (e.g. "you know what think about mental health in India, don't you?). On other occasions, my trainee clinical psychologist status influenced the interview. I was sometimes viewed as an "expert", as I held professional knowledge (e.g. "you would know better"). I thought carefully about how my own personal experiences and being a member of the community (my "non researcher" self) might have clouded my perception as a researcher and influenced how I conducted the interview (Glensne & Peshkin, 1992), approached the analysis and interpreted the findings (Dwyer & Buckle, 2009).

I wondered whether my similarities facilitated an open conversation with participants in some areas but may have equally inhibited exploration of other areas. I reflected on how being an Indian Gujarati and a trainee clinical psychologist were both of equal importance in conducting the research. The interplay between my personal and professional identities will have undoubtedly influenced the way in which I approached the research. Both these identities meant I had an 'insider' and 'outsider' relationship to the participants (Dwyer & Buckle, 2009).

4.3 Evaluation of Research

The robustness of qualitative research can often be questioned. Elliott, Fischer and Rennie (1999) outline a set of guidelines that can be used to evaluate the quality of qualitative research. The following section highlights the steps taken to adhere to these guidelines.

4.3.1 Owning one's Perspective

I have acknowledged my perspective in a statement of positioning in the methodology chapter (see section 2.4.1) to help orientate the reader. I have also included a section attending to issues of reflexivity (see section 4.2.3) to consider how my personal and professional contexts may have influenced the research. In addition, I kept a reflexive journal (see appendix B) to note down any preconceptions, assumptions and thoughts I may have had whilst conducting the interviews and engaging with the data. The reflexive journal allows transparency for the reader and commonly used in qualitative research to maintain rigour (Etherington, 2004).

4.3.2 Situating the Sample

I have situated the sample in sufficient detail by providing a description of the participants detailing factors deemed pertinent (e.g. age, gender, migration history, place of birth, occupation), this will allow the reader to consider the contexts of the findings. In addition, I have provided a description of the methods of recruitment.

4.3.3 Grounding in Examples

I have used quotations throughout the results chapter to illustrate and show the process of analysis and interpretation. The quotations provide the reader with the opportunity to consider the interpretations made, but also invite them to consider the possibility of alternative interpretations as posited in my epistemological position.

4.3.4 Providing Credibility Checks

I checked the process of analysis including the main themes and sub-themes with my supervisor and a peer, a sample of the analysis is provided in the appendices. Furthermore, anonymised extracts of the data were discussed in a TA peer group which provided an opportunity to verify initial codes. Most importantly, credibility checks were carried out with participants themselves within the interviews to check my understanding.

4.3.5 Coherence

In order to address the research questions, I have attempted to provide a coherent account by mapping out themes and considering how they are connected to one another, this is presented in appendices J and K. Where relevant, I have discussed the overlap and connections between themes and highlighted this to the reader.

4.3.6 Resonating with Readers

I was interested in conducting this research based on my own experiences of working with the Indian Gujarati community to raise awareness about mental health in the community. Therefore, I hope this will be an area that draws interest for others.

I hope this study will resonate to a broad audience through the dissemination of this work to mental health services, participants who took part in the study and publication.

4.4 Implications

In this section I will highlight the implications of the findings from the study in three areas: service, clinical and research level.

4.4.1 Service Level Implications

From the research findings, an important question to ask is whether we should be supporting the Indian Gujarati community to access services which they identify as being inappropriate in meeting their needs. Whilst, there are important implications for this community if mental health services remain as

they are, there may be value in supporting this community to access help, if we are to encourage services to think about their practise to foster change.

Members of the Indian Gujarati community felt that the GP was not the most appropriate professional to present for help, despite having an illness construction of distress. They highlighted distrust, judgement, unfamiliarity, and a lack of depth in the relationship they held with them, as factors which would prevent them from seeking help. As a result, there is value in considering pathways to care which bypass the GP. For example, allowing a direct route to access mental health services which does not require a referral from the GP would perhaps make help-seeking easier. It may be useful to produce videos or testimonials of members of Indian Gujarati community who have accessed services sharing their experiences, this may be one way of informing others about the process of help-seeking, but also reflecting on the potential cultural implications of help-seeking.

Members of the Indian Gujarati community highlighted finding it easier to seek help outside of the professional system, most importantly, faith communities were highlighted as an important source of strength and support. It is crucial that statutory services attempt to engage in a learning process from these sources, identifying the factors which make help-seeking easier in these contexts, and understanding the practises used to safeguard well-being, in order to inform service development. As mentioned by members of Indian Gujarati community, statutory services need to actively build connections with faith communities, this will not only help to develop stronger links between the two communities but also reform service provision so that it is more culturally sensitive and incorporates multiple pathways to care .

Additionally, working in partnership with communities may make help-seeking for this group more accessible, as professionals can work together with members of the community in an environment that is comfortable to them, and around the people they trust, this may be facilitative in helping people access psychological support. Furthermore, clinical psychologists have skills in supervision, consultancy and training/teaching, this could be used to share

knowledge with members of the community who already provide support. This way of working allows services to learn from communities and strengthens community resources without direct professional intervention.

There are already examples of multi-agency partnerships working which draw on a community psychology approach. For example, the Hackney BME Access Project (Morgan, Khan, McFarlane, Thomas & Ram du Sautoy, 2009) identified the barriers to accessing services for the African, Caribbean, Turkish, Kurdish, Orthodox, Jewish and Vietnamese communities. In collaboration with the community they co-constructed ways of working that were congruent with communities' own constructions of mental health and wellbeing. Such collaboration allows for factors seen as central to well-being, such as religion and spirituality, to be integrated into the approach.

The findings from the study importantly highlighted the lack of cultural awareness amongst professionals as a significant barrier in help-seeking. Services have tackled the issue of 'cultural sensitivity' by employing two strategies. The first, has been to ensure a diverse workforce. However, this has been argued to be a simplistic solution, as it absolves the responsibility of non- BME professionals to address issues of 'culture' (Patel, Bennett, Dennis, Dosanjh, Miller, Mahtani & Nadirshaw, 2000). The second strategy has involved providing the workforce with cultural competence training, however, Bhui et al., (2004) argues that providing training is only one part of developing appropriate services and tackling inequalities. Training alone is a short term solution, which has important ramifications when applied to service provision in an ad-hoc manner. It will not result in a significant, lasting change as the problems remain within the mental health disciplines themselves, this needs to be considered first, if we are to make any difference (Fernando, 2004). The training of mental health professionals is underpinned by Western, Eurocentric approaches to mental health. Fernando (2004) states that the training and practise of professionals needs to change so that it is relevant and appropriate to the people they serve. He propose change needs to occur at a systemic level, where the knowledge-base of mental health professions is reconsidered, to make changes to current practise. This may involve drawing

on the skills and expertise of service users and communities to co-construct an appropriate 'psychology'. Therefore, services need to be thinking about their practise if they are to make any real difference.

4.4.2 Clinical Level Implications

Historically, the focus has been on increasing access for BME communities both at service and policy level. However, we need to ensure that not only are services accessible, but they must be appropriate and relevant to the populations they serve. Therefore, one needs to scrutinise the current ways on working the statutory services. Current models of practise in mainstream mental health services are based on Eurocentric ideas, however, as evidenced in the findings from the study, this is not a good fit the Indian Gujarati community. For example, Cognitive Behavioural Therapy (CBT) which dominates most services, does not explicitly attend to religion and spirituality, factors seen as integral to managing mental health in this community. Therefore, clinicians need to be thinking actively about using alternative therapeutic approaches that attend to factors seen as important to this group. Narrative, systemic and community psychology approaches may be more suitable ways of working with this community, as they allow clinicians to incorporate social and cultural factors into their work and seek to work in a framework that accounts for different constructions of mental health and well-being (Levine, Perkins & Levine, 1997; McGoldrick, Giordano & Garcia-Preto, 2005; Ncube, 2006).

Despite therapeutic modality, clinicians should actively bring up conversations regarding spirituality and religion with clients from this community, as it is seen as an integral resource and source of strength. Indeed, Griffin and Griffin (2002) propose that spirituality can act as a rich resource in therapeutic work. Clinicians need to find ways of actively asking questions about this topic which draws out the client's resourcefulness and resilience. In response to this, the training of clinical psychologists needs to equip them to be able to work in ways that attend to religion and spirituality.

4.4.3 Research Implications

Future research should explore the perspectives of members of the community who only speak Gujarati or have recently migrated to the UK, as it would allow for a broader, and more inclusive picture of how the Indian Gujarati Community understand and make sense of help-seeking for mental health problems. It would also be interesting to see if there is a difference in how this group make sense of mental health and help-seeking compared to British born Gujarati's.

This study demonstrated that the Indian Gujarati community find it easier to seek help from their community, particularly faith communities. Further research is needed to understand the community context and help-seeking. For example, it would be useful to explore the factors which facilitate help-seeking from the community, what the community offers as an approach to support with mental health, who is approached in the community and how mental health is talked about in this context. This would help to provide a means of understanding why community support is sought over professional help and what services can learn from communities.

Participants spoke about 'keeping mental health within the family', however, it was unclear from their accounts whether distress was actually spoken about openly within the family or just ignored. Future research should focus on how this community talk about mental health in the family, what support is offered and the benefits and challenges of family support.

Finally, some participants discussed family member's experiences of accessing mental health services. To date, there has been no research looking specifically into the experiences of members of the Gujarati community who have accessed mental health services. This research would prove to be beneficial to services to gain a deeper understanding of this community and make changes to service provision where relevant.

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APPENDICES

Appendix A: Delivering Race Equality in Mental Health Care a 12 point plan of the action

Taken from Department of Health (2005), p15.

It was envisaged that by 2010 the aims of this action plan would see a reduction in the following areas:

1. Less fear of mental health care and services among BME communities and BME service users
2. Increased satisfaction with services
3. A reduction in the disproportionate rate of admission of people from BME communities to psychiatric inpatient units
4. A reduction in the disproportionate rates of compulsory detention of BME users in inpatient units
5. Fewer violent incidents that are secondary to inadequate treatment of mental illness
6. A reduction in the use of seclusion in BME groups
7. The prevention of deaths in mental health services following physical intervention
8. An increase in the proportion of BME service users who feel they have recovered from their illness
9. A reduction in the proportion of prisoners from BME communities
10. A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective
11. A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services
12. A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Appendix B: Excerpt from Reflexive Journal

Below is a small extract from the reflexive journal I kept throughout the process of the research:

“After completing this research interview, I noticed that I had a different feeling compared to the previous interviews I had conducted. This participant seemed to identify with more than the others. I noticed that whilst I was asking the questions, she would answer assuming I knew what she was referring to. Even though on several occasions, I asked if she could explain what she meant by a certain term or reference, she continued to assume our shared culture, language and visible appearance meant I could understand her perspective without expansion. I reflected on what this meant for me as a researcher conducting interviews in a community in which I belonged to. For this participant, I represented an insider and for that reason she was able to quickly build a rapport with me and comfortably talk about a topic which is stigmatised in this community. Whilst, I similarities were helpful in the research, I began to wonder how my similarities may have also closed down many conversations with participants’. This was something I wanted to remain mindful of when I began the process of analysis and interpretation.”

PARTICIPANTS REQUIRED



**Are you an Indian Gujarati, aged over 18yrs
and can speak English?**

**Would you be interested in talking about your views
on mental health confidentially?**

**Would you like to take part in a research project
exploring how Indian Gujarati people seek support for
mental health difficulties?**

If your answer to these
questions is 'yes' then
I would like to talk to you.

Please contact Nisha Patel on:

Email: nishaproject2015@gmail.com

Appendix D: Interview Schedule

Demographics:

- Age
- Occupation
- Place of Birth
- Migration Route

The interviewer will be guided by the participant's responses and not limited to the interview schedule.

Introduction: Introduce myself as researcher, reminder about confidentiality/consent, withdrawal, no right or wrong answers and length of interview.

Questions

Ice Breaker: Thank you for taking part, before we begin please can you tell me a little about what interested you in taking part in the research?

- Understandings of mental health:
 - What is your understanding/definition of mental health?
 - What words/images come to mind?
 - If you had to describe mental health what words would come to mind?
 - How did you come to this understanding? (what are the influences?)
- Management of mental health difficulties:
 - How would you manage/cope with mental health difficulties?
 - What would you draw on?
 - Any examples?
- Sources of help for mental difficulties (challenges or facilitating factors)
 - Where might you go to seek help for mental health problems?
 - What is useful about this source of support ?
 - Is there anything that is unhelpful?
 - What is different about seeking help for physical health vs. mental health?

- Why alternative sources of help are not sought
- If participant mention support which is not professional support ask why this source of support is preferred?
- Attitudes, beliefs and views about seeking support for mental health problems
- What are you beliefs and views about seeking help?
- Potential barriers on seeking help from statutory mental health services.
- Do you foresee any barriers in seeking support from professional services
- What could be done to improve access to services?

Ending

Is there anything you feel i have missed and feel is important to share?

Debrief

- How did you feel taking part in the interview?
- Is there anything that concerned you?
- Give details to contact if needed.

Probes/Prompts will be used if necessary:

- Tell more about "X"
- Explain what you mean by "X"
- Can you give me an example of "X"

Appendix E: Malson's (1998) Transcription System

I Interviewer

P2 Participant number to ensure anonymity

() Inaudible or muffled sound/utterance

xx Identifiable information removed to ensure anonymity

/ Overlapping conversation or interruption

(.4) A timed pause in seconds

[Crying] Indicates a non-verbal activity

Punctuation Used to aid reading

Appendix F: List of Initial Codes

1. 'Mind' not at peace
2. 'Special' understanding offered by the community
3. "The will of God"
4. A personal role
5. Adjusting thinking patterns (managing mental health)
6. Altering one's mindset through spiritual readings
7. Attitudes of help-givers in the community
8. Benefits of community support
9. Challenges in accessing professional service
10. Challenges of community support
11. Collective responsibility to help others in the community
12. Comfort in a faith based approach
13. Community as a source of support
14. Confidentiality maintained in a faith based system
15. Confidentiality maintained in the community
16. Consequences of mental health
17. Consulting other member of the community
18. Definitions of mental health in Gujarati
19. Discreet help offered in faith communities
20. Drawing on religious texts /Guidance from religious texts
21. Drawing on religious texts to manage problems
22. Ease of seeking help from the community
23. Eastern view of mental Health
24. Environment of help-seeking
25. Faith as protector/preventer
26. Faith based Support
27. Fear of amplification of mental health difficulties (as a barrier)
28. Fear of gossip as a barrier for help-seeking
29. Fear of isolation and loneliness
30. Financial Crisis linked to poor mental health
31. Gujarati speaking professionals
32. Importance of community support
33. Importance of spirituality
34. Integration of mind and body according to the Hindu scriptures
35. Integration of mind-body
36. Integration of statutory services with community/faith groups
37. Keeping mental health problems hidden
38. Lack of cultural sensitivity
39. Lack of consideration for ethnicity and language in statutory services
40. Lack of interest in mental health
41. Lack of knowledge regarding mental health
42. Lack of support system

43. Limited integration of statutory services with community/faith groups
44. Listening as therapeutic
45. Loosening of the taboo of mental health over generations
46. Loss of honour and reputation in the community
47. Loss of honour as a barrier for help-seeking
48. Loss of support system
49. Management of mental health through suppression/ avoidance
50. Managing discomfort through introspection
51. Managing mental health difficulties using spirituality
52. Mental health as an illness
53. Mental Health caused by base instincts
54. Mental Health Constructed as a loss of status
55. Mental health constructed as feeling low/down/unhappy
56. Mental Health from a religious perspective
57. Mental health viewed as severe/extreme distress
58. Mental health caused by biological factors
59. Opinion on the definition of mental health/ difficulties with the terminology
60. Prayer as a form of support / finding refuge (solace) in prayer
61. Providing holistic care / multifaceted approach
62. Raising awareness through education
63. Responsibility to help each other
64. Seeking guidance/support from the community (internal
65. Solace/comfort in using faith to manage mental health
66. Stereotypes about Gujarati's
67. Stereotypes of people with health difficulties
68. Stigma/shame of mental health
69. Strength derived from a divine intervention (the will of God)
70. Structure of faith communities
71. Suffering as a result of material wants
72. Support structure from within the faith community
73. Tailored guidance offered by the community
74. Talking to others in the community to manage difficulties
75. Underrepresentation of the Gujarati community in mental health services
76. Understanding of the mind through Hindu scriptures
77. Views on the western construction of mental health
78. Denial of mental health problems
79. Whatever happens is destiny / "It was meant to be" = destiny
80. Family as first port of call
81. Creating a self-sustained system within the community

82. Prominence given to professional knowledge
83. Role of community is to prevent
84. Pushed to seek help from others
85. Damage to marriage prospects
86. Mental health as peace of mind
87. Taking responsibility to manage your own well-being
88. Drawing strength from religion /spirituality / managing mental health through drawing on religion /spirituality
89. Engaging in other activities (management)
90. Benefits of family support
91. Comfort in talking to the community
92. Differences across generations (generational beliefs)
93. Managing difficulties alone (battling it out alone)
94. Understanding mental health through religion
95. Mental health caused by one's mindset / interpretation
96. Caused of mental health linked to environmental factors
97. Leaving the burden to someone greater
98. Fear of judgement
99. Ease in seeking help for physical difficulties
100. Complexity of mental health
101. Professionals need to do more than just talk
102. Seeking help from a trusted source
103. Professionals as last port of call
104. Lack of clarity about where to seek-help
105. Raising awareness
106. Karma
107. Relationship with community members
108. Distrust in the professional system
109. Shame/stigma brought on family
110. Primary care professionals unwilling to help
111. Lack of satisfactory professional help
112. Impact of diagnosis
113. Damage to family reputation
114. Psychological therapies seen as irrelevant
115. Professionals sharing knowledge with communities
116. Mental health as a deficit
117. Challenges in seeking support from family/friends
118. Views on improving professional services

119. Culture as a barrier
120. Improving cultural sensitivity
121. Talking through difficulties with family
122. Ease of talking to family/friends
123. Friends/Family offer a deeper understanding
124. Lack of understanding from GP's

Appendix G: Annotated Transcript

Structure / Set up of faith communities

community and the people who make up that faith community, in terms of different tiers. You'd have a lay follower, then you might have a senior in that community, a faith leader, the sadhus and then you know going all the way up towards the spiritual leader or guru.

I: So the sadhus are like monks? or...?

P5: Yeah monks. So the monks, who are basically on their spiritual path and have had their training, in a way. You know, a bit like how psychologists can go through that training, understand people's needs, their wants and if you want to say their (inaudible 07:46) failures in life, that sort of thing. In the same way, a monk, a sadhu, have that understanding of life. Be it from a special perspective, but a special perspective is sometimes better, in understanding someone's needs and their wants. So having that support structure within the mandir, makes a big difference because people are able to – and that second thing with that it's discreet, that helps a lot because sadhus have a personal obligation and a duty, to keep that person's confidential matters confidential. And they will. And – again sadhus are not just mental people. Sometimes you might feel that if you're going to a certain person, they might think – or you're bound to have issues, because you have problems. Sadhus are not like that. They are very embracing of the person's problems and they are willing to take a personal role in helping that person through those rough times.

I: Sure.

P3: And I think that draws upon to what XXXXX has done, for a lot of people in their lives you know. When they've gone through a troubled time, XXX has taken a personal interest to help them through that. You know, not just (inaudible 08:49). "ok look I've sorted your problem out, bye bye", it's more about taking that personal interest in their problems, and seeing them all the way till the end. Rather than just saying "this is your problem, this is how we are going to sort it out nice to see you". So the sadhus are sort of learning from XXXX approach, about taking a personal interest, giving them time, giving them that consideration, making them feel comfortable when they are talking to them. In the Satsang, people have multiple issues. And some of those multiple issues maybe physical, but they can be mental. And in Satsang, the good thing is that you can draw upon the scriptures as well. And in scriptures you can get inspiration. So when you're going through a low patch, sometimes you can read the spiritual books and you can draw inspiration from that, to help you through those tough times. Also God's words helps to give you a mental understanding, about how to go through something.

I: What might be some of those things? Can you give me examples of what some of those things might be?

P5: Ok yeah. In the scriptures there's a section, the first chapter called "Samjan ápatkaday chhe". So basically your understanding measured through tough times. And God says "you could be sitting on an elephant one day, and the next day you're sitting on a donkey, but at the same time you must understand that that is through the will of God". You know whatever happens in

Special understanding offered by particular people in the community (monks)

Internal support within the community

discreet help in faith communities

Attitudes of help-givers

Attitudes of help-givers in the community

Collective responsibility (to help others)

Drawing on religious texts to manage problems

'A person role'

Attitudes of help-givers of the com

Attid of help-c in the Com uni

Receiving guidance from Religious texts

"The will of God"

Gujarati speaking
Professionals

Environment of
help-seeking

when
changing mindset
through
spiritual
readings

Integration of
faith
groups
with statutory
services

Shame / stigma
of MH

Ease Comfort of
help-seeking
from the
community

341 who can speak in Gujarati immediately tears down the barriers,
342 which would otherwise have people resist seeking help. So even
343 these small things like the venue, the settings, the language,
344 familiar faces that I think helps a lot in bringing these issues
345 down to earth and making them much more accessible in a much
346 more homely setting. I think that has been very very helpful.
347 Some of these things we do regularly at the temple such as
348 katha varta- weekly spiritual discourses is therapeutic because
349 spiritual *sadhna* is very much dealing with the mind. That *katha*
350 *varta* is providing positive thoughts that's another way of teaching
351 us thought processes. If this happened how would I overcome it
352 ? Physical acts of say *seva*, *smruti*, *bhakti* has a deep impact on
353 our thinking on our negative thoughts. Other things like
354 discussion groups which happen at the temple where we think
355 together on a topic and learn from one another bounce of ideas
356 form one another. All these things come together as a support
357 service that is within a temple setting. When you say statutory
358 services I'm sure the NHS can't provide that just trying to make
359 their services more accessible, maybe teaming up with these
360 community and faith groups and making professional services
361 more accessible or conducive to people in a way that they need
362 to receive them.

363 I: You briefly mentioned some of the barriers people face in
364 seeking help from statutory services such as the setting,
365 atmosphere and language. Is there anything else that you think
366 that people who are seeking helping may hold as barriers?

367 P1: I think the idea of shame stills holds people back, the social
368 stigma "will I be looked upon as say weak or soft" that probably
369 has a part to play. I've seen this in some people, I've asked why
370 they didn't go earlier. And perhaps its speaking to someone
371 unfamiliar compared to at the temple. Going into a clinic,
372 speaking to someone they don't know is going to be hard for
373 them to open up. But here at the temple it's someone they know,
374 have connected with at so many different levels. That's what
375 makes easier, if there is no prior connection, these relationships
376 take time to build.

377 I: Thank you, very much for your time today and will be touch
378 with our research progresses.

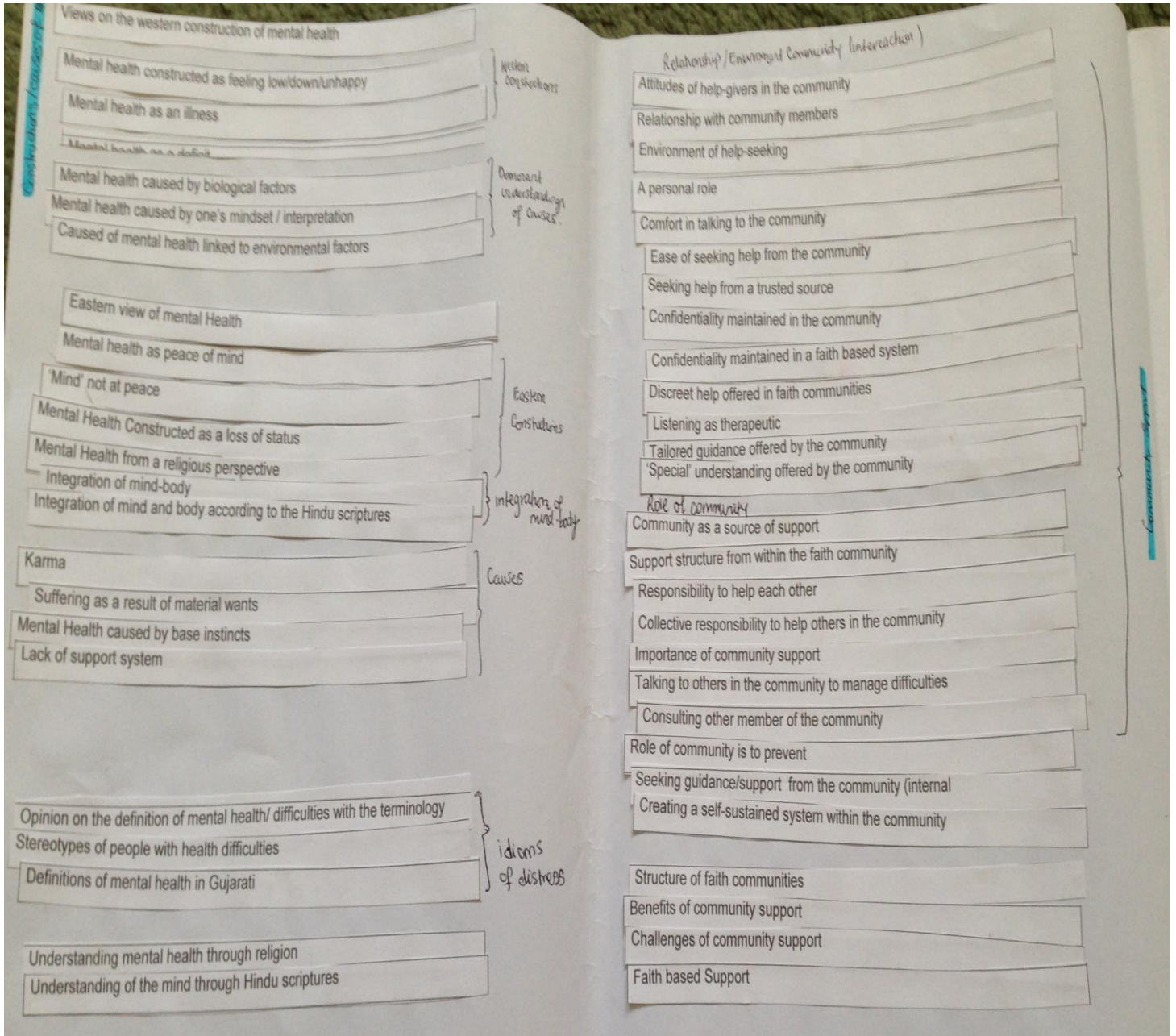
Appendix H: Excerpt from List of Codes and Data Extracts

<u>Code</u>	<u>Definition</u>	<u>Example extracts</u>
<p>Challenges in accessing professional services</p>	<p>Factors which may impede on help-seeking from professional services.</p>	<p>But obviously they face certain stumbling blocks, which are not very tangible sort of subtle things which are not easy to manoeuvre through. But I think that's something that needs to be addressed, and I thought this study would help with addressing that (Rajesh: 14-17).</p> <p>You know, for example if a person wants to go into a hospital room, and sit there in front of someone in a white coat and have to talk about their problems. I think they would be rather hesitant (Rajesh: 272-275).</p> <p>I don't have that kind of relationship with my GP, where I would go and talk to the person about my you know, quite personal situations. I wouldn't do that (Sejal: 113-114).</p> <p>And I think with GP's, it's more the experiences I have had in the past, it's more just going in speaking to them for 10 minutes and that's it. And I don't think these situations are 10 minutes. You know, conversations – I mean these aren't 10 minute conversations you can have with someone. You can't build a trusting relationship in 10 minutes, let alone tell the person what I'm going through. So I think the way GP systems work, from the experiences I've had, wouldn't allow me (Sejal: 122-128).</p>
<p>Stigma of mental health</p>	<p>Knowledge or awareness of the stigma associated with mental health</p>	<p>Yeah, so I think mental health is quite stigmatized (Rajesh: 26).</p> <p>Not so much in the Gujarati community, people tend to stay away. If you've got a mental health issue, they'll probably run out of the room (Rajesh: 100-102).</p> <p>Yes. I think people are not comfortable, being associated with they should have gone through mental difficulties (Dhara: 660-661).</p> <p>Because I feel there is still a bit of a stigma, to be admit to that mental health problem in the first place (Meena: 290-291). .</p> <p>I don't – I think I would feel quite judged and there's stigma attached. Even the stigma, the shame, the judgement (Sejal: 169-170).</p> <p>Yeah. I think again related to the stigma, related the shame they would refrain from going to these services because of that (Sejal: 258-259).</p> <p>I think there is a stigma of some sort. Especially to come out and say because – like if you look – because they've been very advanced in whatever. (Tarun: 139-140).</p> <p>Because actually to see a psychiatrist, to see someone</p>

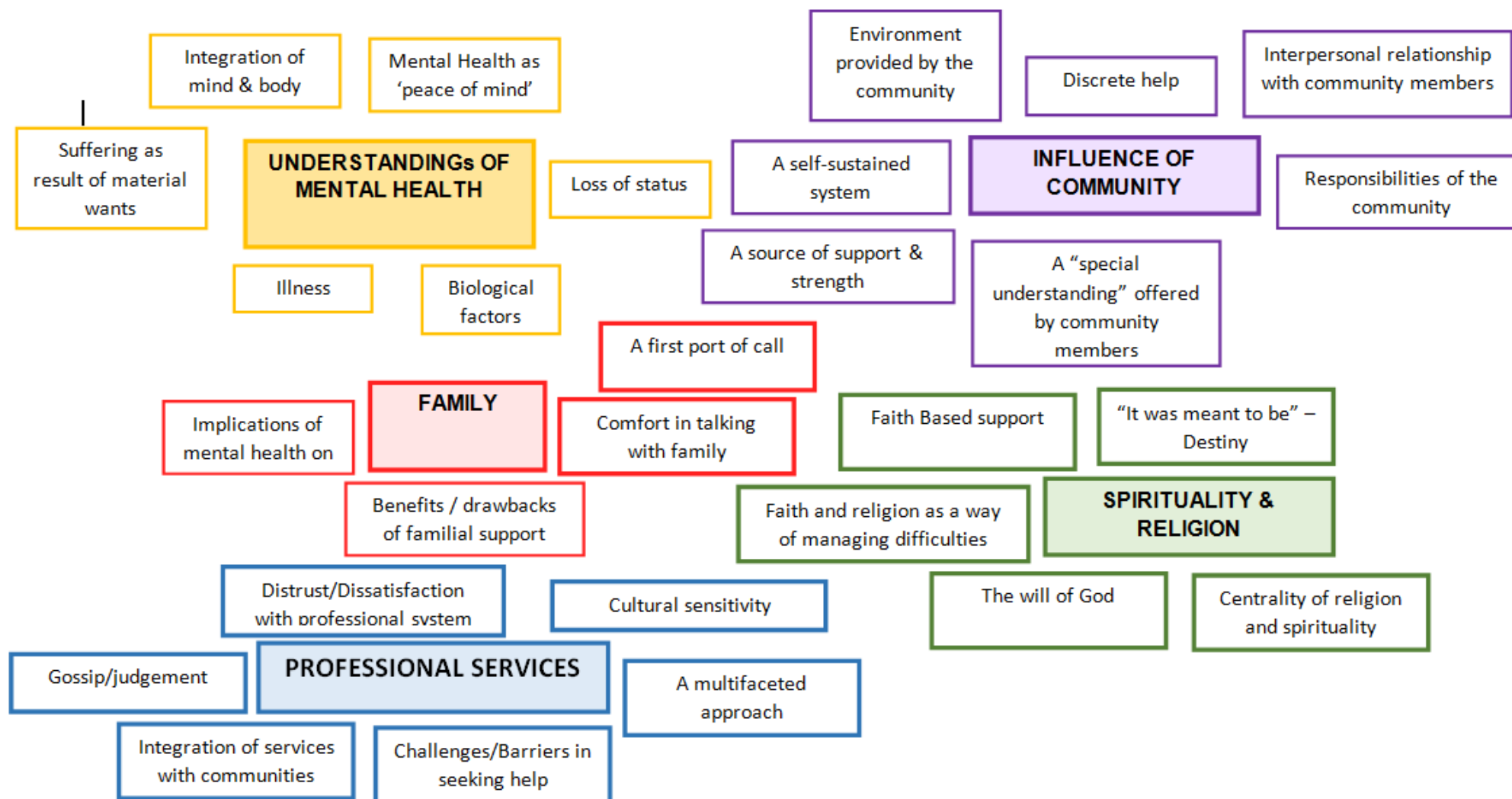
		<p>for help, is not considered very – it's almost like the stigma is so huge that it's considered wrong in many ways (Mansi: 53-53).</p> <p>Well I think one of the biggest things is not even the social stigma, of having mental health issues. It's the personal stigma of it. It's the way that you feel about yourself, if you know that actually I'm not capable of handling my own medical affairs. I don't think that anyone consciously thinks about that, but I think it is – it does make you feel very callous and hopeless actually. It makes you feel down and depressed, the thought of “oh I'm feeling rubbish mentally, and I can't handle myself mentally.” That's not a very empowering thought (Mansi: 534-541).</p>
<p>Fear of gossip as a barrier for help-seeking</p>		<p>Or “what if...” you know gossip spreads and all of a sudden people think I've got issues (Rajesh: 300-301).</p> <p>Whereas I think in the outside of the spiritual environment, if you was to speak to someone in the community, there might still be a little bit of a doubt of hesitation in that person's mind that you know “this is a small world I might end up you know, going home and here's – through the great mind of people, people start finding out that you know I am going to speaking to someone” (Rajesh: 312-317).</p> <p>And if you take your mother to the GP for signs of Dementia, the GP does a few tests, does say “actually you know what, we think your mother could be demented or might have some mental health issues.” The family would not want to take that further, because they think the further we take it, the more people find out. And the more people will start to you know, talk about us or look down on us, or you know the word will spread (Rajesh: 343-348).</p> <p>I have experience at first hand, but I hear that – I hear from friends that it's not... what do you hear? You hear that they're very gossipy about it (Dhara: 73-75).</p> <p>The first thing it's so personal, that first of all I would feel – it's like telling somebody – so when you speak something and tell somebody, that's it it's out there, you can't bring it back. So it could affect what they think of you, judgement, it could affect what they say around other people. What they judge – I obviously wouldn't judge my family or whatever, because that's – maybe someone was mean't to be born like that. So it's personal and it doesn't – once you open up then the secrets are out, you know that sort of thing (Meena: 156-167).</p> <p>From my own perspective, I know my husband was one that sort of rejected all help. Because he feels that “why would you want to tell – wash you dirty laundry in public?”. And then (inaudible 12:42) “well you're not, you're just telling someone – getting help as a family”. So you know different perspective, but I think it's that old Indian thing “keep it in the family” (Meena: 263-270).</p>

		<p>You know it hurts every time you have to say the whole story. You know, it become chinese whispers, because whatever you say will go to somebody else in a different form. So we just didn't want to talk about it (Meena: 656-659).</p> <p>I think again, if I tell my family or if I tell my friends it's more you know, they'll gossip about me or the words will be spread. And then you know, I don't want someone calling up my parents one day and saying that "oh I heard about your daughter going through (inaudible 12:11). You know I heard her mental illness is..." (Sejal: 145-149).</p> <p>You know, what would your kaka say? What would your mama's son's dog say? What would our neighbours say? If they found out you have a mental health problem. This kind of gossip, this fear of society and fear of what everyone else will say and everyone will be talking about us. It's that kind of fear, that stops people from seeking help. (Mansi: 441-445).</p>
<p>Confidentiality maintained in a faith based system</p>		<p>Because people have a sort of a faith based, and a spiritually focused if you want to say, perception that those things will stay confidential (Rajesh: 311-312).</p> <p>That their matters here would be kept private and personal. And I think that's what makes the big difference (Rajesh: 324-325).</p>

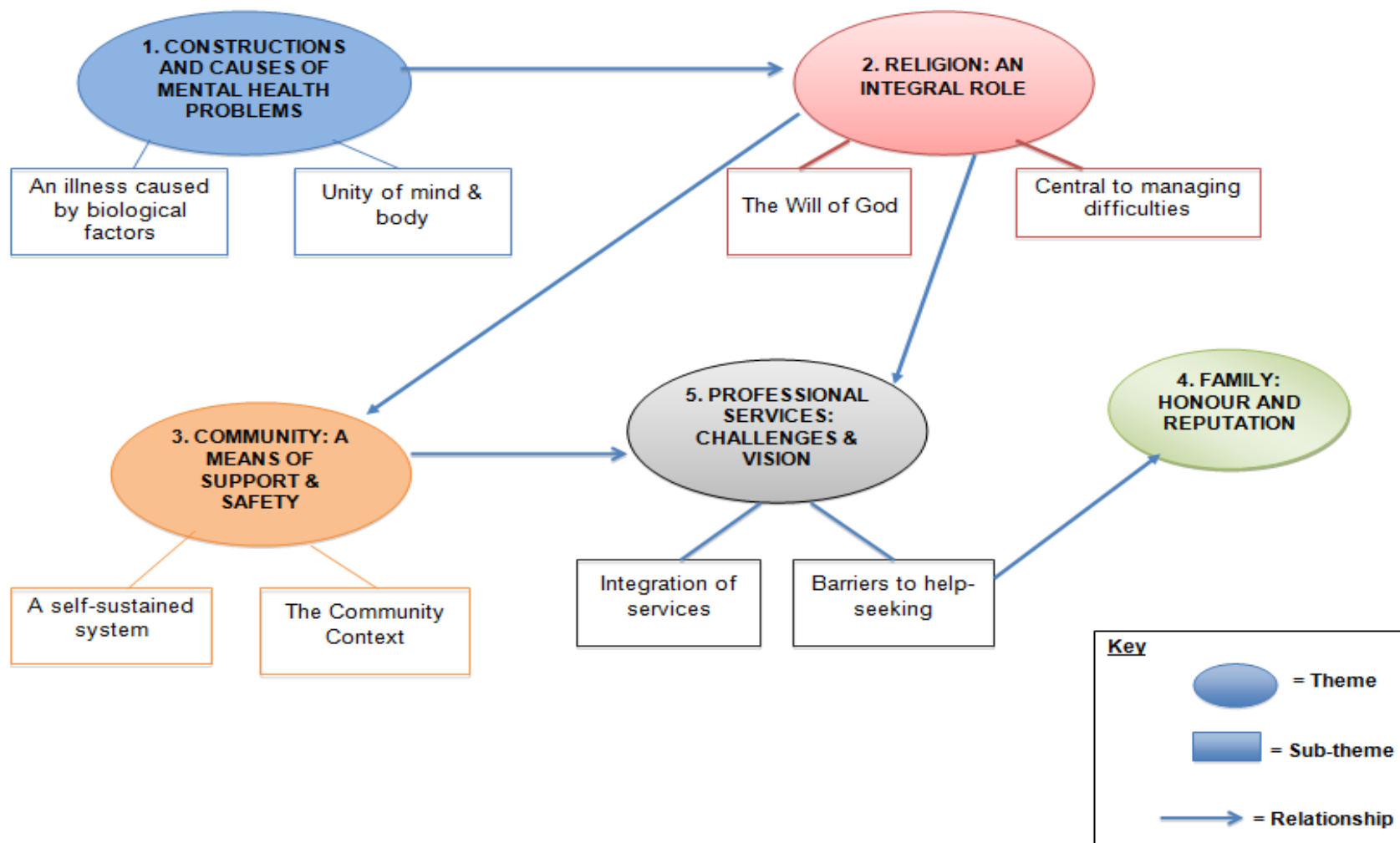
Appendix I: Organisation of Codes into Meaningful Categories



Appendix J: Initial Thematic Map



Appendix K: Final Thematic Map



Appendix L: Ethical Approval Confirmation

NOTICE OF ETHICS REVIEW DECISION For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Maria Castro **REVIEWER:** Meredith Terlecki

STUDENT: Nisha Patel

Title of proposed study: How Do People from the Indian Gujarati Community Make Sense of Help-Seeking For Mental Health Problems

Course: Professional Doctorate in Clinical Psychology

DECISION (*Delete as necessary*):

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required (*for reviewer*):

Please extend the participant right to withdraw from research period, which is currently stated March 2015.

Please clarify whether interview recordings will contain identifiable information.

****This is not a minor amendment. Consider extending your period of data collection as you will not have approval to collect subject data after Jan 2016 without amending your application.**

Major amendments required (for reviewer):

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name : *Nisha Patel*
Student number: U1331805

Date: 10/06/2015

ASSESSMENT OF RISK TO RESEACHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- HIGH
- MEDIUM
- LOW

Reviewer comments in relation to researcher risk (if any):

It would be good practice to make the supervisor and/or a fellow trainee aware of the interview schedule and to arrange brief post- interview contact to ensure the trainee has safely completed an interview.

Reviewer (Typed name to act as signature): M. Terlecki

Date: 10/06/2015

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix M: Participant Information Sheet



How do People from the Indian Gujarati Community Seek Help for Mental Health Problems?

The Principal Investigator: Nisha Patel

Contact Details: nishaproject2015@gmail.com

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study.

Invitation to the study

I would like to invite you to take part in a research project which is being conducted to develop a better understanding of how Indian Gujarati people seek help for mental health problems. This study is being conducted as part of my doctorate training in Clinical Psychology at the University of East London. Before you decide whether to take part, it is important that you understand why the research is being carried out and what this study will involve. Please take time to read the following information carefully and discuss it with relatives or friends if you wish and then decide if you wish to take part. Please contact me if there is anything that is not clear or if you would like further information.

What is the purpose of the study?

In the UK, Indian Gujarati people are under-represented in seeking help from mental health services. There is no research in the UK which has specifically looked at where the Indian Gujarati community go to seek help from for mental health difficulties and if they feel these sources of help are beneficial or not. Developing a better understanding of where people seek help from and what challenges they may face can help health professionals understand how mental health services may be better able to support people from the Indian Gujarati Community.

Why have I been invited?

I understand that you are over 18yrs old, have identified yourself as having an Indian Gujarati origin, a primary speaker of English and are not currently being seen by a mental health service and have not accessed a mental health service in the past.

Do I have to take part?

It is your decision as to whether you take part in the study or not. If you wish to take part you can contact me via e-mail or telephone. If you decide to take part you are free to withdraw from the interview at any time and you will not be asked to give any reason.

What will happen if I take part?

You will be asked to read and sign a consent form. You will be asked to provide some basic information about yourself (which will not have your name). You will then take part in a one to one interview with me. The interview will only be conducted in English. The conversation will broadly cover what you think about seeking help for mental health problems, where you think people of the Indian Gujarati Community go to seek help, why you think they go there and any challenges you think people might have in seeking help.

There are no right or wrong answers as the study is interested in hearing about your personal experience and knowledge. The interview will last for approximately 60 minutes. It will take place at a date, location and time which is convenient to you. The interview will be digitally audio recorded and transcribed (typed into text). The transcription will only be completed by myself and all identifying information (e.g. names and places) will be omitted for confidentiality purposes.

What are the possible disadvantages of taking part?

It is possible that some of the experiences you share may be upsetting to talk about. If this is the case we can take a break, stop the interview or reschedule for another time. If you feel you need further support or advice I can direct you to the relevant organisations. You can also contact your GP for further advice and support.

What are the possible advantages of taking part?

I cannot promise the study will help you however, it is an opportunity for you to talk about what you think about seeking help for mental health problems. The information that I learn from this study may help to direct future research and inform mental health services about how the Indian Gujarati community would like to be supported for mental health difficulties.

Will my taking part in the study be kept confidential?

Your participation will be kept confidential. All material will be stored in a locked cabinet. Any information identifying you (i.e. consent form) will be stored separately from the typed copy of your interview. Your interview will be recorded so I can transcribe and analyse what you say. The recording of your interview and the transcript will be kept in a locked cupboard and will be destroyed after successful examination of the research. Transcriptions will be destroyed after five years to allow publications. Only I, the supervisors of the project and examiners will have access to the data.

What if there is a problem?

If you have any questions or concerns about any aspect of this study, you can contact the researcher who will do their best to answer your questions. You can also contact the study's supervisor Dr Maria Castro Romero at the School of Psychology, University of East London, Water Lane, London E15 4LZ or on 020 8223 4422. You can also contact the Chair of the School of Psychology Research Ethics Subcommittee Dr. Mark Finn at the School of Psychology, University of East London, Water Lane, London E15 4LZ or on 020 8223 4493.

What will happen to the results of the research study?

The results of the study will be written up and submitted as a research project as part of a Doctorate in Clinical Psychology. The results may also be published in a research paper. If this is the case, you will not be identified in any report/publication.

Has the research obtained ethical approval?

The research has obtained ethical approval from the University of East London's Ethics Committee. You can contact Dr. Mark Finn at the School of Psychology, University of East London, Water Lane, London E15 4LZ or on 020 8223 4493 for further information

If you would like to take part in the study or have any questions please contact me, Nisha Patel on:

E-mail: nishaproject2015@gmail.com

Thank you for taking the time to read this information sheet.

Nisha Patel

Trainee Clinical Psychologist

Professional Doctorate in Clinical Psychology (DClinPsyc)

University of East London

Appendix N: Participant Consent Form

HOW DO PEOPLE FROM THE INDIAN GUJARATI COMMUNITY MAKE SENSE OF HELP-SEEKING FOR MENTAL HEALTH PROBLEMS

Principal Investigator: Nisha Patel

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant’s Name (BLOCK CAPITALS)

Participant’s Signature

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.....

Researcher’s Name (BLOCK CAPITALS)

Researcher’s Signature

.....

.....

Date: