An Exploration of Understandings of Mental Health and Mental Health Services among Young British Pakistani Adults in London

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I. List of Abbreviations, Figures & Tables

List of Abbreviations

BAME – Black, Asian and minority ethnic

BPS – British Psychological Society

CAMHS – Child and Adolescent Mental Health Services

CBT – Cognitive Behavioural Therapy

CMDs – Common mental health disorders

DfE – Department for Education

DoH – Department of Health

DWP – Department for Work & Pensions

GDS – Geriatric depression scale

GP – General practitioner

GT – Grounded theory

HCPC – Health and Care Professional Council

IAPT – Improving Access to Psychological Therapies

IPA – Interpretative phenomenological analysis

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

ONS – Office for National Statistics

TA – Thematic Analysis

TV – Television

UK – United Kingdom

WHO – World Health Organization

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II. Acknowledgements

First and foremost, I would like to thank all my participants for their great cooperation throughout the entire interview process. It was truly motivating to witness the keen interest displayed by participants towards my research. The enthusiasm that my participants and I shared kept my passion level ignited throughout the research process. It was inspiring to see that my participants also felt that they could make a positive change in the elementary understanding of mental health in the Pakistani community. It is such thoughts exhibited by my participants which allows me to believe that I have done some justice to the field of mental health research within the South Asian population.

Secondly, I would like to thank my research supervisor, Dr Daphne Josselin, for her continuous support and guidance throughout the doctorate. My knowledge of how to produce a research thesis and my understanding of qualitative research methods were nurtured and enhanced through her supervision. Her flexibility, understanding and empathy towards the various challenges I experienced throughout the write-up process were highly appreciated.

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Last but not least, I am truly grateful and appreciative for the support and encouragement displayed by my friends, in particular, Hibo Ali and Laura Ricketts. Their continued belief in me, even throughout the various challenges and struggles that I faced, was extremely heart-warming.

III. Declaration of Power

I grant powers of discretion to the University Librarian to allow this Doctoral research thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgements.

IV. Preface

My deep-rooted passion and keenness to embark on this research project began prior to commencing my training to be a counselling psychologist. My interest in exploring mental health understanding among young British Pakistani adults was ignited upon completion of my undergraduate degree in psychology, at which point I was adamant that this would be the topic of my doctoral research thesis. My identity as a female Pakistani trainee counselling psychologist greatly influenced both the clinical work that I undertook across the three years of my training (as I made a deliberate effort to work with clients from various South Asian and other ethnic groups) and the three pieces of work presented in this portfolio. The overall research process elicited mixed emotions—from great enthusiasm to feelings of apprehension—as I encountered significant challenges and hurdles. These were overcome, however, through the support of family and friends, the help of my research supervisor, and most importantly my passion and dedication for raising awareness about the mental health needs of young British Pakistani adults.

The existence of health inequalities amongst Black, Asian and minority ethnic (BAME) groups is something that has always struck me. The lack of mental health literacy and acceptance, along with the stigma associated with help-seeking, were commonly witnessed among family and friends across a range of ethnicities during my late teens to adult years. This was similarly seen in my clinical practice, as the majority of my clients were from diverse ethnic backgrounds. As I began witnessing the commonality of these issues, my passion for addressing the minimal mental health awareness and service utilisation within BAME groups and British Pakistanis in particular increased further.

Across the three years of my training, the lack of research attention given to British Pakistanis both surprised and disappointed me. Although I felt passionate to conduct doctoral-level research on the mental health understanding of young British Pakistani adults prior to commencing my training, I almost saw it as a duty once I became aware of the lack of research attention that had been dedicated to this group. Thus, the running theme throughout this portfolio is the way in which

Pakistani culture needs to be considered in order to raise awareness of mental health needs in the Pakistani population and to address the lack of engagement in mental health services by this group. This theme ties the three pieces of work presented within this portfolio together: a doctoral research thesis (Section A), a client study (Section B), and a publishable paper drawn from the thesis (Section C).

Section A: Doctoral Research Thesis

The doctoral research thesis explores the mental health understanding of young British Pakistani adults. In this regard, a qualitative paradigm was used to explore how mental health and mental health services were understood by 12 young British Pakistani adults. Semi-structured interviews were conducted and analysed using thematic analysis (TA), through which seven themes emerged. Findings reveal that participants had minimal mental health literacy and lacked knowledge of mental health services, while Pakistani culture and religious beliefs heavily influenced mental health understanding and served as a barrier to help-seeking. Overall, the findings highlight a lack of mental health acceptance among the Pakistani population due to the strong cultural stigma associated with poor mental health. The impact on participants of my identity as a female Pakistani trainee counselling psychologist was something I remained mindful of throughout the research process. As a result, I believe that participants felt free to talk openly about mental health and the cultural perceptions attached to it regardless of the stigma associated with mental health issues from a Pakistani cultural standpoint.

Yardley (2000) states that a strength of qualitative research is that it seeks to provide a close link between research and clinical practice. In this regard, conducting research useful to other mental health professionals working with Pakistani individuals was especially important to me, as was the possibility that the participants themselves may benefit from the research. It seemed imperative to provide young British Pakistani adults with a platform to illuminate their mental health needs and with an opportunity to engage with mental health research in a meaningful way, especially when considering that this group is underrepresented in health research (Brown et al., 2014; DoH, 2014; Quay, Frimer, Janssen, & Lamers, 2017). Thus, the research gave a voice to this group.

Section B: Client Study

The client study I present here is a personal piece of work, as my identity as a Pakistani trainee counselling psychologist heavily facilitated and shaped the overall therapeutic process. The client study illustrates how theory was linked with practice across 24 therapy sessions. This piece of work also illustrates the significant role of the therapeutic relationship and the powerful healing abilities of the therapeutic alliance. The theme of culture is demonstrated through the work, which was conducted with a traumatised refugee client of Pakistani origin. Culturally adapted cognitive-behavioural therapy (CA-CBT) was used as the cultural and religious values of my client were explored and incorporated in the therapy. My personal understanding of Pakistani culture facilitated the overall therapeutic process and assisted in developing a trusting rapport, which was expressed by my client through the progression of therapy. In addition, as I am bilingual, therapy sessions were conducted in Urdu (my client's mother tongue). This further deepened the therapeutic alliance and created a safe space for my client to be open and expressive, which would have been hindered if our therapy sessions had taken place in English (due to his limited English proficiency). This client study thus highlights that effective and safe trauma work with refugee clients is heavily reliant on the therapeutic relationship, in addition to ensuring that the therapeutic modality is culturally appropriate and sensitive.

As counselling psychologists, we are greatly encouraged to work with culturally and linguistically diverse groups (British Psychological Society [BPS], 2017a), which I feel is strongly illustrated in this piece of work. Furthermore, Bury and Strauss (2006) state that a single case conceptualisation has the scope for in-depth learning while also continuously building upon knowledge that informs and influences clinical practice overall. This piece of work further enhanced my professional development and provided valuable insights that were incorporated into my clinical practice, some of which include the need for establishing safety, the significance of building a trusting therapeutic relationship, and the importance of working sensitively in order to ease clients into therapy.

Section C: Publishable Paper

The publishable research paper was drawn from the doctoral research thesis. The journal *Mental Health, Religion & Culture* has been selected for the paper's potential publication, as its editors are particularly interested in research that explores the relationship between mental health and culture, including religious influences on mental health problems. The formatting of the paper is in line with the journal guidelines. In addition, the novel empirical findings of the paper address a gap in the literature, as British South Asians remain an under-researched group. The paper presents two of the seven themes that emerged in the doctoral research thesis: 'Cultural and Religious Stigma within the Pakistani Community' and 'How Mental Illnesses are Dealt with within Pakistani Families'. It is hoped that the findings will assist practitioners who are working therapeutically with British Pakistani adults.

Counselling Psychology and Concluding Comments

Counselling psychology is well placed to bring research attention to the therapeutic needs of under-represented groups, as maintaining an evidence base is the hallmark of this discipline. Thus, understanding the mental health needs of culturally and linguistically diverse groups is greatly encouraged by the BPS (BPS, 2017a, 2017b). This is something that I have continuously engaged with throughout the three years of my training in both my clinical work and doctoral research.

This portfolio aims to demonstrate the way in which counselling psychology is able to offer a sensitive and effective approach when working therapeutically with the Pakistani population. The rich set of clinical skills derived from our philosophy, training, and knowledge of diverse modalities allows for well-rounded service delivery in diverse contexts. This strongly resonated with me towards the end of my training as I was struck by the array of contributions that counselling psychologists are able to offer. As I transition to the next stage of my professional development, I have mixed feelings of excitement and apprehension. My identity as a trainee counselling psychologist and the direction of the clinical practice that I wish to engage in are now more apparent to me. I thus intend to continue

developing and enhancing my skills as a trainee counselling psychologist working with culturally diverse groups and young adults. My passion for increasing mental health awareness among the Pakistani population—as well as within other BAME groups—has further increased upon completion of the counselling psychology doctorate. I am now looking forward to embarking on my journey as a qualified practitioner and to making further contributions to the field of counselling psychology.

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Section A: Doctoral Research Thesis

An Exploration of Understandings of Mental Health and Mental Health Services among Young British Pakistani Adults in London

Abstract

The United Kingdom (UK) is widely recognised for its diversity in ethnicity and culture, yet there seems to be a gap in our understanding of the impact of mental health difficulties on Black, Asian and minority ethnic (BAME) groups. Despite South Asians representing the largest growing ethnic minority group in the UK, little is known regarding their experiences of and approaches to mental health. Yet high risks of psychological distress and low rates of service utilisation have been reported for this population. Young adults have further been identified as a high risk group, as 18–34 year olds show elevated levels of anxiety and depression.

A qualitative approach was used to explore understandings of mental health and mental health services among young British Pakistani adults. Twelve individuals (six male, six female) aged 18–24 participated in semi-structured interviews, which were analysed using thematic analysis (TA).

Seven overarching themes emerged from the data set: ‘Defining mental health’, ‘General mental health awareness’, ‘Cultural and religious stigma within the Pakistani community’, ‘How mental illnesses are dealt with within Pakistani families’, ‘Openness to seeking support’, ‘Barriers to help-seeking exist’ and ‘Seeking professional help is beneficial although help-seeking stigma does exist’. Overall the findings suggested that participants lacked awareness of mental health problems and of available services. Participants highlighted the importance of generational dynamics and the immediate family system with regards to mental health acceptance and help-seeking. The role of culture and supernatural explanations in understanding mental illness was also flagged, as was the urgent need to raise awareness among the Pakistani community in order to reduce barriers to help-seeking linked to shame, pride and culture.

Based on these research findings implications for clinical practice are outlined. It is hoped that these will help counselling psychologists and other mental health professionals to become more culturally sensitive, and thus approachable, when working with this group.

Chapter One

1. Introduction

1.1 Introduction to the Thesis

The United Kingdom (UK) is widely recognised for its diversity with regard to ethnicity[1] and culture[2], yet there seems to be a gap in our understanding of the impact of mental health[3] difficulties on Black, Asian and minority ethnic (BAME) groups (Bowl, 2007; Dhadda & Greene, 2017; Ineichen, 2012; Mental Health Network National Health Service Confederation, 2012; Moller, Burgess, & Jogiyat, 2016). This is certainly the case for British South Asians[4]. Consequently, mental health prevalence and service utilisation rates among South Asians[5] have begun to receive increasing attention, potentially resulting from concerns regarding ethnic inequalities in the provision of mental health as highlighted by the Department of Health (DoH) (DoH, 2005) in seeking to deliver race equality in mental health care (Moller et al., 2016).

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[1] Ethnicity refers to specific groups that share a common language, nationality, and/or culture. The ethnic qualities of a group are characteristic of the associated culture. Hence, ethnicity is often used interchangeably with culture (Betancourt & López, 1993). Ethnicity acknowledges history and is subjective in the production of identity hence knowledge is context-dependent (Hall, 1992).

[2] Culture has been conceptualised as learned systems of meaning that vary greatly according to Rohner (1984). These learned meanings are shared by a particular division of a population or a group of people. Culture represents ways of life, values, practices, and customs that are passed on from generation to generation (Townsend, 2017).

[3] Mental health refers to a state of well-being, the ability to work productively whilst also contributing to society, and having the ability to manage everyday life stresses (World Health Organization, 2014).

[4] British South Asians refer to individuals with an ethnic identity that is shaped by language, religion, and traditions that are associated with the South Asian culture along with British norms and values (Dey, Balmer, Pandit, Saren, & Binsardi, 2017). The term South Asian in the UK is used to refer to individuals from the subcontinent of India (Minority Rights Group, 2019).

[5] There are various subgroups that comprise the South Asian population which include; Pakistan, India, Bangladesh, Sri Lanka, Bhutan, Nepal, and Maldives Islands. The majority of the South Asian community are from Gujarat (India), north-east Bengal (Bangladesh) and the Punjab (Pakistan and India), with some Punjabis and Gujaratis migrating to the UK from East Africa (particularly Uganda and Kenya). The three main religions across the South Asian population include; Sikhism, Islam, and Hinduism (Minority Rights Group, 2019).

According to the latest census data, South Asians make up around 5% of the British population (Office for National Statistics [ONS], 2012). The Pakistani[6] population has witnessed the largest increase since 2001, from 750,000 to 1,174,983 people, with 1,451,862 of Indian origin and 451,529 Bangladeshi (Minority Rights Group, 2019; ONS, 2013). Given the large numbers residing in the UK, mental health research on the South Asian population has recently started to receive more attention (Moller et al., 2016; Pilkington, Msetfi, & Watson, 2012). However, mental health research on South Asians, particularly British Pakistanis[7], is scarce (Ali, McLachlan, Kanwar, & Randhawa, 2017; DoH, 2014; Mental Health Foundation, 2016), in addition to there also being a lack of specialist referrals by the National Health Service (NHS) for this group. The cultural, religious, and linguistic needs of British South Asians are not being sufficiently met, which may explain their low utilisation rates of mental health services (Mental Health Foundation, 2016). Indeed, BAME communities as a whole are reported to underutilise mental health services and to experience diverse challenges when trying to access support (Ali et al., 2017; Husain et al., 2016; Moller et al., 2016; Weich et al., 2014).

Additional factors that serve as barriers to help-seeking for BAME groups as well as the general public include both mental health stereotypes and stigma. Stereotypes can be defined as learned beliefs associated with a specific group that are both harmful and disrespectful (Angermeyer & Dietrich, 2006; Rüsch, Angermeyer, & Corrigan, 2005). Stereotypes related to mental health problems are imbedded in society and consist of mental health sufferers being viewed as

[6] Pakistan is a South Asian country often referred to as an Islamic Republic with several linguistic and regional groups (Karim, Saeed, Rana, Mubbashar, & Jenkins, 2004; The Change Institute, 2009). Pakistanis belong to four main ethnic groups which are; Balochi (3.6%), Pathan (12.0%), Sindhi (18.2%), and Punjabi (55.6%) (Karim et al., 2004). The estimated population size of Pakistan in 2018 was 212,215,030 (The World Bank, 2019).

[7] British Pakistanis are individuals who hold British nationality and are from a Pakistani ancestry. They are a heterogeneous group with distinct identities as they are divided by varied geographical locations, customs, languages, and religion. Approximately 60-70% of British Pakistanis are from Azad Kashmir (the Kashmir Mirpur) region which is the disputed territory between India and Pakistan (The Change Institute, 2009).

dangerous, incompetent, and unpredictable. These can differ for each mental health problem, for example, individuals suffering with psychosis are viewed as dangerous in comparison to those with common mental health disorders (CMDs), i.e. anxiety and depression. Mental health stigma is a well-documented phenomenon that has persisted in society for several decades (Corrigan, Druss, & Perlick, 2014). Literature repeatedly suggests that a greater number of barriers for accessing mental health support exist in comparison with physical illnesses (Thornicroft, 2007). Mental health stigma is a complex and multi-layered concept. Further, it involves negative attitudes, feelings, and behaviours displayed towards a sufferer (Overton & Medina, 2008; Penn & Martin, 1998). Such stigma can operate both on an individual level (the negative attitudes and behaviours experienced on a one-to-one basis) as well as on a community level, which refers to the negative attitudes and behaviours of the public towards individuals with mental health problems (Evans-Lacko, Baum, Danis, Biddle, & Goold, 2012; Henderson, Evans-Lacko, & Thornicroft, 2013; Rüsch et al., 2009).

Marmot's 2010 Review illustrated that in health outcomes for individuals from disadvantaged areas and groups, the social gradient (e.g. BAME groups with lower socioeconomic positions, who typically have poorer physical and mental health compared with individuals who are more advantaged) is accountable for the poorer health outcomes that exist in England compared to other similar Western countries. Experiences of health inequalities and identity in terms of an individual's ethnicity and culture are interrelated. Thus, individuals from BAME groups typically report having negative experiences and mostly live in deprived areas, which is a result of their socioeconomic status, living environment and ethnic identity (DoH, 2011; Donkin, 2014).

Previous research has shown that inherent biological risk factors for poor mental and physical health among BAME groups do not exist (Bhopal et al., 2002; Darlington, Norman, Ballas, & Exeter, 2015; Kaufman, Dolman, Rushani, & Cooper, 2015; Nazroo, 2001) rather, this is caused by a lack of equal socioeconomic distribution in society. Health inequalities for the purpose of this doctoral thesis have been defined as inequalities that are a result of diverse societal factors, such as an individual's place of birth, the living environment, and working

conditions. The inequalities that exist in mental and physical health are caused by the disproportionate supply of health related social determinants, for example, education, employment, housing (e.g. the prevalence rate of psychotic disorders among individuals from the lower quintile of household income are 9% higher compared to those from the highest quintile) and poverty (Public Health England, 2018). Additional factors include both the discrimination and marginalisation of BAME groups (Darlington et al., 2015; Mitrou et al., 2014). Increased rates of unemployment, poverty, incarceration, homelessness (e.g. the prevalence rates of psychosis is approximately 15% higher among this population), and social isolation exist for individuals who suffer from mental health problems. Further, individuals with severe mental health problems typically live in areas that are more unsafe compared to the general population, with limited access to healthy foods and opportunities to healthy activities (Public Health England, 2018).

Barriers to gaining and maintaining employment also exist as such individuals are overrepresented in temporary work and low-pay. The 2018 National Clinical Audit of Psychosis demonstrated that only 46% (less than half) of unemployed individuals received support in some form to assist them in seeking employment (Public Health England, 2018). Whilst the socioeconomic and political conditions may differ from one ethic group to another, there is a shared consensus that BAME groups are heavily populated in more deprived areas and disadvantaged circumstances. As mentioned above these include: poorer housing quality, under- and unemployment and lower educational and income levels (Darlington et al., 2015; Hills et al., 2010; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005; Nandi & Platt, 2010; Nazroo, 1997). Furthermore, the Labour Force Survey reported that nearly 20 years later high rates of unemployment among BAME groups still exist in comparison to their White counterparts (Department for Work & Pensions [DWP], 2014). Through ‘Improving lives: the future of work, health and disability’ the government aims to tackle the issue of employment among individuals who are suffering with a long-term health condition; by doubling national employment access to services that support individuals with mental health problems in seeking employment (DWP & DoH, 2017). It is of importance however, to note that the process by which health inequalities occur is complicated, multifaceted, and interconnected (Public Health England, 2018).

1.2 Context/Care Pathway for Mental Health Services

In the UK, primary and secondary care clinicians, managers (including commissioners) are responsible for working collaboratively to create and develop local care pathways. These pathways should encourage both access and care in primary and secondary mental health services (Pilling, Whittington, Taylor, & Kendrick, 2011). Primary care mental health support services are typically the first point of contact for mental health problems (that are imbedded in primary care) which include: a General Practitioner (GP), Improving Access to Psychological Therapies (IAPT) services, community pharmacists, and other health visitors (Funk & Ivbijaro, 2008; Mind, 2016). On the other hand, secondary care mental health services require a GP referral in order to access community mental health teams and hospitals (Mind, 2018). Primary and secondary care services should be accessible via diverse routes, for example, self-referral and other entry points. The quality of care that is provided can be improved by developing effective and well-organised local care pathways, however this requires the collaborative work of professionals and managers across both primary and secondary care services. Additionally, improving poor access to mental health services for BAME groups necessitates the collaboration of other professionals (e.g. community based organisations) that go beyond health professionals and settings. Access to mental health services remains to be fairly limited and medication (particularly for milder disorders) may be disproportionately prescribed by clinicians. Hence, the NHS (in line with National Institute for Health and Care Excellence [NICE] guidance) aims to tackle this issue by training 3000 plus new psychological therapists in evidence based interventions such as IAPT (Pilling et al., 2011). A step-by-step care model for CMDs detailing treatments and referral guidance by Pilling et al. (2011) can be found in Appendix A. Further, examples of mental health care pathway maps for various NHS Foundation Trusts in England can also be found in Appendix B.

1.3 Theoretical Model of Access to Mental Health Services

Dixon-Woods et al. (2006) synthesised the literature on access to healthcare in the UK among vulnerable groups which included, older people, children, socioeconomically disadvantaged people, men/women, and members of BAME

groups. Access to healthcare encompasses a body of literature that is wide-ranging and complex. The literature includes empirical work that is both qualitative and quantitative, sociological, psychological, economical, policy documents and political statements. The word 'access' has been defined inconsistently within the field of health research. The measure of healthcare service utilisation (e.g. consultations and follow-up procedures) has typically been used in previous literature to decipher whether access to healthcare is equitable in the UK. Further, literature suggests that identifiable patterns of service utilisation exist for different groups. However, it is often difficult to understand and interpret the significance of these (Dixon-Woods et al., 2006). For instance, higher GP consultation rates have been reported for socioeconomically disadvantaged people (Kumari, 2004). However, more recent literature may be suggestive of social class variables being insignificant in providing explanations for health service utilisation (Dixon-Woods et al., 2006).

Dixon-Woods et al. (2006) suggest that 'utilisation' can be an unhelpful and unreliable measure of equitable healthcare access. This is because conducting utilisation studies pose diverse logistical and practical issues which raise concerns about validity and reliability. Furthermore, these studies rely on untested set of norms regarding how the world should be, whilst also making assumptions about what the correct and accepted level of service utilisation is including the estimate of need (which is difficult to measure). Problems that exist in accessing services for a given group are typically unidentified and unconsidered. Consequently, flawed findings are produced which suggest that the need and service utilisation are proportional. Dixon-Woods et al. (2006) claim that in order for 'access' to be adequately and contextually understood, the receipt of healthcare which is the outcome of diverse complex processes must be recognised.

Dixon-Woods et al. (2006) provide a conceptual framework of access to healthcare by socio-economically disadvantaged individuals, which focuses upon candidacy as the central concept. 'Access' has been defined as dynamic, conditional, and is reliant on continuous negotiation. Health services constantly endeavour to define what objects constitute as 'suitable objects' for both medical interventions and attention. Simultaneously, individuals who are seeking healthcare services also

attempt to understand and define what they consider to be the 'suitable objects' for medical interventions and attention. Candidacy thus, defines the manner in which individuals and health services negotiate and determine the eligibility for health care among themselves. The way in which candidacy is asserted heavily depends on the individuals identification of their symptoms and the need for professional attention. Dixon-Woods et al. (2006) thus claim that individuals from disadvantaged groups and circumstances view candidacy as a sequence of crises. Such individuals are overrepresented in emergency admissions whilst being underrepresented in preventative services (Martin, Sterne, & Majeed, 2001; Watt, 2002). Furthermore, any warning signs experienced by socio-economically disadvantaged individuals may be ignored or relegated due to positive conceptualisations of health being scarce in these communities, the normalisation of such symptoms, and the judgment feared by professionals (Dixon-Woods et al., 2006; Richards, Reid, & Watt, 2002).

Further, candidacy is dependent on several influences that result from individuals and the social contexts of their lives, along with the distribution of resources and practical resources (e.g. finances, transport, and rigid working patterns which impacts help-seeking for the socio-economically disadvantaged). Moreover, the way in which individuals articulate their medical case, for example, disadvantaged groups may struggle to provide coherent explanations that detail their needs in comparison to middle class individuals (Cooper & Roter, 2003; Dixon, Le Grand, Henderson, Murray, & Poteliakhoff, 2003), and the structure of services are further factors that influence candidacy. 'Access' therefore is representative of a dynamic interaction between these simultaneous processes (Dixon-Woods et al., 2006).

The phenomenon of access can be better understood when attention is paid to how vulnerabilities in society develop in regards to candidacy. As a result, recommendations for practice and policy development that are more appropriate and contextualised can be made. In order for accomplishing access to healthcare, a substantial degree of work is required on behalf of the individual seeking healthcare. First and foremost, there must be awareness of the available services and often times there is an assumption made that individuals residing in a particular area have equal levels of awareness. Furthermore, individuals from socio-

economically disadvantaged groups have typically been shown to lack awareness of the support and services (Dixon-Woods et al., 2006; House of Commons Health Committee, 2003). Hence, barriers to the receipt of healthcare may consist of the amount of work required, the complexity that such work may entail, and the perception of social deservingness by professionals for certain groups wherein disadvantaged groups can sometimes be deemed as less deserving. Vulnerabilities are created in relation to candidacy due to the perceptions of health and health services, the gap that exists between the competencies and priorities of socio-economically disadvantaged individuals and lastly, the organisation and structure of health services. The satisfaction with health services and whether the cultural values of such services are aligned with individuals seeking help influence what services are used (Richards et al., 2002). Several operating conditions exist in which candidacy is contextually managed. These include; individual influences and aspects such as gender, face-to-face activity, the setting and environment of healthcare, the availability of resources, such as, finances, time, and policy imperatives, the diagnostic criteria used for various diseases by professionals, and how individuals are categorised. Dixon-Woods et al. (2006) model of access to healthcare is used to conceptualise access, service utilisation, and health behaviour for the purpose of the present study. Further, this framework can be utilised to shed light on the approach adopted by the Pakistani population towards access to health services, service utilisation, and the various barriers and enablers that exist for this group. This model provides a contextualised understanding of access to healthcare which is essential for interpreting the literature on mental health service utilisation among the Pakistani population as a whole.

1.4 Rationale of the Present Study

While South Asians have been highlighted as a group at high risk of psychological distress (Mental Health Foundation, 2016), little is known about their experience of and approach to mental health (DoH, 2014; Moller et al., 2016; Tabassum, Macaskill, & Ahmad, 2000; Waqas, Zubair, Ghulam, Ullah, & Tariq, 2014). South Asians remain inadequately represented in mental health research, especially in comparison to Afro-Caribbean and East Asian minority groups (Bowl, 2007), which in turn contributes to the underdevelopment of services and thus the

maintenance of inequalities in care provision. Interestingly, the United States has mandated legislation specifically to include ethnic minorities in mental health research and trials to counter these inequalities under the guidance of the National Institutes of Health. On the other hand, the UK is yet to introduce such policies (National Institutes of Health [US], 2002; Sheikh, Netuveli, Kai, & Panesar, 2004).

Ethnicity and health may not be directly related; however, ethnicity strongly correlates with the social determinants and experience of health (Darlington et al., 2015). Thus, little is known about how help-seeking among South Asian communities is influenced by social and cultural attitudes. The limited research that exists lacks specificity, as South Asian groups have typically been grouped together (Ali et al., 2017; Husain et al., 2016; Moller et al., 2016; Pilkington et al., 2012; Shefer et al., 2013; Sung, Mayo, Ko, & Lasley, 2013). However, British South Asians are a heterogeneous group with distinct cultural and religious backgrounds, and it is therefore important to disaggregate the South Asian population and to focus on specific sub-groups therein (Ineichen, 2012). It is of importance to acknowledge that British Pakistanis are further divided by distinct ethnic groups, language, culture, and religion (e.g. Islam, Christianity, and Hinduism). British Pakistanis are from four major ethnic sub-groups which include Balochis (3.6%), Pathans (12.0%), Sindhis (18.2%), and Punjabis (55.6%) (Karim et al., 2004). The vast majority (approximately 60-70%) of the British Pakistani population in Oldham, Birmingham, and Bradford (including other areas outside of London) are from Azad Kashmir, whilst the London community is rather mixed as there are proportional numbers of Kashmiris, Punjabis, and Pathans. A small number of Balochis and Sindhis also reside in London (The Change Institute, 2009).

The present study is in line with the aims of ‘No Health Without Mental Health’, as addressing the mental health needs of young adults and BAME groups are a high priority on the UK government policy agenda. This mental health outcome strategy aims to improve the mental well-being of individuals in the UK across their lifespan with a particular emphasis on young adults due to the high prevalence rates among this population. This can be achieved through early intervention, for example, paying close attention to risk behaviours that may appear in the transition from teenage years to adulthood, in response to various emotional and life

problems. Ensuring equity of access to mental health services and those that are of high-quality within BAME groups is also of high regard. As previously mentioned, tackling the health inequalities experienced by BAME groups has been a key focus of policy agendas however, the UK has a great deal of work to do in order to reduce such inequalities (Darlington et al., 2015; DoH, 2011). Further, since 2012/13 the NHS Outcomes Framework holds the NHS Commissioning board accountable for ensuring mental health service equality for BAME groups (as outlined in the Equality Act 2010). Mental health equality is a complex and sensitive phenomenon which encompasses diverse issues that the DoH continually attempt to understand. They aim to do so through the collaborative work with those who are affected by mental health problems, communities, and mental health professionals/services (DoH, 2011).

The current study therefore aims to shed light on how young British Pakistani adults in London understand mental health and mental health services. For the purpose of the present study, British Pakistanis will be grouped together as exploring sub-group differences within the British Pakistani population is not the aim of the study and is beyond the scope of this doctoral thesis. Moreover, by focusing on British Pakistanis as a whole, the researcher is able to address the limitations of previous research (as mentioned earlier) given that the South Asian population has typically been grouped together. The following research question '*How do young British Pakistani adults understand mental health and mental health services?*' will be used to address the subsequent objectives:

1. To explore how mental health is understood by young British Pakistani adults.
2. To explore how mental health services are understood by young British Pakistani adults.

This chapter highlights the great need for mental health research and service providers to address mental health issues among young British Pakistani adults, a group deemed to be at particular risk of experiencing mental health difficulties. It begins with a brief overview of the literature search (Section 1.5), followed by a discussion of mental health needs of South Asian groups in the UK (Section 1.6).

Further to this is an exploration of mental health service utilisation and help-seeking among South Asians (Section 1.7), in addition to a discussion of the barriers to help-seeking experienced by this group (Section 1.8). The particular difficulties experienced by young adults are then considered (Section 1.9), before turning to issues surrounding mental health and help-seeking among British Pakistanis in the UK (Section 1.10). The final section of the chapter states the aims of the research and its relevance to counselling psychology (Section 1.11).

1.5 Literature Search

An extensive literature search was conducted using the following databases: Academic Search Complete, PsycArticles, PsycINFO, SCOPUS, and Web of Science. In addition, Google Scholar and Google's search engine were used to access other material, such as national governmental documents. This search was further refined by selecting papers from the year 2000 onwards, while the following keywords were used in various combinations: mental health, mental health services, South Asian, UK, prevalence, barriers to help-seeking, young adults, adults, and British Pakistanis. The total number of articles found per database were around 3,000, which was further narrowed down by reading the titles and then the abstracts. It is of importance to note that the term 'South Asian' also brought up literature that solely focused on Indians and Bangladeshis. However, for lack of time and space and given that the focus of this doctoral thesis was the British Pakistani population the researcher was not able to focus on these studies. Henceforth, the final number of studies included significantly reduced. The exclusion criteria included physical illnesses, intellectual disabilities, and South Asian migrants, which contributed to majority of the articles that initially came up. As a result, 21 studies were included based on their direct relevance to the research question, and thus those articles that focused on mental health and mental health service understanding, mental health prevalence rates, service utilisation, and barriers to help-seeking among British South Asian's, British Pakistani's, and young adults in the UK were included.

1.6 The Mental Health Needs of South Asians in the UK

Health inequalities amongst BAME populations in the UK have long been highlighted in the literature (Ali et al., 2017; Bansal et al., 2014; Bauldry & Szaflarski, 2017; Brown, Imura, & Mayeux, 2014; HMG/DH, 2011; Memon et al., 2016). In comparison to the White British population, Pakistani, Indian, and Bangladeshi groups typically report poor health with debilitating chronic illnesses (Evandrou, Falkingham, Feng, & Vlachantoni, 2016). The mental health needs of South Asians—and of BAME groups in general—have been repeatedly documented as seriously unmet (Chow, Jaffee, & Snowden, 2003; Hatch et al., 2016; Ineichen, 2012) and remain of significant concern (Bansal et al., 2014).

Mental health prevalence rates are difficult to establish in this group, given the diverse range of presentations and mental health conceptualisations that vary from culture to culture. In addition, South Asians tend to have a complicated relationship with services due to cultural and linguistic barriers (Williams et al., 2015). As a result, the rates of CMDs, e.g. anxiety and depression, among South Asians are more likely to go undetected, and they appear to receive delayed treatment for these disorders (Prady et al., 2016).

However, higher rates of psychological distress have been highlighted in British South Asians (Anand & Cochrane, 2005; Bhugra & Bhui, 2003; Fazil & Cochrane, 2003; Pilkington et al., 2012; Weich et al., 2004). Some explanations for such high rates of distress have been associated with socio-economic factors, including experiencing racism, unemployment, social exclusion, and living in low-income areas (Moller et al., 2016; Sproston & Nazroo, 2002). Studies have indicated an association between the experience of racial discrimination and self-assessed poor health, long standing illnesses that limit work, and physical and mental health problems (Chakraborty, McKenzie, & King, 2009; McKenzie, 2003). Experiences of interpersonal racism and perceiving racism in the wider society have been shown to have a direct impact on the risks of CMDs and psychosis. This finding was corroborated even after controlling for factors such as age, gender, and socio-economic status (Bansal et al., 2014; Karlsen, Nazroo, McKenzie, Bhui, & Weich, 2005).

Weich et al. (2004) quantitatively examined the prevalence of anxiety and depression among White, Irish, Black Caribbean, Bangladeshi, Indian, and Pakistani populations. A cross-sectional survey using the Revised Clinical Interview Schedule was administered to 4,281 participants aged between 16 and 74. Findings revealed that anxiety and depression amongst Irish [adjusted rate ratios (RR) 2.09, 95% CI 1.162.95, $p = 0.02$] and Pakistani men (adjusted RR 2.38, 95% CI 1.253.53, $p = 0.02$) aged 35–54 were statistically higher when compared with their White counterparts. Indian and Pakistani women were also shown to have higher rates of anxiety and depression when compared to White women of a similar age (55–74). This remained the case even after adjusting for socio-economic status (Weich et al., 2004).

It is important to note that assessing psychiatric morbidity amongst BAME groups can be extremely complex due to cultural and linguistic differences in expressions of distress. South Asians are commonly known to somatise psychological symptoms. In this sense, they typically translate anxiety into physical and visually manifested symptoms, which may pose a barrier to help-seeking (Ineichen, 2012; Karasz et al., 2016; Kirmayer, 2001; Mallinson & Popay, 2007; Nazroo, Fenton, Karlsen, & O'Conner, 2002; Zagelbaum & Carlson, 2011). Therefore, participants may have disregarded certain psychological symptoms. Surveys that were translated into given participants' mother tongues could also have led to degrees of bias in their responses (Mallinson & Popay, 2007; Weich et al., 2004).

Williams et al. (2015) conducted a quantitative longitudinal (across 20 years) community-based study to explore prevalence rates of depression in older-age White European, South Asian, and Black Caribbean adults in North-West London. Participants ($N = 4857$) were recruited from GP visitor lists, which included 2,346 European, 1,710 South Asian, and 801 Black Caribbean adults. Out of these, 632 White European, 476 South Asian, and 181 Black Caribbean male and female participants (aged 58–88) completed the full study and the follow-up. The 10-item Geriatric Depression Scale (GDS) was administered to participants, and additional questionnaires were used to collect information on medical history and psychosocial and behavioural disabilities (as well as socio-demographic data).

Findings of this study highlighted that depressive symptoms were double for South Asian and Black Caribbean participants when compared to White Europeans. Ethnic differences between South Asians and other minority groups existed, as later-life chronic disease was elevated among South Asians. Depression rates in the three groups were as follows: 9.7% for White European, 15.5% for South Asian (14.7% Indian, 21.1% Pakistani, and 16.7% East African Asian), and 17.7% for Black Caribbean participants (Williams et al., 2015).

This was a large-scale study comparing depression rates in the three largest ethnic groups in the UK. However, a potential limitation of the study was related to the use of the GDS: rather than being a diagnostic instrument, it is a brief screening tool (although it is a strong predictor of depressive symptoms). Another limitation was the selection bias that arose due to attrition during the follow-up process as well as any missing data. The baseline characteristics (i.e. physical and behavioural health conditions and socio-economic position) of participants with and without GDS scores were compared, which highlighted that healthier participants and those with higher socio-economic positions were more likely to participate in the study. Consequently, compared to participants with poorer health and lower socio-economic positions, depressive symptoms in such participants may have been lower (Williams et al., 2015).

According to Barnett et al. (2019) and NHS Digital (2017b), in comparison to the White population, South Asians and BAME groups generally face increased detention rates under the Mental Health Act (1983) as well as compulsory admissions (Gajwani, Parsons, Birchwood, & Singh, 2016; Weich et al., 2014). In addition, these groups are exposed to an increased risk of hospitalisation for psychosis across all generations (Bansal et al., 2014; Coid et al., 2008; Kirkbride et al., 2006) when compared to the White population.

Bansal et al. (2014) examined the rates of hospital admissions and compulsory treatment in relation to socio-economic indicators amongst Scottish BAME groups, and their findings revealed that BAME groups in Scotland have differing service utilisation rates when compared to non-BAME groups. Furthermore, BAME

groups—and South Asians in particular—are shown to be markedly represented in compulsory treatment admissions and in delayed service utilisation (Bansal et al., 2014). However, the explanations for the ethnic differences are unclear. One possible explanation for the increase in compulsory treatment may be due to BAME groups only seeking help at the point of crisis. According to the findings of Kirkbride et al. (2006), Pakistani women are further highlighted as being at higher risk of hospitalisation for psychotic disorders, while both Pakistani men and women (particularly Pakistani men) are shown to have higher rates of mood disorders when compared to other South Asian and minority groups. The findings of this study stressed the importance of culturally appropriate services to assist BAME groups in accessing specialist and community mental health services. However, a potential limitation of this study was the small BAME sub-group sizes, which resulted in Indians, Pakistanis, Bangladeshis, and other South Asians being combined, possibly leading to inaccurate estimates of sub-group findings (Bansal et al., 2014). However, Weich et al. (2014) also found that South Asians have a higher rate of psychiatric hospitalisation in England when compared to their White counterparts. This finding was related to the adverse pathways to health care experienced by South Asians and by BAME groups in general. Of particular relevance here, 18–35-year olds are seen as an especially vulnerable age group as they have the highest rates of compulsory admissions (Weich et al., 2014).

It is also worth noting that South Asian women experience significantly higher rates of CMDs when compared to the White population (Waheed et al., 2015). The reporting of depressive symptoms, however, is fairly low amongst South Asian women. In particular, Pakistani women do not seek help for their psychological distress despite being flagged as a high-risk group, and they have repeatedly been shown to underutilise mental health services (Waheed et al., 2015). Pakistani women often raise concerns around confidentiality and seem to rely on their social networks for support as a substitute (Kapadia, Brooks, Nazroo, & Tranmer, 2017). In general, South Asian women are less likely than their White counterparts to have a psychiatric history when presenting with para-suicide, in addition to also having lower rates of specialist admissions and follow-ups (Bansal et al., 2014; Cooper et al., 2006; Cooper et al., 2010). These findings may be associated with differences

between Western and South Asian cultures, in particular familial, religious, and linguistic differences (Moller et al., 2016; Sproston & Nazroo, 2002).

A quantitative survey was conducted by Kumari (2004) to explore the physical and mental health needs of South Asian women who attended a voluntary organisation for this particularly targeted group. One hundred Pakistani, Indian, and Bangladeshi women aged between 16 and 60 completed questionnaires, which were available, if required, in the participants' mother tongue. Findings revealed that 65% of women aged 50 and below reported racial discrimination and 35% reported sexual discrimination. Anxiety, depression, and eating disorders were commonly experienced in direct combination with physical pain (57%), while coping strategies for most women included speaking to friends, family, or managing independently. When asked about the causal factors of their symptoms, most women reported not knowing and only a few associated their symptoms with stress. Most women lacked knowledge about where to seek help but expressed a desire to receive confidential counselling from women of the same culture and psycho-education in their own language (Kumari, 2004).

It is worth noting that while GP consultations among this group are fairly high, consultations for psychological distress, anxiety, and depression are extremely low (Kumari, 2004). The high rates of physical pain (57%) reported in the study may be due to South Asians commonly somatising their psychological symptoms (as highlighted in previous literature, e.g. Ineichen, 2012; Kirmayer, 2001; Mallinson & Popay, 2007). A potential limitation of this study was that sub-group differences were not examined, making it difficult to ascertain whether the findings are more representative of a particular South Asian sub-group (Kumari, 2004).

1.7 Mental Health Service Utilisation and Help-Seeking among South Asians in the UK

South Asians—in particular British Pakistanis—underutilise the available services when compared to the White population (Cooper et al., 2013). In addition, they typically display delayed help-seeking behaviours (Bansal et al., 2014) and experience diverse challenges in accessing available support. The National Service

Framework for Mental Health was launched in 1999, which acknowledged these inequalities (Sashidharan, 2003) and highlighted that there is a legal responsibility to provide non-discriminatory services. Similarly, the Race Relations (Amendment) Act 2000 (Home Office, 2001) emphasises the legal responsibility of public authorities to promote and certify race equality. Despite this, South Asians still experience many challenges in accessing the available support (University of East Anglia, 2009), including language and cultural barriers, whereby professionals do not acknowledge or understand the conceptualisation of mental health among South Asian populations (Husain et al., 2016). They also typically report poorer health care experiences due to limited accessible information, inadequate service knowledge, language barriers, and longer waits for appointments. Consequently, slower recovery rates—including limiting health in later life—can result from inadequate mental health and service knowledge and treatment delays. Research has shown that there is a link between the accumulation of negative effects, e.g. discrimination, harassment, and socio-economic disadvantages, and poor health in later life (Evandrou et al., 2016). Underutilisation of services, premature therapy termination, and severe symptom presentation as a result of delayed help-seeking are key areas of concern amongst South Asians (Soorkia, Snelgar, & Swami, 2011).

Most recently, a report published by the DoH on achieving access to mental health services by 2020 (DoH, 2014) has acknowledged the lack of focus on ethnicity and diversity in mental health services (Ali et al., 2017). Over a decade prior to this, a report by the National Institute for Mental Health in England (Sashidharan, 2003) highlighted the lack of research evidence on BAME needs (Dhadda & Greene, 2017). Neale, Worrell and Randhawa (2009) argued that service providers must gain an understanding of the perceptions of mental health as expressed across BAME groups in the UK, in addition to emphasising a need for the development of services that are both accessible and culturally appropriate (Ali et al., 2017; Sung et al., 2013).

Cultural values—including social and religious values—and beliefs are key predictors of both service utilisation and understanding of mental health. While South Asians utilise GP services more frequently than the White community, they heavily underutilise specialist and community outreach services (Bansal et al.,

2014; McGrother, Bhaumik, Thorp, Watson, & Taub, 2002; Moller et al., 2016). Social and cultural variations in the interpretation of distressing emotions in South Asian cultures have been repeatedly highlighted. Mental distress typically involves culturally informed diagnoses, which can lead to mis/under-diagnosis by clinicians who do not share similar cultural or linguistic backgrounds. British South Asians prefer to deal with distressing problems by talking to family or friends, whereby they view mental health services as a last resort. This contrasts with British individuals, who are more willing to access mental health services. To further highlight this phenomenon, it has been reported that Pakistanis may rely more heavily than the British population on prayer as a coping strategy for emotional difficulties (Anand & Cochrane, 2005; Karasz et al., 2016; Moller et al., 2016).

Soorkia et al. (2011) postulated that South Asians tend to differ in their explanatory models of mental health, in addition to associating superstitious beliefs with mental health issues over biological factors and therefore display negative help-seeking attitudes. Many cultural variables have been highlighted as predictors for help-seeking among South Asians, including the level of acculturation to the host country (Barry & Grilo, 2002), spirituality, religiosity/traditionalism (Schnittker, Freese, & Powell, 2000), and individualism versus collectivism (Yeh, 2002). South Asian cultures are more collectivistic, wherein great importance is placed on the family and community over the individual, which may contribute to the high levels of psychological distress experienced in this population (Soorkia et al., 2011).

Soorkia et al. (2011) quantitatively examined the attitudes towards professional help-seeking among 148 students (81 women and 67 men; mean age 20.40). All the students had been born in Britain and included those of Indian (41.9%), Pakistani (20.9%), Bangladeshi (6.8%), and other South Asian descent (30.4%). The findings of this study illustrated that, overall, South Asians presented negative attitudes towards help-seeking. Nonetheless, women generally had significantly more positive attitudes than men regarding professional help-seeking ($\eta^2_p = 0.51$). In addition, small differences were found in attitudes towards professional help-seeking, with the Indian group displaying more positive attitudes than Pakistanis and other Asians. Key predictors of attitudes towards professional help-seeking regardless of gender included cultural mistrust, ethnic identity, and adherence to

South Asian values. Ethnic identity was found to be the strongest predictor, whereby individuals who identified strongly with their ethnicity presented more negative attitudes towards help-seeking. Similarly, those with high levels of mistrust and a stronger adherence to South Asian values displayed more negative attitudes towards help-seeking. However, this study had various limitations, as the self-reported questionnaires were not corroborated with objective behavioural indicators. Further, given that the sample only included university students, generalising to non-student populations is difficult. Finally, the cultural variables explored only included some of the many available (Soorkia et al., 2011).

Factors involved in intention to accessing psychological services were quantitatively examined amongst British South Asians by Pilkington et al. (2012). Participants included 48 females and 46 males, with an average age of 31, of which 61 were born in the UK and 33 were migrants. Questionnaire findings revealed that biological beliefs, shame, and izzat (honour) predicted lower help-seeking intentions. In contrast, higher levels of education and acculturation predicted higher levels of help-seeking intentions. Differences were found between UK-born South Asians and migrants, as shame, izzat, and less time spent in the UK functioned to discourage help-seeking intentions amongst migrants. Acculturation was a significant predictor for UK-born South Asians, whereby help-seeking intentions were higher amongst participants who had acculturated more to the Western culture than the South Asian culture. A limitation that should be acknowledged is that using a questionnaire design may generate bias; in this sense, as there was only a 10% response rate, this may have reflected respondents with higher educational levels, as low educational levels have been associated with small response rates (Gannon, Northern, & Carrol, 1971). Questionnaires were not translated into any South Asian language and were only available in English, which may have affected migrants' responses. In addition, relatively high levels of education were also observed in the sample overall, and therefore the study's findings may be more applicable to educated British South Asians (Pilkington et al., 2012).

A systematic review comprising 21 studies in England was conducted by Kapadia et al. (2017), with the findings highlighting that Pakistani women (aged 16+) were less likely to access inpatient services when compared to their White counterparts.

Access rates to both outpatients and IAPT services were unexpectedly low. Interestingly, compared to White women, Pakistani women had higher rates of access to early intervention services, which may reflect the higher rates of psychosis in older Pakistani women. Further, Pakistani women had similar GP consultation rates as White women, and they were reported to consult their GPs for mental health problems more than women from other ethnic groups (Kapadia et al., 2017; Soorkia et al., 2011).

Moreover, Kapadia et al. (2017) found that the social network and support for mental health problems amongst Pakistani women mostly consisted of family members rather than friends (in comparison to White women). In this regard, Pakistani women were generally shown to lack social support and have limited access to community organisations. In addition, in relation to the nature of help-seeking, Kapadia et al. (2017) found that Pakistani women were heavily influenced by their social networks, and high levels of social isolation were experienced by Pakistani women, whereby they felt that dealing with their problems independently was the only option available. Furthermore, stigma towards mental health service utilisation was higher amongst family members and relatives when compared to friends. In this sense, increased levels of mental health stigma were displayed by families of sufferers. Pakistani women were particularly concerned about health professionals of the same ethnicity disclosing their private matters to others. The findings also highlighted that language barriers had a negative influence on service users' experience, thereby deterring Pakistani women from mental health service utilisation (Kapadia et al., 2017).

1.8 Barriers to Help-Seeking in South Asian Groups in the UK

Mental health stigma operates as a significant barrier to help-seeking and recovery due to sufferers being perceived as harmful to themselves and others, unpredictable, and unable to form normal relations or have normal interactions (Hinshaw, 2006). The challenges facing mental health sufferers are twofold, since they have to deal with the physical challenges of the illness as well as the challenges of facing the embedded negative stigma in society. However, South Asians are reported to be referred to services at a lower rate than the White British

population, even in areas where South Asians comprise the majority of the population (Ali et al., 2017). For some, the fact that treatment rates remain low despite services being available is due to the associated public stigma and shame (Waqas et al., 2014). Schomerus and Angermeyer (2008) thus highlighted that anticipated discrimination as well as self-discrimination contribute to the reduction in professional help-seeking for psychological distress. They found that such stigma, including a lack of mental health knowledge, reduces help-seeking behaviour (Schomerus & Angermeyer, 2008).

A key barrier to help-seeking behaviour amongst the Pakistani community (particularly Pakistani women) is the fear of shame, stigma, and family honour being compromised (Soorkia et al., 2011). Upholding family reputation is extremely important in South Asian and Pakistani cultures, and issues surrounding anonymity and confidentiality create further barriers to help-seeking, as individuals from the Pakistani community do not feel comfortable disclosing mental health problems to practitioners from the same ethnicity (Knifton et al., 2010; Moller et al., 2016). Another cultural conflict regarding help-seeking relates to the ideal behaviour that South Asian individuals are expected to demonstrate in society, which can cause them to hide any mental health issues, thus increasing the degree of reluctance to seek help (Soorkia et al., 2011).

Knifton et al. (2010) explored stigma within BAME communities in Scotland where populations have migrated from Pakistan, India, and China. Two hundred and fifty-seven individuals participated in 26 mental health awareness workshops, which were designed and delivered by community organisations over a nine-week period. Questionnaires were administered pre- and post-workshops to measure changes in knowledge, attitudes, and behavioural intent. Pre-workshop questionnaires identified demographic details for cross-comparison, whereas post-workshop questionnaires consisted of open-ended questions on the workshops to measure any changes in knowledge, beliefs, and behavioural intent. Two hundred and forty-six participants completed the evaluations, with the majority (73%) being female. There were 95 Chinese participants (45–54 years old), 63 Indian participants (65–74 years old), and 50 Pakistani participants (35–44 years old), and the results at baseline indicated significant stigma. For instance, individuals with

mental health difficulties were perceived as being dangerous, and marrying an individual with mental health difficulties was seen as shameful. A report by Rethink (2010) also states that South Asian individuals are reluctant and less willing to marry into a family with a mental health history. Further, two per cent of the sample in Knifton et al.'s (2010) study completed both pre- and post-workshop questionnaires, with the findings indicating significant positive change in relation to attitudes, knowledge, and behavioural intent.

Knifton et al. (2010) argued that tackling stigma is effectively facilitated through community approaches rather than top-down public education. In this regard, shared meaning and understanding within a given community can effectively combat the cultural stigma associated with mental health. The findings of this study are consistent with recent literature (Soorkia et al., 2011; Waqas et al., 2014) that also highlight perceived negative perceptions, shame, and embarrassment to be associated with mental health problems.

A striking finding was the optimism shown by participants in relation to recovery from mental health issues despite the negative cultural values associated with mental health amongst South Asian communities (Knifton et al., 2010). Participants of this study reported awareness of mental health issues being common in society, which may indicate a higher level of tolerance towards mental health stigma and a reduction in shame and secrecy. The authors concluded that a community conversation model may facilitate mental health awareness and acceptance amongst South Asians (Knifton et al., 2010). However, a potential limitation of the study was related to the translation of the script and the subsequent issue of whether the meaning of a question was lost or reduced. Additionally, it is important to consider the possibility that questionnaires may only have assessed mental health knowledge according to Western principles, which may have differed from the participants' cultural principles. Furthermore, generational differences were not accounted for, which may have influenced the participants' level of mental health knowledge and understanding. Finally, the inter-group diversity of participants ages was quite large, as all three groups had dissimilar age ranges, which may have constituted a further limitation of the study.

Garrett et al. (2012) found that explanations for mental illness are heavily influenced by family understanding and traditions, whereby keeping matters in the family is an essential cultural practice. They found that religious and supernatural factors are typically used as explanations for mental health problems. For example, mental health problems are sometimes viewed as a punishment from God, and therefore religious interventions such as prayers are considered as the most helpful method (Garrett et al., 2012; Moller et al., 2016). Furthermore, mental health problems are considered a taboo that is not commonly discussed within the community, and therefore certain mental health conditions such as anxiety and depression may go unrecognised as illnesses amongst some South Asian families. Moreover, seeking support from family, friends, and religious leaders is often preferred over professional help-seeking.

A significant predictor of attitudes towards help-seeking is religion, as represented across diverse cultural and religious groups. Studies have shown South Asian Muslims to have mixed views towards help-seeking due to a strong spiritual connection with their faith. In this regard, since some Muslims seek guidance and strength through their faith in order to manage health and general life challenges, it has been suggested that spiritual values should be incorporated into the treatment when working with the South Asian community (Karasz et al., 2016).

Historically, all major world religions have provided supernatural explanations (e.g. demonic and evil spirit possessions) for mental illnesses (Dein & Illaiee, 2013). In the Pakistani community, Jinn (supernatural spirits) possession is heavily associated with mental illness, as revealed in previous UK-based studies (Ali et al., 2017; Dein & Illaiee, 2013; Khalifa & Hardie, 2005; Khalifa, Hardie, Latif, Jamil & Walker, 2011; Nye, 2012). Therefore, Pakistanis most commonly opt for religious interventions, e.g. faith healers, exorcisms, and amulets. There is a shared belief that help-seeking symbolises weakness, and consequently such a reluctance causes individuals to reach crisis point. Despite these cultural misconceptions of mental illnesses, researchers agree that it is essential for mental health practitioners to consider the individual's explanatory model to effectively facilitate recovery (Khalifa et al., 2011; Khalifa, Hardie, & Mullick, 2012; Rassool, 2015; Uvais, 2017). Cultural barriers such as a lack of English language proficiency and South

Asian cultural values conflicting with Western values can also contribute to minimal service use (Ali et al., 2017; Bauldry & Szaflarski, 2017; Rehman, 2007). South Asians—and particularly Pakistanis—struggle with the identification of mental health problems, which has adverse effects on their management and impacts upon their approach to help-seeking (Mallinson & Popay, 2007).

Interestingly, GPs commonly do not detect symptoms of mental health issues among South Asian groups (Anand & Cochrane, 2005). Burr (2002) found that help-seeking behaviour can be discouraged in instances where negative cultural stereotypes are held by practitioners; for example, practitioners viewing Pakistani culture as repressive and inferior can deter South Asians from seeking help. Furthermore, Ineichen (2012) claimed that interventions in the South Asian population can be ineffective when the patient and GP are of opposite genders. These barriers are in addition to those of location, time, and lack of service advertisement (Ineichen, 2012). Similar barriers are highlighted by Memon et al. (2016), who qualitatively explored barriers to help-seeking among 26 BAME adults (aged 18+; Asian/Asian British [n = 4]; Black/Black British [n = 6], mixed communities [n = 3], and no ethnicity specified [n = 13]). Socio-economic factors including education and income have further been highlighted as explanations for the lack of service utilisation (Platt, 2002; Rethink, 2007).

Gilbert, Gilbert and Sanghera (2004) explored South Asian women's meanings around izzat (honour) and shame brought upon others. The link between these processes and subordination and entrapment were explored in relation to help-seeking. Three focus groups were conducted with women of different ages (16–25 in Group 1; 26–40 in Group 2; and 41 and above in Group 3), and four scenarios were used based on real-life examples known to the personnel of Karma Nirvana, a South Asian women's project in Derby. Findings reflected shame and fear of losing izzat to be the central reasons for the reluctance of South Asian women to utilise mental health services. The theme of subordination was linked to izzat, in which being the carrier of family honour was deemed important within the family (Gilbert et al., 2004), while the experience of feeling physically entrapped through traditional cultural values may have increased the level of psychological distress amongst participants.

Gilbert et al. (2004) highlighted that seeking help from a GP was closely related to concerns around confidentiality, as participants feared that their private issues would be disclosed amongst the community. The findings of this study imply that European clinicians are unable to understand the issues surrounding izzat and family honour. However, it is crucial to bear the limitations of this study in mind, as South Asian women were grouped together and sub-group differences were not accounted for. As the South Asian population is not a homogenous group, it is important to explore intergroup differences.

Moller et al. (2016) qualitatively explored the attitudes of British South Asian women towards counselling—and help-seeking in particular—using a self-administered survey consisting of four open-ended questions, answers to which were then analysed using thematic analysis (TA). Eighty-two second-generation women from Northern England (18–40 years old) participated in the survey, 42% of which were Indian, 24% were Pakistani, 23% were Bangladeshi, 9% were of mixed ethnicity, and 2% were of another ethnicity, with the vast majority of them (74%) affiliating themselves with both South Asian and British cultures. Only 8% had had some exposure to counselling (2.5 hours on average).

Overall, participants felt that seeking help from counsellors was unthinkable and impossible; mental health stigma, cultural values relating to mental health, and minimal awareness about counselling all acted as barriers to help-seeking. In line with Chew-Graham, Bashir, Chantler, Burman, and Batsleer (2002) and Bowl (2007), Moller et al. (2016) also found that members of the South Asian community perceived White counsellors to be ignorant, while South Asian counsellors were considered important yet gossipy. Lack of trust also acted as a barrier to help-seeking. This study further highlighted the significant need for increased attention to be dedicated to this population in order to ensure services are accessible. However, the potential limitations of this study must be considered in that surveys were used rather than interviews, although the latter would have perhaps provided richer responses and thus a richer understanding of the stereotypes and barriers in need of being addressed.

1.9 Mental Health Needs and Help-Seeking among Young Adults in the UK

A third of young adults are reported to experience a mental health problem at some point in their lives (McCarthy, 2016), with 18–34-year olds showing elevated levels of anxiety and depression (Essau, 2005). However, young adults seem reluctant to seek help, something which has been reported both in the UK and internationally (Neufeld, Dunn, Jones, Croudace, & Goodyer, 2017; Rickwood, Deane, & Wilson, 2007). Since mental health problems are typically unrecognised and undiagnosed in this group, exact prevalence rates are difficult to determine and are inconsistent (Mental Health Foundation, 2018). However, NHS Digital (2017a) reported that around 5.5% of young men aged between 18 and 29 were known to have contacted secondary mental health, learning disabilities, and autism services, a figure rising to around 6.5% for young women of a similar age.

Young adults who experience mental health problems are at increased risk of dropping out of school, teenage pregnancy, unemployment, involvement in the criminal justice system, and suicide (Anthony, Taylor, & Raffo, 2011). Alarmingly, the ONS has revealed that the number of young suicides each year has increased over the past decade and that suicide is now the biggest killer of young adults in the UK (ONS, 2016). Self-harm was reported by one fifth of young women under 24 years of age, with an overall increase in reported self-harm by young women and men aged between 25 and 34 (HMG/DH, 2011). The early symptoms of psychosis (prodromal) are commonly experienced in the early adult years.

However, strikingly, 75% of the young adults who suffer from a mental health problem do not receive treatment (Children's Commissioner, 2016), which may reflect the lack of detection of mental health conditions during childhood, since there is an average wait of 10 years for the provision of effective treatment after reaching crisis point. Still, those with life-long mental health problems report experiencing initial symptoms by the age of 14 (HMG/DH, 2011). Depression, in particular, is highly prevalent in individuals aged 20 and under, yet the literature repeatedly highlights a tendency for young adults to avoid seeking help for depression, and when help is sought, therapy is terminated early (Bluhm, Covin,

Chow, Wrath, & Osuch, 2014). In the case of psychosis, early detection—including service provision—is fairly limited (Knapp, McDaid, & Parsonage, 2011).

In an effort to better understand how young adults perceive mental health and mental health services, a number of studies have been conducted. Bluhm et al. (2014) used a qualitative approach to explore experiences of anxiety and depression amongst older adolescents and young adults, including factors contributing to help-seeking. Semi-structured interviews were conducted with 37 participants (27 females and 10 males) aged between 16 and 25. Findings revealed that participants had a strong understanding of mental health disorders, yet they found it difficult to identify whether their symptoms qualified for a formal diagnosis or were simply normal life experiences. Participants expressed concerns around confidentiality and wanting to keep their mental health issues private. Compared to physical illnesses, mental health issues were further regarded as being treated or judged differently by friends and family. Participants also found it difficult to discuss their psychological distress with friends or family unless they had had similar experiences (Bluhm et al., 2014).

Interestingly, young adults commonly resort to using the internet for health information rather than consulting a doctor or practitioner. Marcus, Westra, Eastwood, Barnes, and Mobilizing Minds Research Group (2012) employed an innovative qualitative approach utilising eight internet blogs to understand the experience of mental health problems amongst young adults. The mental health problems of the bloggers included bipolar disorder, depression, anxiety, social phobia, and eating disorders. Analysis of the data highlighted a great sense of powerlessness, which in turn caused participants to feel extremely isolated, lonely, and alienated. As a result, participants felt that their daily functioning was impaired, and they expressed feelings of self-blame for not being able to control their mental health. In addition, the mental health of participants was reported to have impacted on and hindered several aspects of their lives, from relationships to education.

Further concerns included feeling ashamed, scared, and being worried about the reactions of others. The overall message was that participants chose to engage in

self-care activities (e.g. meditation and blogging) rather than seeking professional help. A limitation of this study was its sample size, meaning that the findings cannot be generalised to all young adults. Furthermore, participants only consisted of bloggers, which again is not representative of all young adults, while the mental health problems of participants were fairly high in severity, meaning that their experience may have differed from those of the general young adult population. However, the findings of this study are in line with other studies on young adults' experiences and understandings of mental health (Anthony et al., 2011; Bluhm et al., 2014; Neale et al., 2009). Potential explanations for the findings of Marcus et al. (2012) may include negative past experiences of service utilisation or negative beliefs associated with the mental health support system. Thus, help-seeking in this age group may be improved by raising awareness of available services and providing more friendly environments for young adults (Marcus et al., 2012).

1.9.1 Young adults from BAME groups

While the risk of suicide and self-harm is significantly elevated among Black and Asian young adults, service utilisation rates within this group remain low (Kurtz & Street, 2006; Lowe, 2006; Neale et al., 2009). Self-harm and suicide rates are also disproportionally high amongst young South Asian women when compared to other groups of women, although the lack of disclosure makes exact prevalence rates difficult to assess (Anand & Cochrane, 2005).

In a recent study, perceived social support and psychological problems were quantitatively examined amongst 912 undergraduates aged between 19 and 26 (60% male and 40% female) who were South Asian students from a Pakistani university (Jibeen, 2016). The findings of this study showed poor psychological outcomes to be related to low levels of family support. In turn, negative perceptions of family support were related to depression in adolescence, whereas negative perceptions of friends were associated with emotional problems.

In another study, Neale et al. (2009) explored how access to psychological services by African-Caribbean and South Asian young adults in Luton could be improved. Thirty-five participants, aged between 14 and 22, engaged in five single-sex focus

groups that explored their attitudes towards the Samaritans organisation. Findings highlighted participants' views that contacting an organisation such as Samaritans was a last resort because they preferred to manage their difficulties independently. Additionally, they lacked knowledge of available organisations and were unsure whether the support received would be beneficial to their mental health. Family and friends were identified as participants' preferred support systems. A key predictor of approaching services was confidence both in the organisation as well as in themselves. Suggestions for improvements regarding access to services included building up trust between organisations and young adults, with the intention of enhancing their confidence in such services (Neale et al., 2009). Of particular relevance were word of mouth, visibility of services in schools and communities, and more media advertising (e.g. radio) of services featuring young adults' input in regard to design and delivery.

1.10 Mental Health and Help-Seeking amongst British Pakistanis in the UK

British South Asians are a heterogeneous group, wherein British Pakistanis generally differ in their socio-economic backgrounds and educational status. This group has been reported to have less qualifications, and the percentage of individuals holding professional jobs is lower when compared to other sub-groups (Dobbs, Green, & Zealey, 2006; Ineichen, 2012; Moller et al., 2016). Furthermore, key socio-economic differences exist between this group and other South Asian groups. Pakistani households typically consist of a large number of multigenerational family members, which leads to overcrowding, increased stress, and higher poverty rates. Such factors play a key role in the mental health of this group (Bansal et al., 2014; Netto, Sosenko, & Bramley, 2011).

Waqas et al. (2014) state that mental health sufferers experience the highest levels of stigmatisation in society. They further highlight that, over the years, mental health stigma has mostly been researched within Western societies in comparison to developing ones. The level of neuropsychiatric disorder burden has been reported to be nearly 12% by the World Health Organization (WHO); however, treatment rates are fairly low despite the available services due to the associated public stigma and shame (Waqas et al., 2014).

Waqas et al. (2014) conducted a quantitative study exploring the attitudes and understanding of Pakistani students towards mental illness in the University of Punjab. Five hundred and twenty-seven students (40.8% female and 40.8% male) from various science disciplines completed self-administered questionnaires that consisted of three different sections: a) demographic details; b) general knowledge of psychiatric illnesses; and c) the Community Attitudes Towards Mental Illness scale. The study differentiated between medical and non-medical students and found that those who had some exposure to mental health (whether from reading books or from direct experience) adopted more favourable attitudes towards mental health sufferers (Waqas et al., 2014).

A similar study (Evans-Lacko, Henderson, & Thornicroft, 2013) found that, overall, participants (N = 6754) had minimal knowledge of the bio-psychosocial causal factors of mental illness. Waqas et al. (2014) found that participants who associated substance misuse, alcoholism, and poverty with mental illness tended to have more negative attitudes towards sufferers and felt that they were solely responsible for their condition. Non-medical students and those from rural areas had beliefs about punishment from God (n = 135), evil eye (n = 118), demonic possession (n = 134), and black magic (n = 169) that were strongly associated with mental illnesses, which was followed by negative overall attitudes. Religion was reported as significant for 79.3% (418 participants), whereas 13.7% (72 participants) stated that seeking help from spiritual leaders was highly favourable. A large number of respondents—63.4% (334 participants)—considered psychiatrists to be best able to treat mental illnesses. This result, however, may reflect the attitudes of medical and formal science students. Out of 527 participants, only 41% (215 participants) had ever read an article or book related to mental illnesses. The sample of this study, however, was not representative of the general population given that all participants were from medical and formal science/social science backgrounds. There may also have been a risk of information bias due to questionnaires being self-administered. In addition, the importance of religion was measured using a single question (‘How important is religion in your life?’), which may not have been a reliable measure of the impact of religion on mental health (Waqas et al., 2014).

A qualitative study explored the attitudes of Pakistani families residing in the UK regarding mental health issues (Tabassum et al., 2000). Interviewees consisted of first-generation women (aged 29–70) and second-generation women (aged 12–30) and included the male heads (aged 30–65) of the household who were born in Pakistan. The sample therefore consisted of 29 first-generation females, 23 second-generation females, and 22 males. Pakistani culture can be described as a collectivistic culture, and therefore individual opinions and actions are not emphasised in the same manner as in Western cultures. Consequently, the male heads of the households were present in the interviews, although differences in opinions were apparent (Tabassum et al., 2000).

The findings of this study illustrated that mental health knowledge regarding symptoms of illness was reasonable. As Pakistani culture emphasises politeness and a lack of aggression in social engagements, the management of aggressive behaviours by those suffering from mental health difficulties was problematic. Seeking professional help was viewed as a last resort, as there was an expectation that families would cope with any problems faced, including mental illnesses. Furthermore, faith healers were perceived as an option for treatment alongside GPs and hospital treatment. Preserving family honour, irrespective of the great strain placed on the family, was highlighted as a central principle of cultural norms. There was a greater emphasis on the somatisation of symptoms typically seen in this group by sufferers of depression. Additionally, language, culture, and religion all served as barriers to help-seeking (Tabassum et al., 2000).

Ali et al. (2017) qualitatively examined the perceptions of young British Pakistanis regarding mental health services in Peterborough. Participants (N = 33) included young boys (n = 17) and girls (n = 16) aged between 11 and 19 who were recruited from local schools, community and religious centres. Four single-sex focus groups were carried out, with the aim of participants being able to express themselves more freely in their own gender groups. All participants expressed a lack of knowledge regarding available mental health services, with the internet seen as the primary source of mental health information. Participants did not know about local Child and Adolescent Mental Health Services (CAMHS), whereas some of the

known sources included GPs, school and mosque teachers, and the Samaritans. There was a general lack of awareness surrounding Cognitive Behavioural Therapy (CBT) and Family CBT, with the exception of a few participants having heard of these therapies from their psychology class. Most participants expressed a preference for one-to-one counselling rather than family CBT, as there was a great sense of not being able to fully express themselves in front of their parents. Cultural barriers therefore were very much present. Black magic was reported as a risk factor for mental health issues, and participants felt that turning to Islam or religious leaders would have healing effects. Additional barriers included a lack of trust in and dissatisfaction with GPs and teachers, along with shame, stigma, and embarrassment. Implications for making services more accessible included having detailed information on services available and promoting greater awareness of mental health risk factors. Participants felt that the Pakistani community lacked a solid understanding of mental health and its associated risk factors, which could be improved if more information was made accessible.

Providing mental health information to parents of young people in appropriate languages was also suggested, in addition to a greater need for more Pakistani counsellors due to the lack of cultural understanding by White counsellors. Given that the sample size was fairly small, the study's findings should not be regarded as representative of the perceptions of young British Pakistanis across Peterborough or other areas. However, the findings of this study were consistent with a DoH (2014) report that highlighted the lack of ethnic diversity in mental health service delivery and approaches. The lack of mental health awareness among young people remains a concern, as current interventions targeting this issue have so far been unable to effectively address this gap in understanding (Ali et al., 2017).

The above sections have highlighted the available literature that explores mental health attitudes and understanding among the Pakistani community. To my knowledge, there are no other studies that solely focus upon Pakistanis, particularly young British Pakistani adults in the UK.

1.11 Aims of the Research and Its Relevance to Counselling Psychology

As discussed in Section 1.1, South Asians are a group about whom little research has been carried out, especially in comparison to Afro-Caribbean and East Asian minority groups (Bowl, 2007). Although South Asians represent the largest growing ethnic minority group in the UK (Holt, 2012; Ineichen, 2012; ONS, 2013; ONS, 2018), research on the understanding of mental health and mental health services among young British Pakistani adults is largely lacking (Ali et al., 2017; Husain et al., 2006; Moller et al., 2016; Pilkington et al., 2012; Sung et al., 2013). Young adults are a group that require more mental health research attention, given that one in three young adults between the ages of 18 and 24 experience a given mental health problem in their lifetime (McCarthy, 2016). However, research attention has only recently been dedicated to the mental health experiences and understanding of this group. Furthermore, less than 30% of mental health research is dedicated to this group (McCarthy, 2016).

In order to address the aforementioned gaps in the literature, the aim of the current research study is to qualitatively explore the understanding of mental health and mental health services among young British Pakistani adults. In this regard, the objective is to carry out a qualitative study using TA to explore how the mental health understanding of young British Pakistani adults may have implications on professional practice.

The following research question was formulated to address this gap: '*How do young British Pakistani adults understand mental health and mental health services?'*

As a trainee counselling psychologist, maintaining an evidence base for therapeutic work is a core element of professional practice. This research study is in line with the aims of the British Psychological Society (BPS) in regard to research governance (BPS, 2017b) as it contributes to the advancement of knowledge in illuminating the mental health and mental health service understanding among young British Pakistani adults. In addition, this qualitative exploration is congruent with therapeutic work and process (Morrow, 2007) as it delves into the mental

health understanding of this group. The study's findings can therefore be implicated in professional practice when working therapeutically with young British Pakistani adults, as well as in efforts to increase mental health awareness within this group. Additionally, working with culturally and linguistically diverse groups is highly encouraged as part of the professional development of counselling psychologists (BPS, 2017a).

Health disparities among minority groups in the UK have been well documented (Ali et al., 2017; Brown et al., 2014; Memon et al., 2016), which counselling psychologists should endeavour to reduce (Herman et al., 2007) through addressing the mental health needs of young British Pakistani adults in research. Consequently, the current study has particular significance, given the growing British Pakistani population in the UK (ONS, 2013) and the aforementioned health inequalities in accessing mental health services (Bansal et al., 2014; Bauldry & Szaflarski, 2017; HMG/DH, 2011). Furthermore, it is essential that counselling psychologists recognise the ethnic differences that exist among BAME communities (BPS, 2017b), which is an element the current study aims to address. A fundamental role of counselling psychologists, therefore, involves facilitating health care and service providers to be more culturally sensitive through evidence-based research in health care delivery (Black, 2002). The BPS (2017a) has acknowledged the lack of relevant culturally sensitive psychological therapies available for BAME communities, and therefore the findings of the current study can potentially contribute to the development of more culturally appropriate therapies.

1.12 Conclusion

Safeguarding South Asian populations—specifically British Pakistanis—can be ensured by means of an increased understanding of the impact of mental health difficulties on these groups (Dhadda & Greene, 2017). As discussed earlier, specific ethnic-group research is paramount due to the intergroup differences that exist amongst South Asian populations (Sung et al., 2013). In this regard, devoting research attention to the understanding of mental health amongst young British Pakistani adults will provide crucial insights for both mental health research and

service providers. Thus, the research findings of the current study endeavour to assist service providers in the counselling psychology field to become more culturally sensitive and therefore more approachable.

The following chapter will outline the qualitative research method that was employed to carry out the present study.

Chapter Two

2. Methodology

2.1 Introduction

This chapter presents the research aims of the study along with the selected research paradigm. The research paradigm and methods are discussed by means of a critical comparison between the chosen research method and interpretative phenomenological analysis (IPA) and grounded theory (GT) in order to demonstrate that the selection of the most appropriate research methodology and methods was ensured. The rationale behind the various decisions taken throughout the research process will be demonstrated throughout this chapter.

2.2 Research Question and Objectives

The following research question was used to address the objectives of the present study: '*How do young British Pakistani adults understand mental health and mental health services?*'

The objectives of the study were:

1. To explore how mental health was understood by young British Pakistani adults.
2. To explore how mental health services were understood by young British Pakistani adults.

2.3 The Research Paradigm

2.3.1 Ontology

Ontology refers to the nature of reality and what is 'real' (Fletcher, 2017) and is therefore concerned with the way in which reality is constructed (Creswell, 2007; Willig, 2013). This study subscribed to a critical realist ontology, in which reality is

explicitly claimed to be inherently subjective (Fletcher, 2017; Madill, Jordan & Shirley, 2000). While reality is viewed as being stable and everlasting, an individual's beliefs and values shape their perceptions of this reality; in this regard, one's sense of reality therefore differs from person to person (Finlay, 2006). There is such a thing as a reality, but we can only access it imperfectly as it is always mediated by context and language. The critical realist ontology claims that experience is flexible as it is a result of interpretation and is therefore constructed. This experience of reality is viewed as being 'real' to the individual who is experiencing it (Willig, 2013).

An individual's inner subjective knowledge varies from person to person; however, each unique perception holds similar validity. Critical realism is in concurrence with the philosophy of counselling psychology as it is rooted in phenomenological underpinnings. This is due to counselling psychology researchers being interested in understanding how the reality of an individual is made sense of according to the beliefs associated with their experiences. The current study subscribed to a critical realist ontology as the reality of participants' understanding of mental health and mental health services was viewed as being 'true' and 'real' to the individual. Yet, participants' understanding of the research topic was assumed to vary for each participant, as it was based on their own personal, social, and cultural context (Willig, 2001, 2013).

2.3.2 Epistemology

Epistemology refers to the theory of knowledge, in which claims are made about what knowledge is and how this knowledge is constructed (Carter & Little, 2007). Epistemology relates to ontology as it is concerned with perspectives of knowledge and therefore what can be known about reality (Willig, 2013). The epistemological underpinnings of the present study were contextualist, also referred to as contextual constructionism (Braun & Clarke, 2013). In constructionism, there is a notion of 'truth' that is accepted, and thus knowledge is viewed to be context dependent. This position therefore has a realist dimension (Braun & Clarke, 2013; Madill et al., 2000).

Contextualism reflects the researcher's position according to which direct access to knowledge is never possible as such access is gained through the researcher's interpretation. This position claims that socio-cultural meanings arbitrate access to reality (Smith, 2015) and that, according to the context in which data is collected and analysed, the results will differ. All knowledge is viewed as being dependent on the situation that is also provisional and local, and consequently there is no objective truth (Jaeger & Rosnow, 1988; Madill et al., 2000). Thus, the researchers' and participants' interpretative resources mediate knowledge production. The words that people use allow one to access their unique version of reality (Smith, 2015), and language, culture, context, and history shape what can be known in particular groups and cultures (Madill et al., 2000). As identified by Pidgeon and Henwood (1997), the production of knowledge may be affected by the following dimensions: the participants' personal understandings, the researchers' interpretations, and cultural meaning influencing both the participants' and the researchers' interpretations. Researchers' aim to provide a representation of participants' accounts as the study findings are based on the descriptions obtained from participants (Madill et al., 2000).

Within this contextualist epistemology, a critical realist ontology was applied in the present study, which as mentioned before, contends that while reality is out there, the research produced is an interpretation of this reality (Smith, 2015; Willig, 2001). Moreover, in this study, contextualism utilising a critical realist ontology was utilised as social practices were explicit in the discursive accounts shared by participants. As the researcher believed that the underlying logic of these social practices could be discovered (Madill et al., 2000) and that this epistemological stance was a good fit for the research question ('*How do young British Pakistani adults understand mental health and mental health services?*') as the knowledge produced was dependent on participants' unique understandings, the researchers interpretations of the data, and the fact that the findings produced were context dependent. The contextualist epistemology was also a good fit with the ethos of counselling psychology as clinicians and researchers pay close attention to subjectivity and have a humanistic approach to their clinical and research worlds. In this regard, counselling psychology researchers are concerned with producing

research that is reflexive and informs professional practice (Bury & Strauss, 2006; Kasket, 2013).

2.3.3 Methodological considerations

While quantitative research seeks to understand relationships and causes, qualitative researchers are concerned with meaning and how the world and its events are experienced and made sense of (Willing, 2008, 2013), with the research concern focusing on the 'texture' and 'quality' of experience. In this regard, the aims of the current study were to shed light onto participants' understanding of mental health, making a qualitative approach a natural fit. Furthermore, qualitative research ties in well with the field of counselling psychology, since individuals' unique experiences and how they view the world are precisely what a counselling psychologist aims to understand (Bury & Strauss, 2006; Kasket, 2013).

Despite qualitative methods being extremely diverse and multifaceted, they all share a unifying element, i.e. that some form of 'thematic coding' is achieved (Braun & Clarke, 2013). However, when conducting qualitative research, it is essential to note that there is no one model, theoretical position, or method. What is of significance is that the researcher recognises that these are decisions that need to be made. Ultimately, what the researcher is attempting to understand and know must be compatible with the epistemological framework and methodology (Braun & Clarke, 2006).

2.4 Critically Comparing Interpretative Phenomenological Analysis and Grounded Theory with Thematic Analysis

Based on the epistemology and research question, it was clear that a qualitative approach should be adopted. Originally, three methodologies were considered suitable for a question of this nature: IPA, GT, and TA. All of these approaches could have been carried out from a contextualist perspective, although GT is more suited to a social constructivist position. However, it was decided that the data would lend itself very well to TA. In this regard, Braun and Clarke's (2006) version of TA was chosen as it was clear that the research question would be best tackled

by using their approach. Below is a brief description of the differences between IPA, GT, and the chosen method of TA.

2.4.1 Interpretative phenomenological analysis (IPA)

IPA is interested in understanding the manner in which participants make sense of their lived experiences. It is both phenomenological and interpretative as it is concerned with how people make sense of and talk about events and objects. The interpretative element is present due to the researcher engaging in interpretative work in order to shed light on participants' accounts of their lived experiences (Braun & Clarke, 2006, 2013; Smith, 2015; Smith, Flowers, & Larkin, 2009). This method of interpretation is referred to as hermeneutic, and in IPA there is a process of double hermeneutics as the researcher attempts to make sense of the participant, who is in turn trying to make sense of his/her account (Smith et al., 2009). In addition, themes are identified in each unique transcript rather than across the data set (i.e. across all transcripts) (Braun & Clarke, 2006; Smith & Osborn, 2003). IPA therefore maintains an idiographic focus as themes are identified according to individual transcripts, and consequently smaller sample sizes work best (Larkin, Watts, & Clifton, 2006). Broad research questions are addressed in IPA that illuminate the significant life events of an individual, and findings therefore have implications for the participant's identity (Braun & Clarke, 2013). However, in order to gain insight into the phenomenon under investigation, lived experiences must be captured through a rich detailed account. Here, the focus was on exploring the understanding of mental health held by young British Pakistanis, regardless of whether they had been personally affected by mental health difficulties. Moreover, for ethical reasons, a decision was made early on to exclude potential participants who were experiencing ongoing mental health difficulties. Once I had conducted the pilot study and the first couple of interviews, it became clear that the type of data being obtained did not include participants' lived experiences of mental health problems and that the majority of participants had no direct experience of mental health and mental health services. IPA was therefore ruled out.

2.4.2 Grounded theory (GT)

Another possible methodology was GT, as it is also exploratory and comes in a variety of versions (Charmaz, 2002). Glaser and Strauss developed this methodology with a focus on theory building and development (Braun & Clarke, 2013; Corbin, 2017; Smith et al., 2009). The concepts that are used for theory are generated during the data collection process, and therefore a theoretical framework is not predetermined by the researcher (Corbin, 2017). Instead, GT provides an exploratory framework for understanding the phenomenon under investigation, with a particular emphasis on social processes. Categories are identified and integrated, through which theory is ultimately produced. In this sense, forming links between categories and creating connections between them is of primary importance (Smith, 2015; Willig, 2008). Thornberg and Charmaz's (2014) constructivist version of GT emphasises and focuses on interpretation; however, theory building remains an essential element. Theory development was not an aim of the present study, and social processes were not a prime focus. Furthermore, GT would not have shed light on the understanding participants held towards mental health and mental health services, and therefore GT was not deemed an appropriate fit for this study.

2.4.3 Thematic analysis (TA)

Having conducted a critical comparison between IPA and GT with TA, it was evident that neither IPA nor GT were suited to my research question or data set due to the various reasons mentioned above. In addition, as my study was exploratory, I wanted to engage with the themes across the data set (Vaismoradi, Turunen, & Bondas, 2013) that emerged in relation to my research question. TA was therefore deemed the most suitable research method as it was in line with the ontological, epistemological, and methodological stance of this study. This brand of TA further allowed for the interpretation of findings and therefore to go beyond simply reporting the patterns and meaning that emerged across the data set (Boyatzis, 1998; Braun & Clarke, 2006). It was also particularly suited to the exploratory nature of this study, since very little is known about how young British Pakistani adults understand mental health and mental health services. Further, as TA is a

widely used qualitative methodology that produces analyses that go beyond simply describing the data set (as seen in Moller et al.'s. (2016) study), the researcher felt that this approach was suitable and would produce rich findings. These points are further discussed below.

It is of importance to note that Ritchie and Spencer's (1994) framework analysis may also have been considered. This approach is similar to Braun and Clarke's (2006) version of TA however, it differs in the sense that data can be analysed during the collection process or once all the data has been collected. Further to this, Braun and Clarke's (2006) TA involves the identification of initial codes throughout the data set (phase two) prior to searching for themes. In framework analysis, data that emerges in accordance with key themes is sifted, charted, and sorted. Whilst Braun and Clarke's (2006) TA involves six steps to data analysis, framework analysis on the other hand involves five steps, which include:

i. Familiarisation - with the data set,
ii. Identifying a thematic framework - which involves the recognition of emerging themes in the data set,
iii. Indexing - which requires the researcher to identify sections of the data that correlate with a particular theme,
iv. Charting - all the sections of the data that were previously indexed are then organised into theme charts and,
v. Mapping and interpretation - the analysis of the key characteristics of the themes that emerged in the fourth step is then produced (Srivastava & Thomas, 2009).

The researcher decided to utilise Braun and Clarke's (2006) version of TA over Ritchie and Spencer's (1994) framework analysis for the reasons mentioned above. In addition, the researcher felt it was important to generate an initial list of codes per transcript prior to producing themes and sub-themes, to ensure that all the relevant content related to mental health and mental health service understanding was drawn out and not missed.

2.4.4 Braun and Clarke's (2006) approach to thematic analysis

There are two main approaches to TA: a 'small q' or a 'big Q' approach (Smith, 2015; Willig, 2008, 2013). A 'small q' approach is underpinned by quantitative conceptions and features and was therefore not compatible with the current study's research question and aims. Instead, a 'big Q' approach was adopted, in which the active role of the researcher is acknowledged and researcher subjectivity is taken into account. This approach emphasises meaning as context-dependent, and therefore coding and theme development take an organic form, informed by factors such as the researcher's unique perspective and evolving engagement with the data. This approach is theoretically flexible, and the researcher must make active decisions about what theoretical assumptions will guide the research, the type of data that will be collected, and how TA will be applied (as it can take diverse forms). TA can be used to address a wide range of research questions and can analyse most qualitative data, ranging from interviews to focus groups and diaries. The types of questions that can be addressed can vary from exploring people's lived experiences or perspectives on a certain topic (a contextualist framework) to questions addressing the social construction of a specific topic (a constructionist framework). The flexible and diverse nature of TA makes it more akin to a method than a methodology, and a wide range of research projects can be conducted using this approach (Braun & Clarke, 2013; Smith, 2015).

Over the past decade, TA has become a widely recognised method in psychology and, more generally, in the health and social sciences (Smith, 2015). Braun and Clarke (2006) have made a concerted effort to provide clear and concise guidelines on the theoretical and methodological application of TA. In this regard, their version of TA offers a rigorous approach to coding and theme development, one that is systematic and accessible (Howitt, 2010; Smith, 2015). The identification, analysis, and reporting of themes across an entire data set is clearly outlined and in a sophisticated manner (Braun & Clarke, 2006, 2013). As a result, it has become the most popular approach to TA (Smith, 2015).

For the purpose of the current study, TA was utilised within a contextualist framework. Braun and Clarke (2006) argue that explicitly stating the theoretical

stance of the research is paramount. Transparency on the assumptions made about what the data represents in terms of 'reality' and 'the world'—including the nature of the data—is vital for producing good TA. In this study, using TA within a contextualist methodology ensured that the method was compatible with the epistemological positioning of this study (contextualism) and with its research question, thus allowing for an exploration of young British Pakistanis' understanding of mental health and mental health services.

2.4.5 Validity and rigour in thematic analysis

Thematic analysis has been argued to lack credibility as a research method due to the lack of significant literature regarding guidelines to facilitate researchers in producing a rigorous analysis (Nowell, Norris, White, & Moules, 2017). TA is often referred to as being 'poorly branded' (Vaismoradi et al., 2013); however, Braun and Clarke (2006) address these criticisms by providing robust and systematic guidelines for researchers to follow. In order to produce data that was both accurate and reliable, ensuring validity and rigour throughout the analysis process was key (Fereday & Muir-Cochrane, 2006). It is noteworthy that a study's findings will not be interpreted in the same precise manner by two researchers, and therefore robust data analysis as outlined by Braun and Clarke's (2006) 'A 15-Point Checklist of Criteria for Good Thematic Analysis' was adhered to. As suggested by Joffe (2012), 10–20% of the raw data from the interview transcripts was scrutinised by the research supervisor to corroborate and cross-check findings. In addition, during the analysis process, collated codes and data extracts were shared with the research supervisor in order to verify the interpretation of the data. Further, throughout the written report in the results chapter, data extracts illustrating analytical claims were provided in order to enable readers to obtain a sense of the analytical process and review the validity of the overall analysis. The researcher allocated adequate time to each phase of analysis, which, as suggested in the 15-point checklist of criteria (Braun & Clarke, 2006), included 'Transcription', 'Coding', 'Analysis', and 'Written Report'. Issues surrounding the validity of the findings and overall quality of the research will be revisited in the discussion chapter.

2.5 Procedures

2.5.1 Ethical approval

Ethical approval for this study was obtained on 26 May 2015 by the Department of Psychology at City, University of London Ethics Committee (see Appendix C). The BPS ethical guidelines and the Health and Care Professional Council (HCPC) codes of ethics and conduct were adhered to and the interviews commenced in October 2015 (BPS, 2018; HCPC, 2016).

2.5.2 Ethical considerations

The nature of the study resulted in the research being ethically delicate. Given that the researcher is from the same ethnicity as the participants, this may have caused them to hold back on fully expressing their understanding or to feel judged by the researcher. The researcher remained mindful of this throughout the data collection process. The researcher also aimed to ensure that participants were safeguarded from any physical and psychological harm, which was achieved through maintaining a sensitive approach throughout the study and the interviews. The research topic may have resulted in issues of sensitivity as participants may have been affected by a mental health problem in the past or may have known a family member or friend with past or ongoing mental health difficulties. The researcher's skills as a trainee counselling psychologist were used to monitor participants' well-being throughout the interviews in order to ensure that they did not leave feeling vulnerable. Due to the sensitive nature of the topic, the researcher ensured that the participants were not pressured into discussing matters they did not feel comfortable disclosing, which was done through assuring participants that they did not have to answer any question(s) they felt uncomfortable with. Close attention was paid to non-verbal cues that may have indicated discomfort or emotional distress. Additionally, the debriefing sheet contained details of local mental health services in the instance of further therapy or support being required. The research supervisor was also available should participants have questions or concerns. It is noteworthy that no participant reported having been adversely affected by the research study during or after the interview process. Participants were also notified

that they would be given three months to request withdrawal of their contribution should they decide to revoke their participation.

2.5.3 Data confidentiality

Confidentiality was ensured through the anonymisation of participant details; in this sense, participants' names were replaced with a unique number prior to interviews commencing, and any identifying details were altered during the transcription stage. The transcripts were securely stored in a locked drawer, and participants' names were placed in a separate drawer to the transcripts. Interviews were recorded using an Olympus Digital Voice Recorder (DM-720), and all the audio files were transferred onto a password-protected Dell laptop (Inspiron 15R-5520).

2.5.4 Sampling considerations

Purposive sampling was employed to recruit participants; a homogenous sample was therefore recruited, which assisted in identifying meaningful themes across the data set (Braun & Clarke, 2013). A recruitment advert was designed and distributed to Pakistani community centres and local libraries and through word of mouth (see Appendix D). The recruitment advert was distributed in parts of South East- (Forest Hill, Sydenham, and Dulwich) and East London (Stratford, Ilford, and Barking), for two reasons, firstly due to convenience for the researcher and secondly as the selected areas tend to be frequented by the Pakistani population. As a result, 12 participants who self-identified as British Pakistani and were born and socialised in the UK, aged between 18 and 24 were recruited. The sample size of the current study was in line with the suggested guidelines for a small to medium size project (ranging from six to 15 participants) by Braun and Clarke (2006, 2013). Further, the researcher decided to recruit 12 participants due to time constraints of the doctoral thesis, as well as the time consuming process of the analysis phase.

2.5.5 Inclusion and exclusion criteria

Inclusion criteria included:

- Participants holding British citizenship either through birth or naturalisation
- Participants self-identifying as Pakistani
- Participants between the ages of 18 and 24.

Exclusion criteria included:

- Participants not able to provide informed consent
- Participants suffering from a mental health problem and/or utilising mental health services at the time of the study, as using vulnerable participants would have raised ethical concerns
- Participants not fluent in the English language.

2.5.6 Participants

Twelve young British Pakistani adults (six female and six male) aged between 18 and 24 (M = 20, SD = 1.35) took part in the study. Participants included were neither suffering from a mental health condition nor seeking mental health support at the time of the study. All participants were in full-time education (mostly university students, excluding one, who was in the last year of college) and were based in London.

2.5.7 Data collection

The data was collected by means of semi-structured interviews. Training for conducting semi-structured interviews was received on the professional doctorate in counselling psychology, wherein there were specific workshops targeted at interviewing and transcription skills delivered by Dr Carla Willig and other colleagues. Focus groups were not seen as a suitable data collection method as participants may have felt intimidated or uncomfortable when asked to openly

speak about mental health and mental health services (due to mental health still being viewed as taboo within the Pakistani community). An interview guide was designed in advance, which contained 16 open-ended questions (see Appendix E), however the order and wording of the questions were adapted to the participants' evolving accounts (Braun & Clarke, 2012, 2013). The choice of questions were influenced by the following qualitative studies: Moller et al. (2016) who explored the attitudes towards counselling among second generation South Asian women living in Britain, Tabassum et al. (2000) who explored the attitudes of Pakistani families towards mental health issues living in the urban areas of the UK, Neale et al. (2009) who explored the perceptions of the Samaritans and the mental health needs of young African-Caribbean and South Asian adults living in Luton, Ali et al. (2017) who explored the views of young people living in Peterborough towards the barriers that exist in seeking mental health support, and lastly Bluhm et al. (2014) who explored the experiences of older adolescents and young adults suffering with anxiety and/or depression including the factors that led them to seek help. In conjunction with this, the researcher utilised their skills as a trainee counselling psychologist in order to design the interview guide. It was paramount to remain mindful that the words of the interviewees may not have been a direct reflection of their thoughts and feelings, as interviews are a co-construction between researcher and participant (Kvale, 1996). However, this approach allowed the researcher to hear young British Pakistani adults talk about their understanding of mental health and mental health services. The emphasis was on meaning rather than lexical comparability, and therefore the researcher endeavoured to understand what the interviewees meant (Smith, 2015; Willig, 2008, 2013).

2.5.8 Procedure

Stage 1: Piloting of the measuring tool

The interview guide was piloted with two volunteers who were recruited using the recruitment advert (one female and one male participant). This provided the researcher with the opportunity to assess whether the interview schedule questions would elicit rich detailed accounts, in addition to also being able to test out if the

wording of the questions were easily understandable and sensitive enough, given the nature of the study.

Stage 2: Interview procedure

A recruitment advert was used to recruit participants for the study through which the participants obtained the researchers contact information. A screening questionnaire (see Appendix F) was conducted via telephone with potential participants that were interested in taking part in order to ensure that vulnerable individuals or anyone seeking mental health support at that time would not be included in the study (for ethical purposes). The screening process also allowed participants to ask any questions regarding the study. A resource sheet (see Appendix G) for individuals that did not meet the inclusion criteria for the study was created; however, no participants were screened out as they all met the inclusion criteria. Once participants had been screened, a date and time to conduct the semi-structured interview were mutually agreed. Participants were then assigned a number to ensure anonymity. The location of the interviews varied according to what was convenient for the participants, and all interviews took place either in public libraries around London or in a booked room at City, University of London.

All participants were contacted via telephone, at which time information about the study and the content from the information sheet (see Appendix H) were verbally discussed. During this telephone consultation, participants were provided with the opportunity to ask questions or raise any queries about the study. All participants were offered to have the information sheet emailed to them prior to setting a time and date for interviews; however, they all felt content with the study information provided during the telephone conversation. Before commencing with the interviews, participants were provided with an opportunity to read over the information sheet for themselves and ask any questions. Once participants had read this, the informed consent sheet was provided in order to obtain consent, in which participants' rights to withdraw were clearly outlined (see Appendix I). A separate sheet of paper was used to record participants' details, such as names, ages, and contact details. After each interview had been conducted, the participant's details

sheet was kept in a locked drawer. Prior to commencing with the interview, participants were provided with an opportunity to ask any remaining questions or clarify any concerns regarding the study and the interview process. A digital recorder was then used to record the interview.

The interview schedule was used to guide the interviews. Open-ended questions were utilised in a flexible manner, through which prompts/follow-up questions facilitated the process. Interviews typically lasted between 35 and 60 minutes, and participants were monitored throughout the interviews and offered breaks as and when required. After the interviews had ended, participants were provided with a debriefing sheet containing information about the study's aims (see Appendix J). A verbal debriefing was also provided, in which any additional questions regarding the study or comments about the interview process were discussed. In case the sensitive nature of the study had affected the participants, the debriefing sheet also included details of local mental health services. The audio recordings of all 12 interviews were transferred to a password-protected USB, which was then stored in a locked drawer along with the participants' details sheet.

2.6 Analytical Strategy

2.6.1 Thematic data analysis

It is important that the method of data analysis is compatible with the research question, method of data collection, and the epistemological underpinnings of the research project, and researchers must be clear and concise regarding how analysis was conducted (Braun & Clarke, 2006, 2013; Willig, 2008, 2013). When engaging with the process of analysis from a TA approach, it is important to understand that themes do not just emerge from within the data. Analysis is generated from the bottom up (data driven), the researcher's skills, knowledge of the topic, and the assumptions of the theoretical framework that underpin the study construct and the analysis (Braun & Clarke, 2013; Clark, Braun, & Hayfield, 2015).

As discussed earlier, after a gap had been identified in the literature, a TA approach was adopted since the present study aimed to explore how young British Pakistani

adults understand mental health and mental health services. The researcher therefore aimed to be fairly broad ranging in the manner in which the data set was approached and to remain interested in what came out of the data set in relation to the themes that the researcher wanted to explore. The research question guided the identification of themes throughout the entire data set, with a dual focus on participants' understanding of mental health and how participants understood mental health services. In this regard, two areas of focus were used to extract information that seemed relevant and important to this particular study.

2.6.1.1 Transcription

Transcription is an integral process in qualitative research when using audio data. There is a tendency to treat this process as a technical matter when, in fact, it is much more than that. For example, several decisions must be made regarding how speech and sounds will be translated into written text (Kvale, 1994; Kvale & Brinkman, 2009). A researcher should ensure that transcriptions are of a high quality and as thorough as possible. Since a transcript is produced as a result of the interaction that the researcher has with the audio recordings, it is important to acknowledge that, through the process of transcription, the resulting transcript does not entirely retain the original form but is slightly altered (Braun & Clarke, 2013; Smith, 2015). The original transcripts produced followed an orthographic method of transcription, wherein the aim was to provide a clear and concise written account of what was said during the interviews. All verbal utterances by both the researcher and the participant were recorded. All actual words and non-semantic sounds, such as 'erm' and 'mhmm', were also recorded. The audio data was not 'cleaned up' as collecting spoken data allows one to capture the manner in which individuals express themselves (Braun & Clarke, 2013). In this regard, it was essential that the transcripts retained all the information in the verbal accounts and were as close as possible to the original nature of the audio (Braun & Clarke, 2006). All transcripts were checked against the audio recordings to ensure 'accuracy', as per the criteria of Braun and Clarke (2006) for good thematic analysis. For the purpose of the write-up, the researcher adhered to an intelligent verbatim style to clean up the transcripts of the data extracts in a minor way, e.g. inserting punctuation for legibility. It was during this process that the researcher became familiarised with

the entire data set, which is where, according to many researchers, the process of analysis begins (Braun & Clarke, 2006). The identification of each speaker was clearly marked by the use of 'R' for researcher and 'P' followed by a unique number for the participants. For the purposes of anonymity, participants were referred to as 'P1' to 'P12' for each individual transcript, with participant numbers subsequently being replaced by pseudonyms (see Appendix K). Further, any identifying details were altered to protect confidentiality.

2.6.1.2 The six-step process to thematic analysis

Braun and Clarke (2006) have provided a six-phase step-by-step guide to perform TA. They claim that while all phases are not unique to TA, as some may be similar to other qualitative analytical methods, these phases must be adhered to. This particular version of TA allowed the researcher to explore how participants understand mental health and mental health services in an active manner. Whenever researchers engage with the texts they interpret, each phase lays the foundation for the next one, and therefore it is essential that a solid foundation is set in the previous phase to ensure confidence in the evolving analysis (Smith, 2015). The researcher may begin to notice patterns of meaning in the data early on, even during data collection, which is when the process of analysis truly begins. However, rather than being a linear process, analysis is a recursive one. In this regard, constantly moving back and forth between the entire data set, the extracts of data that are coded and are being analysed, and the analysed data that is being produced, are integral parts of the analysis (Braun & Clarke, 2006, 2012; Smith, 2015). The writing process is crucial and does not only take place at the end; indeed, writing should proceed throughout all phases via making notes on ideas. In addition, coding should be continuous throughout the entire process of coding and analysis. Below is an outline of the six phases of the analysis process.

Phase 1: Familiarising oneself with the data

As the data was collected by the researcher, they also had some prior knowledge of it, including some analytical thoughts relating to the research question. Repeatedly reading the transcripts was carried out, which allowed the researcher to become

familiar with its ‘depth’ and ‘breath’. In addition, the entire data set was read twice before making any initial notes. As the researcher read through the data set, initial ideas and possible patterns emerged and coding began to take shape. The researcher aimed to become familiar with all aspects of the data, as this phase anchors the rest of the analysis. Further, the initial ideas for coding were referred back to in the subsequent phases. The more formal process of coding then took place, which, in essence, is constantly developed and refined throughout the entire process of analysis (Braun & Clarke, 2006).

Phase 2: Generating initial codes

As this phase began, the researcher was familiar with the data set and had generated a list of initial ideas about what was in the data and what stood out in relation to the research question. A list of initial codes was then produced. A feature of the data that is relevant to a researcher is referred to as a code, i.e. a basic element of the data regarding the phenomenon under investigation that can be assessed in a meaningful manner. Consequently, a list of codes was developed that seemed relevant to mental health and mental health services and the researcher then began to organise the coded data into meaningful groups. The researcher aimed to code the content of the entire data set using the two areas of focus in the research question (i.e. participants’ understanding towards mental health and their understanding towards mental health services) to guide this process. Each data item was worked through systematically, paying equal attention to each transcript. Aspects of the data that seemed relevant to the research interests were also identified, as they may have formed the foundation of themes (i.e. repeated patterns) across the entire data set. Coding was carried out by making notes on the text that was being analysed using highlighters to indicate potential patterns (see Appendix L). Once the codes had been identified, the data extracts that illustrated particular codes were matched together. In this phase, it was important that data items were coded and later collated, which involved copying and pasting extracts of data from each transcript and collating each code in a separate Microsoft Excel document. During the coding process, the aim was to code as many themes/patterns as possible as they may have been potentially useful and interesting as the analysis evolved. Extracts of data were inclusively coded, e.g. a little of the surrounding

data was kept to ensure that the context was not lost (which is a common criticism of this phase) (Braun & Clarke, 2006).

Phase 3: Searching for themes

At this point, all of the data had been initially coded and collated; as a result, a list of all the identified codes across the entire data set was produced (see Appendix M). In phase three, the codes were organised into potential themes along with the coded data extracts. In this regard, the codes were analysed and the researcher thought about how certain codes may combine to form overarching themes, and the different codes were organised into themes using tables to organise theme-piles. The relationship between codes, themes, and the different levels of themes, which consisted of overarching themes and sub-themes were considered. At this stage, some initial codes formed main themes, some formed sub-themes, while others were discarded. In addition, a theme titled 'miscellaneous' was created for codes that did not seem to fit into the main themes. This phase produced a collection of overarching themes, sub-themes, and data extracts that were coded in reference to them. Once the overarching themes had been set, phase four of the analysis process took place (Braun & Clarke, 2006).

Phase 4: Reviewing themes

In this phase, the overarching themes were refined. In this sense, those that did not have enough data to support them became evident, in which case they no longer remained as overarching themes, some themes were combined together, while others were broken down and separated. At this stage, data within themes meaningfully cohered together and there were explicit distinctions between themes. Themes were then reviewed and refined at two levels. Level one involved reviewing the coded extracts of data, which required reading the collated data extracts for each theme in order to consider whether a coherent pattern had been formed. At this level, it was essential that all the overarching themes fit, and in instances when this was not the case, reworking was required, which may have consisted of creating a new theme for the data extracts that did not fit or selecting a theme that already existed for which the data extracts would fit. Completely

discarding themes from the overall analysis was another option. Once the researcher was satisfied that the overarching themes had captured the essence of the coded data, an initial thematic map was produced to visually depict the overarching themes (see Appendix N). Level two required the reviewing and refinement of overarching themes in relation to the entire data set, in which how valid each theme was in relation to the data set was considered. The thematic map produced earlier was then reviewed to ensure that it was an accurate reflection of the meanings in the data set in relation to the research question. Rereading of the entire data set also took place at this point to ensure that the themes worked in relation to the data set as discussed above, in addition to also providing an opportunity to code any additional data within themes that may have been missed in the earlier coding process. As coding is an ongoing process, the recoding of data is to be expected to a certain extent. By the end of this phase, there was a clear sense of what the themes were, the manner in which they fit together, and the overall narrative they expressed about the data set (Braun & Clarke, 2006).

Phase 5: Defining and naming themes

As a satisfactory thematic map (see Appendix O) of the data was produced, theme names had now been defined and further refined. Refining consisted of identifying the crux of each theme, and therefore determining what aspect of the data each theme captured was essential at this phase. Reviewing the collated data extracts for each theme in order to ensure that they represented a coherent account was important at this point in order to ensure that a theme was not too complex. A detailed analysis was written up for each theme, in which the 'story' behind each theme was identified and discussed. Considering how it fit into the overall analysis of the data in relation to the research question was key, which assisted in ensuring that overlapping themes were minimised as much as possible. It was necessary to study the themes individually and in relation to one another. The refinement process also consisted of identifying whether sub-themes existed within a theme. Sub-themes provide structure to a large or complex theme and further assist in representing the hierarchy of meaning within the data. By the end of this phase, clear definitions of what the themes did and did not represent was achieved, which was tested by seeing whether the content of each theme could be described in a few

sentences. Working titles had already been assigned to each theme by this phase, and theme names were then assigned, providing an immediate sense of what the theme was about in a concise manner (Braun & Clarke, 2006).

Phase 6: Producing the report

After having a set of themes worked out, the sixth phase consisted of the final stage of analysis and the write-up of the report. A TA write-up consists of telling the complex story of the data used to produce an analysis, which conveys the validity of the data. The researcher aimed for this account to be as concise as possible regarding the story told through the data within and across themes. This meant including adequate evidence for the themes by providing enough data extracts to signify the dominance of certain themes. As an interpretative lens was being employed, in this phase the analysis went a step beyond simply describing the data to capturing the profound meanings embedded in the data and interpreting their importance (which, according to Braun and Clarke [2006], constitutes the criteria for good thematic analysis). It is during this phase that an argument about the data is made in relation to the research question. In the present study, this meant that themes regarding mental health and mental health services were interpreted to illuminate the deeper meaning of the data. The analysis produced was in line with the study's epistemological stance, in which an element of interpretation informing the themes was accepted. The researcher therefore had an active input in the process in that the themes were co-constructed with the participants (Braun & Clarke, 2006).

2.7 Reflexivity

2.7.1 Researcher reflexivity

In selecting a methodology, I had to maintain an open mind to different possibilities, a decision-making process that qualitative researchers are typically faced with. In this regard, it was imperative that I thought very carefully about the most appropriate method to tackle this particular set of data. As discussed earlier, I had to make a decision about what approach would work best with my data, which

was necessary because the type of data produced after a couple of interviews suggested that participants did not have a great deal of experience of or knowledge about mental health and the support available. This may have been because of their young age, which perhaps resulted in them not having had much exposure to mental health and mental health services. Excluding potential participants with ongoing mental health difficulties may also have had an impact. Moreover, recruiting for participants proved to be slightly difficult as the response rate to the recruitment advert was initially fairly low. There may have been some resistance to participate in this study due to the sensitive nature of the topic. As seen in the introduction chapter, mental health awareness is an aspect that is largely lacking in the Pakistani community. It is of importance to acknowledge that participant names were used as a marker for their gender, and thus an assumption was made by myself in regard to their gender classification. In hindsight, including a question (on the screening questionnaire) requiring participants to specify their gender would have avoided an assumption being made.

My role as the researcher, the sensitive nature of the study, and the chosen method contributed to the type of data produced. It may have been that having a female Pakistani researcher conducting the interviews may have potentially restricted the information that participants shared with me. Some participants may have felt more comfortable and at ease than others when discussing the sensitive topic of mental health and mental health services. However, TA allowed me to better understand the participants' psychological worlds through engagement with and interpretation of participants' accounts. I adopted a reflexive attitude during the analysis process, using interpretation to understand the deeper meaning and importance of the data. As the researcher, I was an active participant in co-constructing themes with the participants. Allocating adequate time to each phase of data analysis and ensuring that the written report consisted of a balance between analytical claims and data extracts was crucial for meeting the criteria of good thematic analysis (Braun & Clarke, 2006). A reflective diary was kept throughout the research process, in which research assumptions and comments were documented in order to maximise transparency and reflexivity (Pidgeon & Henwood, 1997).

Additional precautionary measures may have included being cautious about the interview schedule and location of interviews and ensuring that the participants were at ease. Despite all of the above, however, my identity as a Pakistani researcher would still have contributed to the overall process. As a qualitative researcher, I had to remain mindful of this throughout the research process (Willig, 2008).

2.7.2 Personal reflexivity

The lack of knowledge and awareness in Pakistani communities regarding mental health has always struck me. The negligence towards accepting and understanding the existence of mental health difficulties has been witnessed by myself among family members, friends, and the community. Since embarking upon building a career in psychology, I have been passionate about raising mental health awareness among the Pakistani population, which in turn will contribute towards my skills and development as a trainee counselling psychologist and will inform my practice when working with ethnic minorities.

My previous knowledge of Pakistani attitudes towards mental health difficulties was that it is viewed negatively. There are numerous cultural barriers hindering help-seeking that also apply to mental health education. As a Pakistani trainee counselling psychologist, I was unsure as to whether participants would feel intimidated about talking openly in regard to their understanding of mental health and mental health services. My preconception was that male participants would be more uncomfortable than female participants when speaking about mental health during the interview process. In reality, this was not an issue at all, as both male and female participants appeared to be confident and at ease during the interview process. To my surprise, the fact that I was from the same ethnic background as the participants actually aided them in expressing their thoughts openly since it facilitated the establishment of a good rapport. During the overall interview process, it was heart-warming to hear participants express a great desire for mental health to be more accepted and understood by the Pakistani community. In addition, it was inspiring to hear how participants were supportive of friends and family members that had experienced mental health problems in the past, despite

the lack of acceptance within the Pakistani culture. My preconceptions of how mental health problems and services are viewed in the British Pakistani community is that there is very little acceptance, literacy, and awareness. I was of the impression that mental health is not widely discussed (if at all) within British Pakistani families, and a generational gap in regards to how mental health problems are viewed exists. During the analysis phase I utilised my reflective diary to make a note of these preconceptions in an attempt to bracket them off so that I was able to analyse my data with a blank slate, thus ensuring that the analysis was not influenced by these preconceptions.

2.8 Conclusion

Given the aim of the study—to explore how mental health and mental health services are understood by young British Pakistani adults—TA was identified as the most suitable research methodology. The following chapter will outline the research analysis and findings.

Chapter Three

3. Results

3.1 Introduction

This chapter presents the results of the qualitative data analysis. Braun and Clarke's (2006) version of TA was used to analyse the data obtained from 12 semi-structured interviews to answer the following research question: *'How do young British Pakistani adults understand mental health and mental health services?'* An interpretative form of TA was applied to the data set, whereby the researcher—played an active role in going beyond simply describing the data. Such a flexible approach to qualitative data analysis allows researchers to identify and highlight key patterns within the data set. In total, seven overarching themes emerged with corresponding sub-themes, which are presented in Figure 1 as a thematic map.

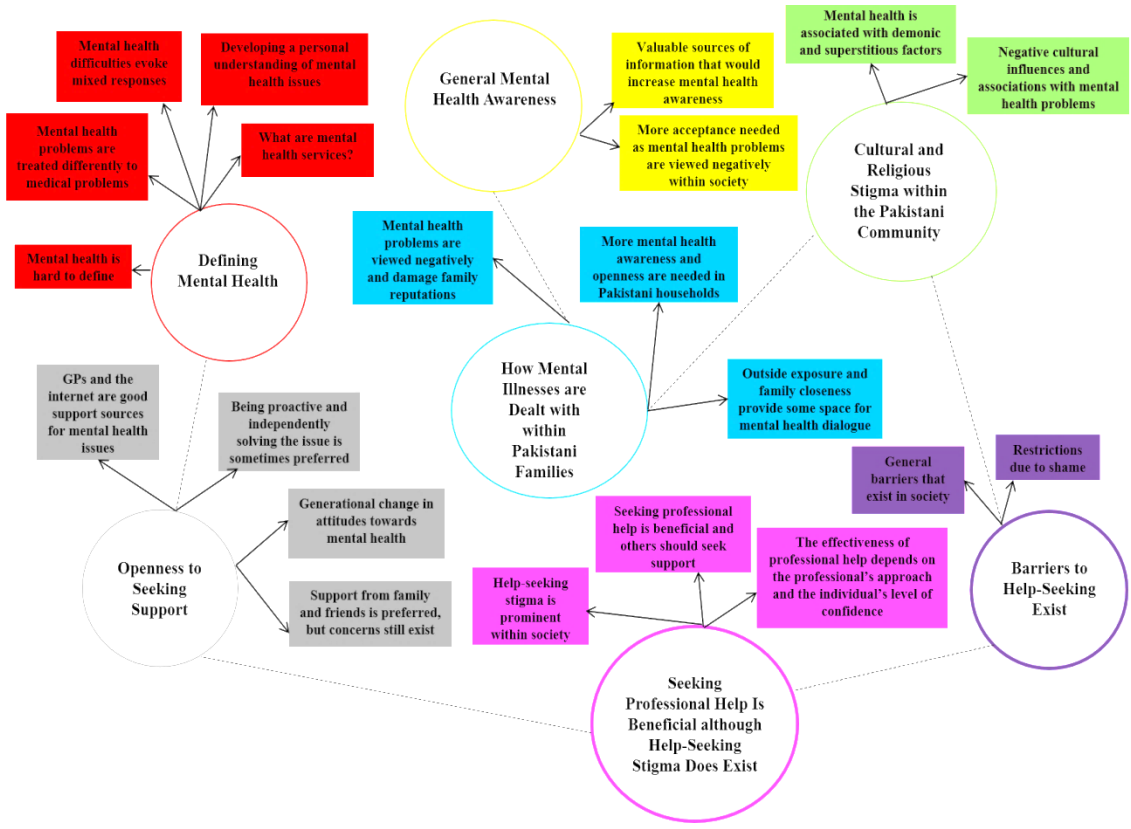

Figure 1. Final thematic map of overarching themes and sub-themes

= Overarching Theme

= Sub-Theme

------ = This was used to represent the link and overlap between the overarching themes

Some examples of code names and data extracts for each theme can be found in Appendix (P); however, for the purpose of this analysis, a few data extracts were selected to illustrate a given theme. This presentation is in line with Braun and Clarke's (2006) recommendations for the write-up of TA.

3.2 Presentation of the Analysis

3.2.1 Theme 1: Defining Mental Health

The first theme captured the manner in which participants defined mental health and mental health difficulties. In this sense, they shared their knowledge of mental health problems and services, in addition to the factors that have influenced this knowledge. This theme was broken down into the following five sub-themes: 'Mental health is hard to define', 'Mental health problems are treated differently to medical problems', 'Mental health difficulties evoke mixed responses, 'Developing a personal understanding of mental health issues', and 'What are mental health services?'

3.2.1.1 Mental health is hard to define

Participants expressed their knowledge of mental health problems, including the factors that contributed to such problems and the overall impact that mental health problems have on a sufferer.

Participants described mental health problems as being quite diverse and hard to define, a view shared by a third of participants:

> '…and I feel like there's such a wide range of issues that are basically termed mental health problems' (Aaliya, L5, p.1).

Maya felt that defining mental health problems can be rather difficult given the wide range of diagnoses that exist. Consequently, they cannot be categorised together:

> '…because of something that is I don't know, it's hard to actually know sort of how to define mental health; I don't think it fits in one box' (Maya, L9–10, p.1).

Maliha went further, as she said that differentiating between diverse mental health problems can be difficult:

> 'I just think that it's hard to differentiate the difference as in, like, psychological issues. There's such a range; some are really extreme and some are considered as weak' (Maliha, L20–21, p.1).

When discussing their understanding of mental health, nine participants highlighted the mental health problems they were most familiar with. The most common mental health problem that participants were aware of was depression:

> '…mental health issues like depression…' (Hamza, L22–23, p.1).

> 'I think there's lots of things to do with mental health; I think depression comes in there as well, which is very, very common these days' (Maya, L27, p.2).

Aaliya also spoke about depression; however, she displayed some hesitation as to whether depression is considered a mental health problem:

> 'I did erm I knew about it; I think depression that's considered a mental health issue isn't it or is it not?' (Aaliya, L17, p.1).

Aisha displayed awareness of three different types of mental health problems:

> 'I would say something like schizophrenia, depression, anxiety…' (Aisha, L5, p.1).

The same applied to Hina, although her use of diagnostic categories seemed less confident:

> '…if you're depressed or if you're going through like if you're erm if you've got schizophrenia and you say things out loud or if you've got another illness where you're acting as two people…' (Hina, L23–24, p.2).

Half of the participants expressed the view that the causal factors of mental health problems are rooted in scientific or biological factors or are in some way inherited. Hina spoke about chemical and hormonal imbalances leading to the development of mental health problems:

> '…it's about chemical imbalances within your brain and not having the right levels of, like, hormones like serotonin and dopamine and stuff like that' (Hina, L13–14, p.1).

Aaliya mentioned biological deficits and additionally adverse life events as causal factors. She also displayed some sympathy:

> 'It's just, you know, unfortunate; I think events sometimes can cause this or just biological issues that people have' (Aaliya, L22–23, p.2).

Hina also believed that mental health problems can be triggered by adverse events that a sufferer experiences as a child or throughout adulthood:

> 'To me, mental health problems are sort of like medical problems that people have that stem from issues they have when there're sort of younger, or issues that they've had throughout their life…' (Hina, L2–3, p.1).

In contrast, Omar explained that an individual in their adolescent years is more susceptible to the development of such problems due to the exposure of various stressful events:

> '…I think when they go through adolescence they go through different types of stresses, and then certain types of things kind of merge that mean

> they may be susceptible to certain mental problems in the future' (Omar, L209–211, p.10).

Five participants referred to mental health problems as being isolating in nature, leading to a sufferer feeling extremely lonely and alienated from others. Participants felt that this was part and parcel of the associated symptoms regardless of the mental health diagnosis. Hamza indicated that sufferers avoid socialising with others and prefer not to be visible:

> 'You would rather just hide away, not see people for example…' (Hamza, L51, p.3).

Hina spoke about something from within (an internal battle) causing a sufferer to feel secluded and that they are left to deal with their challenges alone:

> '…obviously it's hard because you're fighting whatever's inside you, and whatever's inside you—inside your brain—is telling you that you've got no one with you' (Hina, L304–305, p.14).

Similarly, Aaliya stated that regardless of the large number of people that may be around to support a sufferer, the condition that they have makes them feel extremely isolated:

> '…a person with mental health, I think that person feels really alone. Even if they're surrounded by 100 people, because of the condition that they're in, they just feel so alone and they just feel so excluded so they need somebody' (Aaliya, L241–245, p.12).

A handful of participants described mental health problems as having an impact on a sufferers' functional ability. Five participants highlighted the impaired daily functioning that results from such problems:

> '…and they struggle with the basic day-to-day routine, so that's how I've developed this understanding' (Hamza, L11, p.1).

> ‘I see it as problems where you can’t function properly…’ (Aaliya, L4, p.1).

Abdul expressed a similar idea, although he disagreed with it:

> ‘…which is not right is that this person is not is not capable of doing day-to-day activities…’ (Abdul, L13, p.1).

Mental health problems were described as having an impact on a sufferer’s cognitive ability by three participants:

> ‘For example, depression or erm actually some, like, mental disability in terms of them being able to think straight…’ (Abdul, L2–3, p.1).

However, participants sometimes disagreed with this idea:

> ‘They’re seen as a bit more, not as erm intelligent enough, and I feel like that’s so so wrong’ (Aaliya, L26–27, p.2).

Although participants demonstrated having some knowledge and awareness of mental health problems, they simultaneously highlighted that it can be quite difficult to identify and recognise whether you or somebody else is suffering from a mental health problem. Five participants shared this view:

> ‘…if there’s anything wrong with them, they won’t notice it anyway’ (Aisha, L202, p.11).

> ‘…I think a lot of people who have them don’t realise it, yeah’ (Forida, L13, p.1).

Seven participants spoke about mental health problems causing a shift in a sufferer’s behaviour from what is considered to be acceptable and appropriate in society to behaviour that differs from the ‘norm’:

> '…mental health problem, so erm just issues that lead to your behaviour being a little bit different to your normal everyday life' (Hamza, L2, p.1).

Aaliya further stated that through social situations, a sufferer's behavioural change is more noticeable to others:

> 'You kind of stand out when you're out and about with people, basically in social situations' (Aaliya, L4–5, p.1).

Abdul shared a similar view to Hamza and Aaliya as he also described mental health problems causing 'abnormal behaviour':

> 'Well, to me, when I hear the word mental health problem, it usually comes up with something to do with abnormal behaviour' (Abdul, L2, p.1).

The belief that mental health problems have lifelong implications was shared by a third of participants. Hamza spoke about this in reference to depression, in which he felt that depressive symptoms can linger for far too long, to the extent that the symptoms manifest in every aspect of a sufferers life:

> '…some issues, like depression sometimes it just goes on for too long and it's ruined your whole life as well…' (Hamza, L26, p.2).

Abdul shared a similar view to Hamza; however, he spoke about this from the viewpoint that others hold about such problems. He maintained that mental health problems are viewed as unresolvable and cause an individual to remain 'crazy' throughout their life:

> 'They don't see it as an actual erm as an actual issue or something that can be resolved; once he's crazy, he's crazy forever' (Abdul, L351–352, p.17).

Forida spoke of the imprint mental health problems leave on one's personality, with the implication that this causes a long-term shift in a sufferer's personality:

> '…it just leaves a mark sometimes like, like on your personality and how you are' (Forida, L149–151, p.8).

3.2.1.2 Mental health problems are treated differently to medical problems

The discussion of mental health problems highlighted the fact that participants felt a significant difference exists in the outlook and treatment of medical illnesses when compared to mental health problems. Five participants stated that a generally accepting and more positive approach is adopted by individuals regarding physical injuries. Hina argued that the discriminatory treatment towards mental health problems must be challenged in order for such problems to be perceived in a similar way to physical injuries:

> 'I think it should be treated a lot more like we treat physical illnesses because you break a leg, like, the doctor will fix it straight away and everyone around you will be supportive' (Hina, L18–19, p.1).

Similarly, Abdul highlighted the positive approach towards physical injuries, in which help-seeking is rather straightforward, while this outlook does not relate to mental health problems:

> 'It's just not urm like a pain or physical or something that happens to you, for example like a cut or a wound that is discussed very positively: "Oh, so you fell over. Let's go to the doctors"' (Abdul, L124–126, p.6).

3.2.1.3 Mental health difficulties evoke mixed responses

This sub-theme was used to capture the emotional responses participants held towards mental health problems. Participants spoke about various emotional responses to mental health suffering.

Four participants conveyed sympathy towards a sufferer, given the challenges that they are faced with. In this regard, both Hamza and Riaz expressed feelings of sadness:

> ‘So, erm, it’s a bit sad…’ (Hamza, L183, p.9).

> ‘…well, I feel like it’s a little bit sad…’ (Riaz, L158, p.7).

Aisha spoke about the instantaneous sympathy that the knowledge of an individual suffering from a mental health problem triggered:

> ‘...this person has some sort of problem and, erm, if they, like, it’s automatically it starts to develop sympathy’ (Aisha, L11–12, p.1).

Aaliya described the compassion that Asian families feel towards a sufferer in which a mental health problem is viewed as a dire ‘disability’:

> ‘…it’s seen as an unfortunate event like people would be like, “That’s a shame. She’s got this kind of thing or this disability”’ (Aaliya, L78, p.4).

Six participants described how essential it is to adopt a sensitive approach when interacting with a sufferer. Participants felt that one must be accommodating and mindful of the vulnerability that a sufferer experiences, and therefore great compassion and empathy must be displayed. Yusef expressed such a view and stated that one should show that they are willing to go above and beyond to ensure that a sufferer is made to feel comfortable:

> ‘Give them as much support as you can, be there for them, show them there’s somebody that cares about them show that, show them that you are willing to do whatever is necessary to help them out’ (Yusef, L326–327, p.15).

Similarly, Riaz felt that a sufferer should be shown compassion and not feel neglected:

> ‘…don’t try to brush them off; I think you have to take extra care for someone suffering…’ (Riaz, L255–256, p.11).

On the other hand, Omar indicated that maintaining a fine balance between taking a slow pace and simultaneously asking questions to check in on a sufferer's well-being is key:

> '…I think there's two sides to it; I think being patient with them and being like, okay look, you don't have to probe them with questions, but at the same time make the effort to listen. I know they sound like two different things, but you have to try and find a balance between being patient and checking on them to see if they're okay' (Omar, L63–65, p.3).

Half of the participants also asserted that when engaging with a sufferer, one's choice of words is critical due to the powerful effect that spoken language has on an individual. Participants felt that if caution is not taken, there may be negative implications on a sufferer's well-being, thus perhaps evoking their own anxiety. Hamza stated that given the vulnerable position of a sufferer, one's words may inflict harm:

> '…they're a little bit vulnerable, I would say; it may be any word that you say where you hurt them for some reason' (Hamza, L222–223, p.10).

Hina similarly raised concerns about her choice of words leading to negative consequences. In this regard, she expressed feelings of apprehension regarding her choice of words causing damage to the extent that a sufferer may feel suicidal:

> 'The only concern that I'd have is that something I could say could lead to a lot more possible circumstances. So, if someone feels that they're on the edge of life, I don't want to be the person that says the thing that sets them off and helps to make them, like, commit suicide or attempt to commit suicide; I don't want to be that person' (Hina, L285–287, p.13).

Aaliya also testified to feeling anxious about her choice of words causing unintentional harm and being magnified in a manner that was not intended:

> ‘The main concern would be, again, it just depends on what condition they have; maybe they might think I might say something and they take it completely out of context…’ (Aaliya, L286–287, p.14).

Likewise, Forida stated that one’s word choice must be carefully selected, taking into account a sufferer’s condition:

> ‘…I think I would have to be more cautious about what I say, maybe because, depending on what they have because of the way they take it I guess, like, if they, for example, got depression, you shouldn’t I guess, you shouldn't talk so negatively’ (Forida, L175–176, p.9).

A third of participants maintained that the onset of mental health problems is rather unfair. They felt compassionate towards sufferers given that they have no control over the development of mental health problems:

> ‘I think it’s just like any other illness; it’s not fair on the person that is suffering from it’ (Hina, L18, p.1).

> ‘…it’s not the person’s fault; it’s not something that they can control’ (Aaliya, L22, p.2).

> ‘It’s not something that the person chooses; it’s something that is inflicted upon them’ (Abdul, L44–45, p.2).

3.2.1.4 Developing a personal understanding of mental health issues

This fourth sub-theme highlighted the various factors that influenced participants’ understanding of mental health. In this regard, they mostly spoke about the media, personal interests, education, and exposure to others’ lived experience of mental health problems as contributing to the development of their understanding.

Half of the participants demonstrated that their knowledge of mental health stemmed from the media and what they had seen on television (TV) shows,

documentaries, and the news. Noman expressed a sense of guilt and embarrassment when stating that most of his understanding stemmed from TV shows:

> ‘It’s really bad, but mostly the TV; it’s mostly from TV programmes [laughs]’ (Noman, L36, p.2).

Aaliya similarly expressed that the media was the greatest source of exposure to information on mental health:

> ‘It’s basically what you see in the media, erm, what you read in the news, what you see on television shows on documentaries’ (Aaliya, L10, p.1).

In contrast, Maya explained that both the media and her work with patients suffering from mental health problems contributed to her understanding:

> ‘The things you see on TV maybe, erm, interactions with patients; I’ve had patients that are schizophrenic bipolar erm so, I’ve got a mixture; so, I think it’s to do with all of those things’ (Maya, L20–21, p.2).

As well as media influencing participants’ understanding of mental health, four participants spoke about their personal interest leading them to increase their knowledge by reading relevant books and articles:

> ‘Well, I did read a book once, erm, because I was interested in psychology in general’ (Noman, L4–5, p.1).

Similarly, Hina expressed that that her keenness in understanding mental health in more depth led her to researching it further:

> ‘…you’re always interested, so you research it yourself; so, that’s how I have learned the stuff that I know about mental health’ (Hina, L9, p.1).

Aaliya expressed a similar idea:

> ‘Again, what I’ve read, erm, I’ve never had experience of being counselled, but what I read about, erm, in the books and the news…’ (Aaliya, L62, p.3).

Half of the participants declared that their education played a significant role in the development of their understanding, in addition to further expressing that higher educational levels facilitated increased awareness and acceptance of mental health problems:

> ‘…I’ve done psychology as an A-level, so I think I have better understanding (Riaz, L9–10, p.1).

Similarly, Abdul stated that he had gained more of an understanding through involvement in a society at university:

> ‘I think just generally being part of a society called Disability Awareness Society and, erm, there’s another society which I cannot think of the name at the moment, but they kind of work together in university level’ (Abdul, L22–23, p.1).

Eight participants affirmed that the experience of family and friends was another factor contributing to their mental health understanding. Many participants felt that had it not been for the experience of others who suffered from a mental health problem, they would not have had much exposure to or knowledge about such problems:

> ‘What has influenced my understanding [pause] I guess, to be honest, erm, just people around me who have told me about, you know, situations with their own family, and so has kind of made me understand’ (Yusef, L12–13, p.1).

Hina stated that although she had some knowledge due to mental health education in school, if she had not personally known somebody who had suffered from a mental health problem, she felt that her understanding would have been restricted:

> ‘If I didn’t have this family experience, or if I wasn’t friends or like close with people that suffered from depression, the only reason I’d know about mental illness is because of being taught it in school; so, although my immediate family would have taught me, I’d miss out on the whole…’ (Hina, L419–421, p.19).

Aaliya similarly stated that her understanding derived from her mother, who suffered from depression, which provided her with a basic understanding from a young age:

> ‘My mum’s got depression, and she was diagnosed 10 years ago, so that’s why I was a bit familiar; I don’t know everything about depression, but I was familiar with it and the basics of it, so I personally did know about mental health from a young age’ (Aaliya, L19–20, p.1).

3.2.1.5 What are mental health services?

This final sub-theme highlighted the views participants held towards professionals and mental health services. Half of the participants described what they deemed mental health services to be. While participants displayed some understanding of what mental health services are, it was clear that many were unsure of what such services offer. Hamza described the role of services as providing guidance to facilitate the recovery of a sufferer:

> ‘I’d say it’s a pretty self-explanatory service to help people that go through these issues to try guide them to the right direction to come out of it’ (Hamza, L67–68, p.4).

Aisha described a similar idea to Hamza, in addition to speaking about ‘classes’, which may have been referring to psycho-educational classes or group therapy:

> ‘I think, like, different kind of services that help those kind of people who have mental illnesses…just helping them probably having, like, a erm a class’ (Aisha, L77–79, p.4).

While Abdul stated that he had not heard the phrase ‘mental health services’ often, he provided an explanation of what he assumed such services to be:

> ‘I don't really come across that term that much, but from what it sounds like and just thinking about it, isn’t it mainly where, like, for example erm counsellors or somebody who is a psychologist erm somebody who can kind of listen to somebody who has depression or a mental health issue’ (Abdul, L81–84, p.4).

3.2.2 Theme 2: General Mental Health Awareness

The second theme emerged as a result of participants frequently speaking about the great need for mental health awareness to be increased in society overall. Participants felt that mental health is not widely discussed (if at all) in society and that the lack of dialogue is to be blamed for this deficiency in mental health awareness. In addition, participants felt that developments in the field of mental health are greatly needed in order for mental health problems to be more widely accepted. This theme was broken down into two sub-themes: ‘Valuable sources of information that would increase mental health awareness’ and ‘More acceptance needed as mental health problems are viewed negatively within society’.

3.2.2.1 Valuable sources of information that would increase mental health awareness

Two participants spoke about mental health sufferers providing mental health education. For example, for Yusef, others’ first-hand experience was key as it can both inform and inspire those facing mental health difficulties:

> ‘…in terms of education, if somebody’s overcome it, it’ll be quite nice to understand, you know, the kind of stuff, then again, it’s life experience: they’ve gone through it; they’ve conquered it; there’s so much stuff to learn from...’ (Yusef, L295–296, p.13).

Likewise, Omar felt that people with similar difficulties are best placed to provide support:

> '…I think that, like, a family member's not going through the same thing as you are or a friend not going through the same thing as you erm or even a doctor who has experienced it, they are still not going to understand what your viewpoints are as well as someone who is going through the same thing as you. So, I think support networks with other people with the same problems, erm, and access to them as well' (Omar, L104–107, p.5).

Both participants spoke about mental health sufferers sharing their experiences with other individuals being extremely helpful as a means of mental health education. They felt that non-sufferers, whether family members or friends, are not able to relate to those in a similar situation. Furthermore, they felt that non-sufferers are unable to inform individuals about mental health as well as someone who has had direct experience themselves.

Two participants also expressed their view of authoritative figures in society bearing responsibility for bringing about mental health awareness. In this regard, they felt that religious leaders such as Imams and celebrities could use their platforms and voices to educate the general public about mental health. Given their esteemed position in society, it was argued that individuals would take an interest in listening to their views around mental health problems, including their suggestions on how to tackle the issues and seek relevant support. Hina conveyed the importance of respected religious leaders (e.g. Imams) assisting in bringing about mental health awareness by educating their community members about mental health problems:

> '…you've got, like, people that run the local mosques, you've got the Imams, you've got people that are respected in the community, and I think it's important to go down avenues like that' (Hina, L452–454, p.20).

Similarly, Omar spoke about mental health awareness being brought about by public figures; however, in this instance he referred to celebrities rather than

religious leaders. Omar particularly felt that public health campaigns advertised on TV featuring celebrities would facilitate the dissemination of mental health understanding in society:

> ‘I think okay so, more public mental health campaigns that maybe celebrities get on board with that are, like, featured on television…’ (Omar, L194–195, p.9).

Five participants spoke about the need for outreach programmes to encourage community conversations; for example, Omar and Aisha pointed to the role of mental health campaigns in raising awareness:

> ‘I don’t know how you tackle that; I guess it’s more of an awareness thing, so awareness like mental health campaigns like, you know, making people have those conversations erm because if you did get to a point where people do have mental health problems and they can talk about it, I think that would help other people...’ (Omar, L99–101, p.5).

> ‘Telling people what’s the symptoms, like small awareness classes, these kind of things, awareness leaflets posters around these kind of things’ (Aisha, L563–569, p.30).

Nine of the participants felt that mental health advertisements are rarely seen, whether in the form of TV, adverts, posters, and/or billboards. They felt that the lack of attention given to mental health advertising is a maintaining factor for minimal mental health awareness in society. Hina felt this needed addressing urgently:

> ‘I’d say it isn’t strong enough, like I’ve seen a flyer, but some people that don’t really leave their house, they’ve not seen a flyer. There’s no adverts on TV, and there’s no letters that get through the houses, so, like, people are really blocked off from it. I think there needs to be a massive push because it holds everyone back...’ (Hina, L462–464, p.21).

Aaliya agreed that information regarding mental health services should be widely disseminated:

> ‘So, if they kind of just make mental health services a bit more, you know, as the doctors, as going to the dentist orthodontist, if it’s as widely documented, then I think more people would know. So, just bringing it more into the limelight rather than just having it on the side’ (Aaliya, L395–396, p.19).

Omar spoke about not being able to recall or identify any mental health adverts or campaigns being used to increase mental health awareness. He also talked about the importance of adverts specifically targeted at ethnic minorities:

> ‘I one hundred per cent think mental health awareness is not advertised as much as it should be at all, because, even looking now, when you asked me that, I was thinking: “Okay, what advertising can I think of? What campaigns can I think of that target mental health, not just mental health within the Pakistani community or the Black community or whatever erm or ethnic minorities…”’ (Omar, L172–174, p.8).

Aisha similarly pointed out that mental health advertisements are largely lacking in society:

> ‘I think there needs to be more awareness; there is very less awareness; I don’t see any leaflets about mental awareness; I see leaflets about sex education’ (Aisha, L506–507, p.27).

Moreover, six participants argued that schools should promote mental health awareness and education. In this regard, they felt that the schooling system should take responsibility for providing the mental health education that is currently lacking. With mental health education not being included in school curriculums, participants felt that this was a contributory factor to the lack of mental health understanding in society:

> '…I think it's important for, like, agencies and the government to intervene in schools at a young age and teach them about it' (Hina, L485–486, p.22).

> 'Talking about it more in schools, maybe, I think definitely, as well as A-Levels, oh my God, yes! Okay, so secondary schools I think secondary schools will need to have, like, really, really good well-invested pastoral care counsellors, that kind of thing…' (Omar, L204–205, p.10).

In addition, Maya conveyed her dissatisfaction with the mental health education provided at both school and graduate levels:

> '…I think it's not very well taught at a graduate level or taught to people in schools' (Maya, L24, p.2).

Finally, participants spoke about ethnic minorities requiring specific mental health targeting. Three participants felt that culturally appropriate advertisements are required to assist in increasing the understanding and awareness of mental health problems among ethnic minorities, which would trigger more household and community conversations and thus potentially increase acceptance and understanding.

Omar highlighted this as a dual issue:

> 'I think, in general, there's there's not enough awareness about mental health problems, and at the bottom of the pile is targeting it towards ethnic minorities...I've never heard of any kind of mental health awareness programmes or mental campaigns that target ethnic minorities. I've never heard of any, actually' (Omar, L174–184, pp.8–9).

Furthermore, Maya felt that in order to bring about mental health awareness, relevant advertisements should be featured on Asian TV channels in a comprehensible manner for the targeted viewers:

> 'Changes, erm, maybe advertising. You know, when they are watching all

the Asian channels, there should be something added like this is not normal: Do we need help? This is the medical condition. Describe in the way that people can understand and relate to them' (Maya, L509–510, p.23).

3.2.2.2 More acceptance needed as mental health problems are viewed negatively within society

This sub-theme sheds light on how negatively mental health problems are perceived in society. Seven participants felt strongly about this, as they pointed out that mental health problems do exist in society, and therefore mental health should be taken more seriously:

> 'I just feel like mental issues should be taken seriously because I feel like sometimes, erm, people don't take them seriously' (Riaz, L18, p.1).

> '…it's not really a joke erm even, as I said, your whole life changes…' (Hamza, L19, p.1).

Hina stated that the first time she came across mental health problems was the point at which she realised such problems exist and thus mental health is a serious matter:

> 'And that was the first time I heard about it, and it really like stuck with me, like this is real! I've not heard of it before, but it's real, so it's something that you should take seriously' (Hina, L192–194, p.9).

Seven participants stated that lower educational levels lead to a distorted understanding of mental health problems. Noman spoke about his family consisting of both educated and non-educated individuals, and he felt that the latter would associate mental health problems with 'Jinn' possession:

> '…my extended family is quite split, so some of them are very highly educated some of them aren't, so the people that aren't will probably believe that Jinns have possessed them' (Noman, L63–64, p.3).

Yusef generally stated that the misunderstanding surrounding mental health is due to a lack of education:

> ‘I do think there’s a lot of misunderstanding, and I think education is the main pivotal kind of downfall for that actually’ (Yusef, L111, p.5).

Maya shared a similar view to Yusef, while adding that those who are uneducated typically regurgitate what they have learned from others rather than increasing their understanding by reading up on mental health:

> ‘I think it comes down, like I keep saying, to education—not being educated. People just say what they’ve been taught and what they heard from other people rather than going out and reading about things and knowing’ (Maya, L533–534, p.24).

Five participants felt that more acceptance of mental health problems stemmed from higher educational levels. Participants indicated that educated Pakistani individuals have an open-minded approach to mental health, unlike those with minimal education:

> ‘There are loads of Pakistani’s out there who are so educated; they know their stuff; they’re so open-minded about it’ (Aaliya, L334–335, p.16).

Likewise, Riaz stated that openness to mental health within Pakistani culture depends on how educated an individual is:

> ‘…within the culture, there’s also education; it depends if you’re educated or not…’ (Riaz, L299–300, p.13).

Four participants felt that the majority of individuals in society are extremely ignorant of mental health problems in the sense that they tend to brush such problems to the side. Aisha demonstrated this in relation to herself, as she

described an individual suffering from depression in a critical manner where the diagnosis had been completely overlooked:

> '…if someone is in depression, I would just think: "Oh, they're lazy or they're really tired"' (Aisha, L307–308, p.16).

The judgemental approach of individuals towards sufferers was described by half of the participants. Aaliya stated that sufferers are singled out in society and made to feel alienated, which has a negative impact on them:

> '…if you've got people pointing fingers at you or people saying things about you, that's just going to make you feel so much worse' (Aaliya, L245–246, p.12).

Abdul shared a similar view to Aaliya: sufferers are viewed as lesser humans who should not socialise with others in society:

> '…it's so put aside in society, like they are away from us that we don't think twice about them, that they're not human; in a way, they are something we should stay away from and not interact with' (Abdul, L102–106, p.5).

Riaz asserted that depression can be easily overlooked. Therefore, it should be more widely spoken about in order for individuals to be able to identify the onset of a mental health problem:

> '…depression I feel like sometimes they're so undermined that they should be spoken of more, and people need to realise when they are suffering from a mental illness…' (Riaz, L21–22, p.1).

Participants spoke about the derogatory terms and phrases used to describe mental health and mental health problems. A third of participants pointed out that mental health is generally spoken about in a negative manner and that sufferers are looked

down upon in society. Aisha highlighted that mental health sufferers are openly referred as being unbalanced:

> ‘But, yeah, I mean if someone actually has a mental problem, then if you say they’re crazy they would feel it…’ (Aisha, L144, p.8).

On the other hand, Forida stated that mental health problems are made fun of in society, similar to the way in which a homosexual person is spoken about. She further argued that mental health problems are spoken about too light-heartedly and that the severity of such problems are overlooked. In this sense, mental health problems are talked about rather casually and in a similar manner in everyday language to the term ‘retarded’.

> ‘…people joke about it sometimes like, “Oh, you’ve got mental issues”, you know, how some people are like, “Oh you’re so gay”; they use that as a derogatory term. So, I think people just use it, as a word, too frivolously; they don’t really realise what they’re saying and, like, when people say, like, retarded, what’s the other one? I don’t remember the other one, but yeah, I think people yeah I think it just comes across in casual conversation…’ (Forida, L54–59, p.3).

Abdul highlighted the derogatory terms that he himself previously associated with mental health that he no longer agreed with. Similar to Aisha, Abdul referred to sufferers being seen as unbalanced people who are completely out of touch with reality:

> ‘…it kind of made me realise that having mental health issues doesn’t mean you’re that crazy loopy person in the background doing various weird things; you can be very normal and interact with people have a normal life…’ (Abdul, L233–238, p.12).

Three participants highlighted that society labels sufferers as a diagnosis rather than viewing them as an individual. Aisha, however, felt that depression is less stigmatising when compared to other mental health problems. Therefore, she would

feel uncomfortable disclosing anything other than depression, as she would not want to be stuck with a label:

> ‘There is not really a lot of stigma with it, so I probably would be like, “Okay, I’ve got depression”. But if I had anything else, I wouldn’t really say cos people are actually labelled so I don’t want that’ (Aisha, L196–197, p.10).

Omar also spoke about how easily a sufferer is labelled in society without any knowledge or understanding:

> ‘…it’s very easy to just label something, label a disease onto someone, erm, without just understanding’ (Omar, L12–13, p.1).

Seven participants highlighted the dangerous associations with mental health problems held by themselves or others in society. Participants also raised concerns regarding their safety when in the company of a sufferer and the subsequent worries they had:

> ‘I think, with mental health problems, it scares a lot of people, I don’t know why’ (Omar, L153, p.7).

Abdul expressed feeling frightened by a sufferer as he would be uncertain about the potential violent tendencies that they may have. He further expressed anxieties regarding a sufferer losing control and going into attack mode:

> ‘…is someone that we should be afraid of; for example, if I have a person who has a mental health problem sitting on the bed, for example, or on the chair, then I will stay distant or, like, I don’t know what they might do to me; they might attack me or they might just go crazy or something’ (Abdul, L14–18, p.1).

Likewise, Maya referred to individuals suffering from schizophrenia as being dangerous and therefore great caution must be taken:

> ‘I see that, okay, they’re schizophrenic several things come across your head; you have to pay notice, so is this patient going to have violent tendencies? What’s this patient going to be like?’ (Maya, L34–36, p.2).

Equally, Maliha stated that she felt as if many crimes in society are committed by mental health sufferers and, for this reason, she had a negative outlook towards them. She felt fairly strongly about this, owing to personal experience:

> ‘Like I said before, a lot of the crimes that are committed today are due to mental disorders that a person may have had; so, for that reason, I do have a negative outlook on it. And, erm, also the way that my friend got murdered was because of her boyfriend, who had a psychological disorder’ (Maliha, L161–164, p.8).

Seven participants described sufferers as being marginalised in society, while also passionately expressing that this must change as it is unfair on sufferers. Noman stated that what a sufferer is going through should not be brushed aside, as others around them should be more proactive in trying to understand their diagnosis:

> ‘You shouldn’t put it aside; you should actually look for some sort of resolution in order to combat what type of mental illness they have’ (Noman, L15–16, p.1).

Similarly, Aaliya said that sufferers regularly experience discrimination and are typically side-lined in society:

> ‘…they’ve got a mental health issue, erm, they’re discriminated against, you know? They’re kind of placed on the side’ (Aaliya, L25–26, p.2).

3.2.3 Theme 3: Cultural and Religious Stigma within the Pakistani Community

The way cultural and religious influences contribute to participants’ mental health understanding emerged as a prominent theme in the data. This third theme is

further explored through the following two sub-themes: ‘Mental health is associated with demonic and superstitious factors’ and ‘Negative cultural influences and associations with mental health problems’.

3.2.3.1 Mental health is associated with demonic and superstitious factors

This sub-theme illustrates the demonic and superstitious factors associated with mental health within the Pakistani culture. Participants felt that cultural and religious influences played a strong role in mental health understanding and acceptance, which in turn contributed to the negative outlook on mental health held by Pakistanis.

Seven participants spoke about demonic and spiritual possession (Jinn) being associated with mental health problems; compared to Western society, this was said to illustrate the lack of advancement towards mental health understanding within the Pakistani community:

> ‘…they tend to believe that it was Jinns or stuff like that, so they always bring in their own culture…’ (Noman, L53–53, p.3).

This view was shared by Riaz, with the addition of religious beliefs being viewed as the causal factor:

> ‘…I think they would come up with the idea of being possessed [laughs] rather than seeing it as a mental illness. I think that’s a good one because they feel like, “Oh no, you’re possessed” or actually there is a different cause, or there will be like a religious explanation or something’ (Riaz, L69–71, p.3).

Similarly, Hina spoke about mental health problems being associated with spiritual possession. Additionally, she stated that sufferers would be perceived as seeking attention as they may express particular thoughts and beliefs and perhaps have delusions that are outside of the norm:

> '…you're having thoughts and you're seeing things; people say like you're either going through a phase or attention-seeking or that, like, there's some spirit inside you that's making you do stuff like this' (Hina, L24–26, p.2).

For Yusef, the association of black magic with mental health problems is based on the fact that an individual suffering displays behaviour that is 'out of the ordinary':

> '…something happened to somebody through black magic. Sometimes, they class that as mental health because that person is not who they are, you know, how they use to be and so on…' (Yusef, L34–35, p.2).

Two participants spoke about cultural and religious remedies being preferred to professional help-seeking. Riaz said that, in his opinion, these remedies do not have the same effect as professional counselling:

> '…they would perhaps give their own remedies or their own ideas, which I don't think would count as counselling…' (Riaz, L66–67, p.3).

Similarly, Maliha highlighted the significant role that faith plays in her life and the belief that mental health healing is derived through this faith:

> 'Like I said, personally I feel like my family's got a lot of, erm, we put religion into our life every day. So, it's like if we have any thoughts or, I don't know, we just discuss it with our God…' (Maliha, L438–439, p.20).

Six participants spoke about mental health problems being viewed as something that is a God-given punishment or a test for Pakistani Muslims. Participants felt that, from a cultural and religious perspective, mental health problems are beyond human control and are inflicted upon a sufferer:

> '…they've got mental problems they would mostly think that it's a God-given sin…' (Noman, L55–56, p.3).

Maliha highlighted that, among Muslims, mental health problems are viewed as

being a ‘life test’ from God, in which sufferers should not lose ‘hope’ as this hope facilitates the recovery process:

> ‘…with us Muslims, we feel like, you know, there’s someone listening to us, and this is part of our test of life, erm, so we have hope…’ (Maliha, L442–444, p.21).

Aisha felt that many people reject treatment for mental health problems—i.e. medication—as they strongly believe that it was ‘God’s decision’. Therefore, suffering from mental health difficulties is perceived as a destiny that cannot be tampered with:

> ‘And some people don't believe…in medicine as well and stuff as well. There are so many people out there who are just like, “Oh, it’s God’s decision” and they wouldn't even take the medication; they wouldn't take any help’ (Aisha, L371–377, pp.19–20).

3.2.3.2 Negative cultural influences and associations with mental health problems

This sub-theme captured the heavy cultural stigma associated with mental health discussed by participants. It was clear that the influence of Pakistani culture was deemed to be very strong, which has various impacts on mental health according to participants.

Eight participants spoke about the White British community being more understanding and compassionate towards mental health problems than the Pakistani community. In this regard, they felt that British culture is freer from mental health stigma and shame when compared to Pakistani culture. For Hina, this underpinned a stronger support system:

> ‘And that’s another difference—the support system in Pakistani culture isn’t as strong as it necessarily is in the White British culture because they’re a lot more open with their problems’ (Hina, L364–365, p.17).

Similarly, according to Aaliya:

> ‘Yes, completely. Why, basically, erm, White British people are very accepting…mental health is not seen as negative…’ (Aaliya, L293–294, p.14).

Participants clearly stated that exposure to mental health difficulties is greater in Western cultures when compared to South Asian cultures. A third of participants maintained that their mental health understanding stemmed from the open culture towards mental health problems in the UK. Hina explained that members of her family have incorporated Western values while simultaneously staying in touch with their Pakistani roots. Along with the fact that her parents grew up in England, this allowed her family to adopt an open and accepting approach to mental health, as the parents understood the importance of becoming informed about such problems:

> ‘…because we’re quite Western—we’re not separated from Asian culture—but because my parents grew up in England, they’ve been in the exact same position and they know that if you don’t talk about mental health, then you’re just leaving the gap there for other people to come and fill your brain…’ (Hina, L56–58, p.3).

Aaliya stated that, in comparison to Pakistani culture, Western cultures are more advanced in receiving and developing knowledge on mental health. Aaliya also felt that mental health has become more widely discussed in recent times:

> ‘I think it’s lack of knowledge, erm, I even think, you know, Western society always gets, you know, like knowledge and everything before us and more advancement in mental health. I don’t think it has been around for too long, but it has become, for the past, I don’t know how many good years, it’s become more documented upon’ (Aaliya, L301–303, p.15).

Likewise, Omar pointed out that mental health is talked about more freely due to Western values, which promote an open dialogue:

> ‘But here, you know, like because you pick up, erm, cultural habits cultural traits, maybe it is more easily talked about here, I think’ (Omar, L146, p.7).

Abdul voiced a similar idea to Omar, in which he felt that Western societies acknowledge and understand that mental health problems are often rooted in scientific factors, unlike Pakistani culture, which typically utilises spiritual possession as the root cause:

> ‘But, I mean, when you come to Western culture, mental health is taken more seriously, and it’s taken as an actual medical aspect rather than something, erm, like spiritual or something like that’ (Abdul, L37–38, p.2).

Four participants explained that marrying a mental health sufferer would be condemned in Pakistani culture, as this would be associated with shame, embarrassment, and the family image being damaged. Aaliya said that mental health problems are seen as something to steer clear of, and therefore marrying a mental health sufferer would be avoided:

> ‘If I did have a mental health issue and people found out, they would, I don’t think anybody would kind of want their sons to marry me because they think, you know, she’s got something we don’t want our sons to be associated with that…’ (Aaliya, L332–333, p.16).

Omar felt that mental health problems were highly stigmatised compared to other illnesses as individuals would not be as concerned about inquiring into a family’s diabetic or cancer history. He strongly emphasised his viewpoint with regard to not wanting one’s offspring to be ‘mental’:

> ‘I don’t agree with it, but I think it would turn off people, being like, “Oh, I don’t know if you should marry into this family because they have a history of this and, er, you don’t want your kids to be mental”, do you know what I

> mean? You don't want your kids to be mental. You never think you don't want your kids to have diabetes, you don't want your kids to have cancer, or something like that because it's a totally different thing but, again, I think it's the stigma behind it; it's illogical, but, erm, it exits' (Omar, L155–158, pp.7–8).

Moreover, 11 participants spoke about the cultural stigma associated with mental health problems. Aaliya explained that mental health sufferers are judged and 'outcast' in Pakistani society:

> '…in Pakistan, it's definitely it's seen as a negative thing. It's looked down upon if somebody has a mental health issue in a Pakistani community. They are outcasted, erm I believe they will, as I said, I think I've mentioned this, they will literally think they're crazy or somebody has done black magic or just really lame theories come into it' (Aaliya, L294–296, p.14).

Maya indicated that mental health problems are heavily stigmatised by individuals of Asian backgrounds despite cultural influences being put aside:

> '…I don't know why, but I just feel like, even with I think, keeping the culture crap out of it completely, I still think just being Asian, being brown, you still have all the stigma, I just feel they are judgemental' (Maya, L498–500, p.23).

Nine participants spoke about Pakistani culture adopting a very narrow-minded approach to mental health. They spoke about the culture limiting mental health understanding as the community lacks mental health knowledge overall, as well as the culture proliferating incorrect information as explanations for mental health problems. Aaliya pointed out how impossible it felt when attempting to speak to community members about mental health: 'It's basically like going to a brick wall'. She felt that Pakistanis are largely misinformed and lack knowledge about mental health problems, which made it difficult to engage in such dialogue:

> 'As I said, they just lack the knowledge. It's basically like going to a brick

> wall; if you talk to them about mental health, they won't know it, or what they will know is basically so factually incorrect that there's no point. So, you're wasting your time trying to tell them about that' (Aaliya, L146–151, pp.7–8).

Additionally, Riaz provided an example of what his grandmother's take would be, through which it was clear how overlooked mental health problems are:

> '…my grandmother, who is Pakistani, would perhaps be like, "Oh, it's okay, you'll be fine" sort of attitude' (Riaz, L276–277, p.12).

Aisha also spoke about the narrow-minded approach she felt that Pakistanis adopted towards mental health problems:

> 'I still see so many, erm, Pakistanis, and they still have narrow thinking' (Aisha, L471, p.25).

This view was shared by Forida, who spoke about Pakistanis being 'behind' in developing an open-minded approach:

> '…sometimes, Pakistanis are a bit more behind in that aspect. In terms of developing more, erm, openness to things like this; so, yeah, that's all [laughs]' (Forida, L220–221, p.11).

Eight participants felt that Pakistani culture has a dismissive attitude towards mental health problems. In addition, community members would overlook a given individual's symptoms and hold the impression that they will feel better with time:

> '…if you are sad, an aunty wouldn't really speak to you about it and wouldn't really say, you know, "Tell me what's wrong" or "I think you've got depression" or "You should perhaps seek help". With them, it would probably be like, "Oh, it's fine; you'll be fine; you just need to get out more; it's fine; it's okay, or distract yourself"' (Riaz, L63–65, p.3).

Aaliya described a dismissive attitude in which very little attention is paid towards mental health problems. She felt that Pakistanis overlooked the issue and offered religious suggestions as a solution:

> 'I think that's why Asian people don't really look at mental health, and if somebody is diagnosed with mental health, they don't really attend to it. They'll just be like, "Oh, whatever, they're not feeling well" or "They will get better if you read the Quran" or whatever. I think that's how it is, but they should definitely accept it more' (Aaliya, L110–112, p.6).

Abdul underlined the perceived foreign nature of therapy for Pakistanis and felt that family/friends would not understand the symptoms of depression as they would assume that a sufferer's mood could be easily lifted:

> 'For example, if somebody were to take therapy for like depression or something, it would be very unusual. Like, "Can't you just talk to us? What's wrong with you? Why don't you smile? I mean, we're having so much fun, you're just staying to the side", but they don't understand that there is this actual issue that requires certain ways to tackle it' (Abdul, L41–44, p.2).

Similarly, Yusef emphasised the great degree of unawareness and lack of acceptance towards mental health problems:

> '[pause], erm, in a Pakistani family, no way! Again, I think they really lack the understanding of it; I think, er, they think it's a non-existent problem to be honest' (Yusef, L132–133, p.6).

3.2.4 Theme 4: How Mental Illnesses are Dealt with within Pakistani Families

The fourth theme highlighted the crucial role that families played in mental health understanding and acceptance for participants, who overall felt that Pakistani parents lacked mental health awareness and consequently adopted judgemental and dismissive attitudes. There were further concerns around family image and pride

being compromised, which are both key values upheld in Pakistani culture. This theme was further broken down into the following three sub-themes: ‘More mental health awareness and openness are needed in Pakistani households’, ‘Mental health problems are viewed negatively and damage family reputations’, and ‘Outside exposure and family closeness provide some space for mental health dialogue’.

3.2.4.1 More mental health awareness and openness are needed in Pakistani households

Seven participants explained that dialogue around mental health is rather scarce in Pakistani households, echoing Noman’s remark that:

> ‘... mental health problems—we don’t tend to discuss that at home’ (Noman, L51, p.3).

In addition, Forida pointed out the assumption that mental health is more widely discussed among Western families:

> ‘Yeah, I think it’s, I think in Pakistani families, it’s very, erm, there’s a lack of conversation about it. It’s not discussed as much in Pakistani families as it would be, for example, in a modern Western family’ (Forida, L61–62, p.4).

Abdul similarly felt that individuals from Asian backgrounds, in particular Pakistanis, do not have much exposure (if any) to mental health problems and to those suffering from them:

> ‘…because before that, I mean, being a Pakistani and Asian generally, uh, we don’t really get to interact with mental health issues’ (Abdul, L32, p.2).

Participants spoke about more openness towards mental health problems being needed in Pakistani families. In this sense, five participants spoke about the need for Pakistani families to take more of an open-minded approach. Being open about personal problems and concerns is not a typical cultural norm within Pakistani

culture, and therefore being open about mental health problems is something that would not often be seen:

> ‘I think that Pakistani families need to be more open…’ (Noman, L203, p.10).

While Omar shared the same views, he felt that White British families are less concerned with what other relatives may say or think about a sufferer because they are more individualistic when compared to collectivistic Pakistani families:

> ‘In my eyes, okay, so I think if I was going to take a stereotype of what my opinion is of how a White family is compared to an Asian family or White community is compared to the Pakistani community, I think maybe they are more free to express themselves than in the Pakistani community…I think that, definitely, erm, because I think within White families maybe there is not as much emphasis on what the rest of the generation will say compared to Pakistani families. I think you can be more of an individual in a White family rather than in a Pakistani family’ (Omar, L135–140, p.7).

Similarly, Maya asserted that White British families are more understanding and empathetic towards an individual suffering from a medical or mental health-related issue:

> ‘…I think White people about generally any medical condition not just about mental health, when you go to them about a problem, I think they are a bit more attentive and understanding, and I think they know [pause], kind of, they are just not as judgemental…’ (Maya, L477–479, p.22).

Six participants felt that mental health education is very much needed within the Pakistani community; however, uncomfortable discussions around these issues may be a concern:

> ‘…you know, obviously, it’s not the most happiest of discussions, but they should have some kind of understanding of mental health issues because it’s

just so widespread in society…' (Aaliya, L100–101, p.5).

Yusef agreed:

> '…I think, again, the lack of education in terms of this subject, in terms of the Pakistani community, really, er, doesn't help' (Yusef, L106–107, p.5).

Forida pointed to high rates of domestic violence that exist within the Pakistani community and how this would have an impact on one's mental health. For this reason, there is a pressing need for Pakistani families to increase their mental health knowledge:

> '…like, especially, there's a higher rate like domestically and stuff like that. Actually, that happens a lot in White cultures too, but I just think, because of that, there's a lot more people who have it, and so there is a big need for it to be more, erm, discussed within the Pakistani community…' (Forida, L226–228, p.12).

Noman spoke about this discriminatory treatment in a family context, in which he expressed that Pakistani families tend to overlook mental health problems as they are not physically visible:

> 'I think it's basically overlooked by families because it's not a physical problem that you have, like, you know, if you've broken your arm, you can physically tell that you've broken your arm' (Noman, L211–212, p.10).

Three participants spoke about the limited understanding that exists within Pakistani families. Hina stated that the absence of mental health discussions amongst Pakistani families causes individuals from the Pakistani community to 'lose out' as they are unable to provide support for someone that is suffering from a mental health problem. She further felt that the absence of mental health understanding is harmful as it negatively impacts a sufferer:

> '…it's not doing any person a benefit us not talking about it. Rather, it's

> doing everyone, like, harm not talking about it because we lose out if we don't talk about it. We don't learn everything, and the people that suffer they lose out because people around them don't know, like, what to say and don't know how to approach them' (Hina, L402–404, p.18).

Aaliya also had similar views to Hina:

> 'So, if they don't know and nobody in their family discusses it or kind of, erm, supports it, like the support from mental health, then they won't know where to get that help from. And a lot of the times, I don't know if this is correct, but mental health can get worse, you know, you can become yeah, so' (Aaliya, L124–126, p.6).

3.2.4.2 Mental health problems are viewed negatively and damage family reputations

This sub-theme was used to capture the judgemental nature of Pakistani families towards mental health and the issue of participants feeling uncomfortable disclosing such issues to family members.

Eight participants feared being judged by their parents and family members if they were to inform them about a mental health problem. Participants indicated that they would feel as if they would be viewed in a negative light and that their families would not have an accepting or comforting approach. For this reason, participants felt that it would be quite nerve-wracking to be open with their families because they would feel extremely vulnerable and perhaps misunderstood. Aaliya stated that she would feel judged by her family and be perceived as 'crazy' if she were to disclose a mental health problem within the family:

> '…[pause], erm, I don't think I would feel uncomfortable. I know that they would kind of have this judgemental view, you know, and they think you've gone crazy, basically, if I discussed it with them…' (Aaliya, L130–131, p.7).

Similarly, Maliha asserted that family members would not adopt an open-minded approach as a psychologist would:

> ‘Because, obviously, when you talk about your ‘whatever’, you feel, erm, weird with your parents and stuff; they I don’t know, you want that open mind that the psychologist gives’ (Maliha, L342–343, p.16).

Aisha also expressed concerns regarding feeling judged by family members and being perceived as abnormal due to having a mental health problem:

> ‘…again, as I said, you don’t know how everyone’s going to take it, and, erm, what if I am acting normal but they start judging me that I’m not acting normal’ (Aisha, L222–224, p.12).

Abdul raised concerns about family members believing that the mental health problem he was experiencing was somehow self-induced, i.e. as a result of bad company or being drug related:

> ‘…so, for example, when you have your close friends or your close family, you feel as if you will be judged. You’re not able to speak your mind, or if you think differently to the way they do, then you’re somehow weird or you’ve been hanging around with the wrong people so that’s why you’re like this, or you must be taking some drugs, or you might be really badly influenced that’s why you’re in this state right now…’ (Abdul, L55–58, p.3).

Six participants spoke about mental health problems being shameful and ruining family pride and image. Participants felt that Pakistani families associate mental health problems with personal shortcomings, which in turn would embarrass the family and compromise the family status within the Pakistani community.

Hina stated that mental health problems cause community members to look down on the family of a sufferer:

> ‘And then that’s an attack on their pride, that they’ve not done as well as everyone else’s parents because everyone else doesn’t have mental illnesses’ (Hina, L84–85, p.4).

Omar spoke about the shame associated with mental health problems and the negative consequences that the wider family would experience:

> ‘…maybe if they talk about it more, maybe they, erm, there is less shame in it and there is less ramifications on the wider family than in Pakistani families, I think’ (Omar, L147–148, p.7).

Similarly, Abdul’s words of admonition suggest that sufferers are treated in a negative manner and are viewed as bringing shame upon the family:

> ‘Do not degrade them, do not put them down, actually support them, and just because a person is going through counselling, it does not mean he’s bringing shame to the family or things like that…’ (Abdul, L317–318, p.16).

Aaliya highlighted the importance of family image within the Pakistani community and conveyed that mental health problems have negative consequences on this image:

> ‘I don’t think it’s seen as a taboo, but it’s not seen as a good thing either. And with Asian people, obviously, you know, image is everything—what people think of you, you know, that’s everything…’ (Aaliya, L105–106, p.5).

Two participants spoke about families blaming themselves and feeling as if it is due to their shortcomings that a mental health problem has developed in a given family member. Hina stated that the parents of a sufferer would feel as if they have ‘failed’ their child if they have developed a mental health problem:

> ‘Because parents feel like if you need to go to a counsellor and get medicine

for your mental health illnesses, then the parents have failed you' (Hina, L82, p.4).

Similarly, Abdul spoke about the self-blame that the family of a sufferer would feel. Additionally, family members would question their upbringing and feel as if the mental health problem developed as a result of being mistreated or falling short in fulfilling the emotional and physical needs of a child:

'…the family and friends feel as if it's their fault that you have an issue. So, they'd be like, "Oh, what did we do wrong in terms of did we not treat you right, did we not give you everything you need?"' (Abdul, L570–571, p.29).

3.2.4.3 Outside exposure and family closeness provide some space for mental health dialogue

This final sub-theme captured the way participants spoke about the conditions that allow for and encourage mental health dialogue in Pakistani families.

Two participants felt that having an open and free relationship with parents and family members made it easier for topics such as mental health to be discussed. It was clear that confidence to speak about mental health was instilled through having an open relationship with parents:

'Yeah, my family's very, well, my own personal family is very open to conversations like this…' (Noman, L93 p.5).

Hamza also spoke about good family ties creating an open space to disclose any issues experienced. Hamza stated that he felt comfortable speaking openly with his parents regarding his emotional well-being, which resulted from the support previously provided by his family in a past situation:

'So, I'd say just, on a day-to-day basis, if I was to, if I was upset, then I'd say it to my parents, you know, "I'm upset today" talk about why I'm upset. If I'm happy, then yeah I'm happy. Just your normal day-to-day

> conversation: how you doing, I'm happy, I'm sad, it's not all the time going to be I'm happy when really I'm sad maybe even upset, do you know what I mean? So…just the fact that, as I said, my parents were not judgemental when I told them about my issue, and they supported me all the way; so, now I know that I can talk to them openly about anything and that they won't judge me' (Hamza, L129–134, p.6).

Outside exposure leading to family discussions was further expressed by Noman, who spoke about mental health discussions taking place at home due to him sharing his experience with his parents. Noman clearly felt that this would trigger conversations that otherwise would perhaps not have taken place:

> 'Like I said, I was discussing dementia with my mum; I was just telling her how upset I kind of felt when I did do the NCS thing…' (Noman, L95, p.5).

3.2.5 Theme 5: Openness to Seeking Support

The fifth theme captured the various sources of support that participants were mostly open to. Participants spoke about their willingness to seek support from their GP and the internet for mental health-related issues. However, they were more inclined to seek support from family and friends or try to solve the problem independently. The following four sub-themes are presented below: 'GPs and the internet are good support sources for mental health issues', 'Being proactive and independently solving the issue is sometimes preferred', 'Generational change in attitudes towards mental health', and 'Support from family and friends is preferred, but concerns still exist'.

3.2.5.1 GPs and the internet are good support sources for mental health issues

Ten participants were aware of GPs being a helpful source of support for mental health problems. Participants felt confident about speaking to a GP and seeking advice for any mental health problem, as stated by Noman:

> '…would pop to my local GP and say to them: "Look, these are my problems, what would you recommend?"' (Noman, L270–271, p.12).

Yusef further stated that GPs are a first point of contact and are key in providing the relevant support required:

> '…I think even going to the GP nowadays, you can go get, erm, counselling done. They'll provide it and so on, but again most times when you do go through stuff like this, I think your doctor plays a big role because they advise you on stuff like that and, yeah, because you do, that's the first place you go if you're suffering from something like this…' (Yusef, L284–287, p.13).

Similarly, Riaz spoke about his GP being the first point of contact:

> 'In terms of, like, if I was to seek a doctor, I mean, initially I think I would go to a doctor, a GP perhaps, then I'm guessing they would refer you…' (Riaz, L203, p.9).

Four participants spoke about the internet being a good source of information on mental health. Although knowledge on support sources for mental health problems was foreign to Yusef, he expressed feeling comfortable consulting the internet for further information:

> 'If it's available, I don't know where I would start, but I think a quick Google search' (Yusef, L283–284, p.13).

The same idea was voiced by Riaz:

> '…I'll just read stuff on the internet that will give a broader or wider knowledge' (Riaz, L12, p.1).

3.2.5.2 Being proactive and independently solving the issue is sometimes preferred

A third of participants felt that it was important to take responsibility and play an active role in their recovery. The idea of developing self-awareness and making a general effort was conveyed by Forida:

> '…you're an obstacle to yourself; that sounds weird, but, like, you have to push yourself to do that because, in a way, you have to erm firstly know yourself and know that you've got a problem and accept that and then seek help' (Forida, L170–173, p.9).

Hamza described the importance of mentally preparing oneself and adopting a positive attitude in an attempt to elicit change:

> '…it's a mental thing; you either decide to stay sad or you can try do something positive and change your life around back to how it was…' (Hamza, L23–24, pp.1–2).

Seven participants spoke about being resilient, knowing their situation best, and wanting to deal with their problems independently rather than being reliant on others for support. Hamza spoke about pride acting as a barrier to seeking outside support.

Interestingly, he used the psychoanalytical term 'ego', which illustrated the prevalence of psychological words in popular culture:

> '…your ego doesn't allow you to go to strangers, random people, to help you. You'd rather just stay and help yourself, for example try to sort it out in your way in your style without seeking professional help…' (Hamza, L301–303, p.14).

Similarly, Hina used an existential turn of phrase when describing her preference for self-reliance:

> 'She was like: "I don't want to go; I want to be an independent person; I

> want to fix this alone; I've come into the world alone, I'm going to leave the world alone, so I need to fix this alone"' (Hina, L248–249, p.12).

Yusef felt that the individual experiencing the problem is the expert on deciding how to go about resolving it:

> '…you're the best person to know what you're going through, how to fix it, what kind of stuff you need to do…' (Yusef, L68, p.4).

Five participants felt that it was best to conceal their problems from others. This may be due to participants being at risk of feeling vulnerable, as well as lacking control over what others know about their personal affairs, which very much goes against exhibiting the independent competent attitude they valued. Discussing mental health problems openly with friends was almost viewed as having negative consequences that would impact on family honour. Yusef further expressed that this would cause a malicious 'Chinese-whispers' effect:

> '…everyone likes to talk; I can tell you something, and you'd pass it on to maybe a few other people, and pass it on to a few other people, and word gets around. So, it's like with anything, anything that's private in your life and you don't really want it to get out. Your family as well wouldn't want it to reach out because then it comes back to them…' (Yusef, L185–187, pp.8–9).

Similarly, Hamza stated that 'problems' should be kept private and not disclosed to others as people will then become aware of your private business. There was a sense that disclosing problems would potentially have negative consequences for the individual; however, Hamza drew a distinction between 'people that I know' and others:

> 'Yep, it's just that, erm, I don't like people knowing about my private stuff. I guess it's not about being open or closed it is, if it's, like, a problem, then I would rather not share it with the whole world; I would rather share it with people that I know and that are with me every step of the way. It's like I'd

> see it as, what's the point of people knowing about your private life, what will it get, what benefits will you get out of it? You won't get no benefit; it would just go around the whole world, my private stuff would just go around, and it wouldn't be private no more will it? It will just be public [laughs], so yeah' (Hamza, L164–168, p.8).

3.2.5.3 Generational change in attitudes towards mental health

Four participants felt that a generational gap exists in the acceptance of mental health problems, whereby the older Pakistani generation are more narrow-minded and judgemental. In this regard, participants pointed out that it is more difficult for the older generation to have an understanding of mental health due to differences in education, upbringing, and cultural norms:

> '…it depends on, erm, perhaps how old you are as well; I feel like the older you are in an Asian culture, the more you're going to disregard it, whereas I feel like the youngsters are really trying to having a different outlook to it, and I feel like they're becoming more aware and they're more willing to talk about it, yeah' (Riaz, L300–302, p.13).

Yusef similarly explained:

> 'I don't think they attribute it to mental health, so I think it's very hard to understand, to explain stuff to, erm, your parents, but I think that's changing; I think that's normally what you find with the older generation' (Yusef, L134–135, p.6).

A third of participants spoke about the younger Pakistani generation having more of an open and accepting approach to mental health. Participants expressed that this approach was influenced by their upbringing and was due to higher acculturation levels to their country of birth. Yusef illustrated this and expressed that an understanding of Western culture has assisted in the development of an open-minded approach to mental health, which allows for beneficial healthy dialogue:

> ‘I think, with the newer generation, I think you’re slightly, you know, you’re finding out that actually they’re more understanding; they understand the culture you were bought up in, and you can actually have a real conversation which you think will benefit you…’ (Yusef, L135–137, p.6).

This was also brought up by Maya:

> ‘I think, when it comes to newer generation, they are a lot more understanding, a lot more open-minded, and we have a bit of Western cultural understanding…’ (Maya, L534–535, p.24).

Six participants stated feeling that mental health problems are more accepted in society these days when compared to previous eras. Riaz asserted that increased awareness of mental health problems exists (e.g. eating disorders), which previously were not well understood, thus reflecting the openness towards such problems adopted by individuals these days:

> ‘…I feel like people are more aware of situations to be regarded as a mental illness, i.e. anorexia or bulimia, which, back in the days, would perhaps have been: “Oh, what’s wrong with you? Why are you not eating properly?” Whereas now, it could be like: “Actually, you know what, you could be anorexic or you might have bulimia”. So, in that terms, I feel like people are becoming aware and more open…’ (Riaz, L323–325, p.14).

Both Forida and Abdul spoke about the increased acceptance of mental health problems in relation to the Pakistani culture. Forida spoke of the growing acceptance of such problems among Pakistanis:

> ‘…but I think it’s becoming a little bit more, erm, more widely discussed in the Pakistani community than it was probably a few years ago…’ (Forida, L213–214, p.11).

Abdul extended Forida's view by stating that Pakistani culture was changing rapidly, unlike other cultures, which he felt remained unaccepting of mental health problems:

> '…I believe that Pakistan and Pakistani culture are becoming more open very quickly, compared to other cultures, whereas they are still close minded' (Abdul, L409–412, p.20).

That new understandings of mental health have emerged among young Pakistanis was further reflected in the opinions expressed by participants. Aisha acknowledged that referring to an individual suffering from depression as 'crazy' is unacceptable and a rather fallacious statement:

> '…you can't call a person who has depression *pagaal* cos they're fine; everything is okay. It's just that they're depressed, you know? You can't just say *pagaal hai,* and *pagaal* means like crazy' (Aisha, L426–430, pp.22–23).

Noman stated that, irrespective of his belief in 'Jinns', he did not believe that mental health problems are solely the result of such possession:

> 'I do believe that Jinns do exist, as it's part of my faith, but I don't believe that if you have a mental illness or if you have mental problems, it's always related to Jinns' (Noman, L60–61, p.3).

3.2.5.4 Support from family and friends is preferred, but concerns still exist

The final sub-theme referred to the highly preferred support system of family and friends. Participants spoke about family members and friends being able to provide the most effective support and comfort for mental health problems. Given the close and intimate dynamics of these relationships in an individual's life, seeking support from such people during times of hardship was viewed as the most beneficial option.

Three participants spoke about the high value placed upon a close family unit within Pakistani households, which explains why participants would not be left alone to deal with mental health problems. Participants felt that, similar to other minority cultures, Pakistani culture adopts a collectivistic approach to family life, whereby the family bond is very important. Therefore, if and when problems arise, they would be tackled together as a family unit. Yusef further expressed that being caring and empathetic towards a family member who is expressing hardship is a typical trait amongst Asian families, particularly parents. He felt that these traits are uncommon in other cultures:

> '…Asian parents are a bit more caring well, I wouldn't say caring, but I'd say, in terms of the family bond, it's much stronger than maybe other kinds of, erm, cultures out there…' (Yusef, L157–158, p.7).

On the other hand, Hamza stated that, in general, families would provide a constant source of support:

> '…she didn't find it helpful talking to a stranger; she would rather have told her close friends or her family because they know her a lot better, and they would actually be able to help her progress through her day because, obviously, she lives with her family, so they are always going to be there to help her, whereas the counselling, like, they're not going to be with you 24/7 like a family…' (Hamza, L203–205, pp.9–10).

Seven participants felt that family is a highly valued support system due to their family being the closest people to them and, in turn, knowing them the best. People outside of family are viewed as strangers who would be unable to understand you or relate to you as well as family members. Again, this illustrated the close family ties associated with Pakistani culture. Regardless of whether parents and family members had shared understanding of the mental health issue at hand, it was clear that participants felt that the most beneficial support would derive from their families due to the strong bond within Pakistani households. This was expressed by Hamza:

> '…for me, it would have been a lot better if I went to my family at the time rather than a stranger, someone who doesn't know me at all…' (Hamza, L97–98, p.5).

And also by Maliha:

> 'But I would, I'd definitely discuss it with my parents because, obviously, it was such a crucial time that I really needed that help' (Maliha, L151, p.7).

Abdul explained that, irrespective of whether his family had a negative outlook on mental health, they would still provide support:

> '…even though the family may have a negative, erm [pause] negative outlook on mental health, they're still your family…' (Abdul, L157–158, p.8).

On the other hand, a third of participants spoke about feeling more comfortable and more open with regard to disclosing mental health problems with their friends rather than their families. Participants preferred to disclose their problems to their friends because they felt that they would not be judged or dismissed, which may be a concern when opening up to family due to the lack of understanding and acceptance around mental health problems within Pakistani culture. Regardless of whether friends had sufficient mental health knowledge, similar outlooks between friends would induce a feeling of comfort. This was expressed by Noman:

> '…find it easier to talk to my friends about it than my family, yeah' (Noman, L103, p.5).

As well as by Riaz:

> '…I don't know what to do and, erm, yeah, I think I'd be alright speaking to a friend. Actually, I think it would be, yeah, perhaps a bit more comfortable because I feel like you're more on a wavelength with friends at times'

(Riaz, L105–106, p.5).

Six participants felt that friends would be the support system of choice for them due to sharing a similar mentality. Participants spoke about friends offering a comfortable and non-judgemental space to disclose and discuss any problems, free from the cultural viewpoints or biases that other Pakistani individuals may hold. As expressed by Noman:

> '…I would be more open to speaking about it with my friends because they don't see it from a cultural viewpoint…' (Noman, L100–101, p.5).

Similarly, Forida spoke about friends being open-minded and there being no 'rules' with regard to what you are able to disclose and discuss with friends:

> 'I just feel, erm, with my friends I just think I am more open, like it's more easy, like you don't have any rules or any anything with your friends, so I think you can just say whatever and then bear the consequences [laughs]' (Forida, L93–95, p.5).

Aaliya also described the shared understanding that exists among friends, given that they are from the same generation and have been exposed to similar experiences and messages growing up:

> 'I think I would feel more comfortable because obviously, you know, my friends are mainly people that I have met at University; they know about mental health, erm, and because they're my friends, they've been kind of brought up here, they have the same kind of mentality…' (Aaliya, L155–156, p.8).

Still, five participants spoke of feelings of vulnerability when discussing such matters with friends. They also raised concerns regarding confidentiality around their personal matters:

> ‘It’s just that trust issue, I guess; just with friends, you don’t know what they’re going to do; they can tell anybody…’ (Hamza, L150–151, p.7).

Abdul shared a similar view to Hamza as he also described feeling apprehensive with regard to disclosing a mental health problem to his friends, given that they are not as immediate and close as family members are. This was strongly emphasised by the use of the term ‘outsider’:

> ‘I would be more worried or scared to discuss it with my friends because I would feel as if, even though the family may have a negative, like, outlook on mental health, they’re still your family, whereas friends are kind of, still they’re not a part of your family; they’re an outsider’ (Abdul, L157–159, p.8).

Yusef stated that keeping up appearances to mask any challenges or issues that he was going through in front of his friends was essential, and for this reason he would not want his friends to have any knowledge of him experiencing a mental health problem:

> ‘You don’t really want to talk about that kind of stuff with your friends because you want to play that everything is fine. You don’t really want to get them, you know, into that kind of I don’t know, I wouldn’t personally get my friends involved…’ (Yusef, L176–178, p.8).

Five participants raised concerns about remaining anonymous and wanting their problems to stay confidential upon disclosure to others. It was clear that participants felt anxious about their personal problems being spread amongst others, by which they would feel quite exposed and vulnerable. Hamza strongly argued that the problem he was experiencing must be kept strictly confidential, and that only those close to him could be informed about what he was going through:

> ‘…make sure that it’s kept under wraps that no one else I’m not really close with should know; it should just be kept with them. They can help me just to make sure that it doesn’t go anywhere else it just stays within that circle’

(Hamza, L159–161, p.8).

Similarly, Maya conveyed the importance of counselling being kept confidential so that others have no knowledge of it, as people may display judgmental views:

> 'You know, like, what are people going to say, you know? "This girl is unstable". Maybe, erm, so you would want to know that maybe it's not secretive but, like, that you could get counselling without other people knowing' (Maya, L434–435, p.20).

3.2.6 Theme 6: Barriers to Help-Seeking Exist

Various barriers to help-seeking that exist in society were discussed by participants, who also highlighted barriers specific to Pakistanis. This sixth theme was further broken down into two sub-themes: 'General barriers that exist in society' and 'Restrictions due to shame'.

3.2.6.1 General barriers that exist in society

This sub-theme was used to group together the barriers that participants felt are being faced by everyone, regardless of ethnicity.

Five participants felt that seeking professional help requires great dedication and consistency, which can be quite off-putting. Participants spoke about the lengthy waiting lists for therapy appointments and the time-consuming process of travelling to see a professional serving as barriers to help-seeking:

> '…you go and ask for help, and then they tell you, "Oh, sorry, like, you know, there's a list", you would have to wait, like, three months, and then you would maybe be like, "Okay, forget it then". Do you know what I mean?' (Omar, L259–261, p.12).

Abdul expressed that he felt accessing counselling can be rather difficult and complicated and therefore that making psychological treatment easier to access is

essential:

> '…in terms of the normal general public, it should be made more widely available. In terms of not having to wait six months or a long time in order to get counselling, it should be something more easily, erm, available' (Abdul, L480–482, p.24).

Maya stated that, for a sufferer experiencing a given mental health problem, lengthy travelling times to see a professional can be an obstacle:

> '…if I have to go travel really far for a counsellor being depressed as it is, I'd be like, "Forget it" [laughs]; you know, if you're feeling shit as it is and then you have to go travel an hour somewhere, because maybe that's where the counsellor is if they are not that widespread, I think that would be a problem…' (Maya, L443–445, p.20).

The time-consuming process of counselling was highlighted by three participants, which was described as being quite off-putting. Maliha expressed this in a darkly humorous manner, in addition to pointing out that an individual does not overcome their problem in one session:

> 'Be prepared to give up your time [laughs]…you're not going to be fixed in one session; you need more' (Maliha, L299–307, p.14).

Similarly, Aaliya highlighted the fact that recovery takes place across a lengthy period of time and, as a result, changes will manifest in an individual's behaviour:

> '…it's something long term, so I see it as something that you can't just do in a day. It will take some time, and there's kind of a slow and gradual change in the patient' (Aaliya, L54–55, p.3).

Three participants felt that the cost implications of private therapy would cause people to opt out of seeking help, whereas therapy that is free of charge would probably encourage more people to consider seeking help. However, if there are

any financial implications involved, participants felt that the likelihood of engaging in therapy would be very low:

> ‘Because I’ve had the psychological help myself, erm, I had to I needed psychological help, and I know that for one hour they charge quite a lot of money. So, I wouldn’t really, erm, I don’t know if I would get it done again, even though it helped, because of the expense; it’s too much’ (Maliha, L51–56, p.3).

The same idea was expressed by Aaliya:

> ‘I think my mum’s one was free as well because she was really limited on finances, but erm, I think if it does get to the stage where I think you start paying, that would be an issue’ (Aaliya, L270–271, p.13).

Omar felt that charities should take the responsibility of investing in private counsellors so that the general public does not incur therapy costs. He further expressed that speaking to friends regarding a mental health problem would be preferred to paying for private therapy, particularly due to the fact that people shy away from confiding in others:

> ‘Maybe if you got, like, charities that invested in private, erm, counsellors, that kind of thing, erm, I don’t think people would pay to talk to someone, which is, you know [laughs], a lot of people don’t want to talk they would be like, “Okay, I’d rather talk to my friends than pay to talk to a professional”’ (Omar, L292–294, p.14).

Seven participants felt that they were not aware of the mental health services and sources of support available to sufferers. Participants spoke about this being a big concern and that more should be done in order for people to be aware of the support available to them. Abdul reported having no knowledge of where to seek relevant support outside of university and that, during the school years as well as in working life, efforts should be made in order for services to be more easily accessed:

> ‘Outside university levels, you don’t know who to approach, for example in secondary school or in the working life, you wouldn’t know where to go, erm, so I think it should be targeted more widely in terms of it should be made easily available (Abdul, L469–470, p.23).

Similarly, Maliha said:

> ‘…I just don’t think many people are aware of that psychological help that could be offered’ (Maliha, L114, p.6).

Forida stated that despite more efforts being made in the UK to address mental health, she still felt that there is not enough support available for those affected by mental health problems:

> ‘Well, I know there’s more, erm, things in the UK being done that address these problems, but I don’t really think there’s enough help for people who have them…’ (Forida, L12–13, p.1).

3.2.6.2 Restrictions due to shame

This sub-theme captured the shame and embarrassment that participants associated with help-seeking. They spoke about both help-seeking and confiding in friends as being deplorable and compromising one’s pride.

A third of participants spoke about turning away from possible sources of help due to various personal beliefs. For instance, Noman stated that:

> ‘…your own personal barriers that you set up like maybe you don’t want to discuss it with people, so I think that’s one of the key obstacles…’ (Noman, L170–171, p.8).

Forida shared similar views:

> '…if you're older, I think yourself, you're an obstacle to yourself…' (Forida, L170, p.9).

On the other hand, Aaliya spoke about external barriers that may hinder help-seeking, which related to the perception of others towards an individual that is seeking professional help, as well as what is regarded as the 'norm' in society:

> 'Barriers would be, you know, just what everyone thinks and what everyone's saying, so basically just kind of social protocols that we have in, like, families, what is right, what is seen as the norm, and what you should and shouldn't do; that's basically the main one' (Aaliya, L252–253, p.12).

Three participants felt that professional help-seeking causes one to be perceived as weak. Hamza voiced these concerns and highlighted the role that pride plays in decisions regarding help-seeking:

> '…well, erm, ego perhaps: "Nah, I don't want to seek professional help", you know? So, people have massive egos…' (Hamza, L294–205, p.14).

Hina also spoke about how seeking help might cause one to fear looking weaker than others. However, she felt that help-seekers should not be judged as being 'strong' or 'weak':

> 'I'd say pride, but that's I've explained that before, people wouldn't want to go get help because then they're seen as a weaker person and they want to be a stronger person, which I think is complete nonsense; there's no such thing as a weak or strong person…' (Hina, L342–343, p.16).

3.2.7 Theme 7: Seeking Professional Help Is Beneficial although Help-Seeking Stigma Does Exist

Within the final theme, participants' views on professional help-seeking were highlighted, in which participants touched on the different aspects of help-seeking that were most significant to them. Overall, they expressed a positive outlook

towards help-seeking; however, they also raised concerns and outlined the drawbacks of professional help. The following sub-themes were evoked: 'Help-seeking stigma is prominent within society', 'Seeking professional help is beneficial and others should seek support', and 'The effectiveness of professional help depends on the professional's approach and the individual's level of confidence'.

3.2.7.1 Help-seeking stigma is prominent within society

The general stigma associated with mental health was discussed by five participants, wherein they all highlighted the negative manner in which mental health problems are perceived. Aisha voiced her disagreement with this:

> 'I think I'm really against the stigma which is with a mental problem' (Aisha, L15, p.1).

Maliha highlighted how displeasing such problems are to discuss, and as a result mental health-related conversations are avoided:

> 'Yeah. I would, but, erm, it's quite a negative thing, you know, mental health; it's not like, you know if I do talk about it, like, "Oh, okay; let's just not go there"' (Maliha, L135, p.7).

Similarly, Forida stated that she would rather deny the fact that she was suffering from a mental health problem, given how stigmatising it is to admit:

> 'I guess you're trying to avoid thinking it's a mental health problem cos you don't want to have, don't want to think you have that problem' (Forida, L78–79, p.4).

Eight participants highlighted the fact that stigma still exists around help-seeking and that it plays a significant role in the underutilisation of services. Hina stated that it is very common for people to know an individual that has suffered from depression; however, knowing individuals who have sought counselling is

uncommon:

> '...everyone knows someone that's sort of gone through depression, but not many individuals know people that have gone counselling' (Hina, L345–346, p.16).

Maya explained that if an individual seeks professional help, they are perceived to be 'crazy'. Furthermore, she stated that the lines are blurred between seeing a counsellor and a psychiatrist, which may carry even more stigma:

> 'I think the reason why people avoid counselling is because they think that others will think there's something wrong with them if they were to actually go maybe seek counselling: "Oh, you're seeing a counsellor, okay she must be crazy", you know? You think counsellor and they think psychiatrist, what everyone thinks: "Oh, she's a psycho" I think that's probably why people avoid it' (Maya, L115–118, p.6).

Yusef referred to help-seeking as wasting time, and there was a sense of arrogance as he stated that he was able to deal with his problems independently:

> '…nah, it's a waste of time. Why do I need to go speak to somebody when I can deal with it myself or whatever, you know? They really don't understand it' (Yusef, L331–332, p.15).

Five participants spoke about professional help being the last resort as they would not willingly seek counselling. Aisha pointed out that professional help is only sought when symptoms become unbearable:

> '…when it gets like really, really bad, that's when they seek help' (Aisha, L358, p.19).

Similarly, Maliha maintained that the reason she had sought counselling was due to it being a mandatory requirement set by her teacher:

> ‘So, my teacher said that I had to go to it, so it was more it wasn’t voluntary it was, erm, like, it was compulsory’ (Maliha, L104–106, p.5).

Half of the participants expressed that if an individual seeks professional help for a mental health problem, then they are perceived as being mad and abnormal by others (and also by some of the participants themselves). This view was expressed by Yusef, for whom undergoing counselling may have adverse effects as it causes an individual to feel that they are deranged due to requiring outside support to manage their symptoms:

> ‘…but, you know, counselling or whatever, when you’re going through all this kind of stuff, I think it will make matters worse because you’re thinking now really you’re a nutcase, not a nutcase but you’re going through something that you’re requiring all this help…’ (Yusef, L228–231, p.10).

Hina stated that counselling is not taken lightly in society as it is associated with symptoms or challenges that are severe in nature. She further highlighted that an individual seeking counselling is viewed as being internally damaged:

> ‘People take it as a really big thing like, if I need counselling, I’m like a lost soul or I’m a broken person and stuff like that’ (Hina, L480, p.22).

Likewise, Aaliya described an individual seeking counselling as being detached from reality:

> ‘…if people knew I was going to seek support, they would think I’ve gone crazy’ (Aaliya, L265–267, p.13).

3.2.7.2 Seeking professional help is beneficial and others should seek support

This sub-theme captured the views of participants regarding the effectiveness of professional help. Participants adopted a positive outlook as they felt that it was beneficial and, in some instances, the most appropriate solution given that it is non-

judgmental. Nine participants stated that they would encourage others to seek professional help. Riaz articulated that professional help does not have any adverse effects, and therefore help should always be sought if required:

> '…seeking help can never be bad, or mental illness services; I feel, like, as long as it helps you, you should totally go for it' (Riaz, L198, p.9).

Likewise, Maliha stated that the advantages of professional help outweigh the potential disadvantages:

> 'I would say go and get psychological help; like, I think that, erm, it's really good; it has its advantages, the advantages over the disadvantages' (Maliha, L252, p.12).

Forida acknowledged that people typically shy away from psychological counselling but that professional help should still be sought:

> '…I think they should just go out and speak about it, and I think, yeah, that's right, you shouldn't be closed up cos that's not gonna help anything or anyone' (Forida, L165–166, p.9).

However, three participants felt that for professional help to be beneficial, certain conditions need to be met. Aaliya explained that an individual suffering from a mental health problem requires a counsellor who is empathic and compassionate:

> '…the right kind of support; not just, you know, somebody sitting there emotionless; you need the right kind of support' (Aaliya, L229–231, p.11).

Yusef stated that professional help is the most appropriate solution when an individual is unable to manage their symptoms or challenges independently due to feeling mentally weak:

> 'You're not strong enough or you're not mentally capable of, you know, dealing with stuff, and you require somebody else there to maybe not advise

> you but, you know, help you, or maybe, I don't know, whether it's medication, whether it's just a plan for you, but I think, yeah, when you can't handle it, it's probably the time that you maybe seek help…' (Yusef, L235–237, p.11).

A third of participants felt that professional help provides a safe space to disclose issues in confidence. Maliha also spoke about the approach of professionals being more comforting than that of others:

> 'I feel like their approach is nicer; you can ramble on and you can keep on talking and there's no judgement' (Maliha, L338, p.16).

Omar referred to his friend's experience and how she had probably felt more comfortable talking openly about personal matters:

> 'So, I think she was just using the counselling service just as like an extra support—just like someone to talk to—and maybe there's things that she spoke about with them that she would never speak to me about' (Omar, L40–41, p.2).

When asked how they would describe the approach of mainstream mental health services towards minority groups, seven participants stated that minority groups did not face any discrimination by professionals in mental health services. They held this assumption regardless of whether they had had direct experience of mental health services. This was echoed by Riaz, as he felt that professionals would view the service user as an individual and not be influenced by their ethnicity:

> 'I'm not aware as such, but I would feel like [pause] I don't know if it really affects people like that; I feel like, they would look at an individual as a whole rather than seeing what background you come from, erm I wouldn't really know because I haven't really seen someone myself to be able to judge…' (Riaz, L308–310, p.14).

Likewise, Aisha also assumed that equality would be provided to all service users:

> ‘I think they would provide the same services and stuff. I don’t think there would be any, erm, differences. I think there would be equality, but I’ve never had any experience, so I don’t really know, but I’m assuming it’ (Aisha, L492–498, p.26).

3.2.7.3 The effectiveness of professional help depends on the professional’s approach and the individual’s level of confidence

This sub-theme sheds light on the different factors that contribute to a positive and beneficial help-seeking experience according to participants, who felt that professional help is valuable but that its effectiveness is dependent on the professional’s approach as well as on the individual’s level of confidence. Three participants spoke about the importance of professionals adopting a friendly and relaxed approach, which was illustrated by Omar, who also highlighted the importance of meeting in person:

> ‘Making it informal in that sense, erm, yeah like having your first port of call as an informal chat someone to just sit, a friendly person to just sit and talk to face-to-face not just over the phone’ (Omar, L269–272, p.13).

Aisha provided an example of an individual being more likely to adhere to their medication if the professional displays a positive and encouraging approach:

> ‘So, erm, if you counsel them with a positive aspect, they’re actually gonna be like: “Yes, I am gonna take my medications”. Otherwise, they don’t really care’ (Aisha, L90–91, p.5).

A third of participants asserted that they were against taking medication for mental health problems as they felt that there were more negative implications than benefits. In this regard, Riaz felt that counselling is more beneficial than taking medication:

> ‘I don’t know how happy I was with her taking antidepressants because I felt like counselling is better’ (Riaz, L171, p.8).

Similarly, Maliha stated that medication only works as a short-term solution, and it is only with psychological therapy that one is able to get to the root cause:

> ‘…you should get the psychological help because medication just fixes it, it doesn’t really fix it long term; it’s just a short-term fixer’ (Maliha, L258–260, p.12).

Hina also felt that the disadvantages of taking medication outweigh the benefits, which is why she was against taking medication for such problems:

> ‘Again, the person that I was quite close with, they were really depressed and they would have turned to tablets, and I wouldn’t tell them to turn to tablets because I didn’t know quite enough about it. They say that you should do it because there’s so many pros and no cons, but, like, you shouldn’t because there’s no pros and so many cons’ (Hina, L49–51, p.3).

Five participants pointed out that professional help-seeking, including seeking support from others, requires both confidence and courage. Noman explained that seeking help and having confidence go hand in hand:

> ‘…I have that kind of confidence in me; I think it does correlate with confidence as well’ (Noman, L258–259, p.12).

Omar highlighted that seeking help requires a significant amount of ‘courage’:

> ‘…I think it requires quite a lot of courage for people to actually ask for help’ (Omar, L257–258, p.12).

Two participants stated that opening up about personal problems requires an individual to feel comfortable enough to do so. In this regard, Hamza maintained

that professional help is only beneficial and effective when an individual feels comfortable and relaxed:

> ‘If you don’t feel comfortable for any reason, then it won’t be effective for you; it’s as simple as that’ (Hamza, L93, p.5).

Aisha declared that she required more time to feel comfortable in order to disclose personal matters:

> ‘I think it’s different with different people cos, with me, I think I would need more time to express that thing, whereas others they just say, “Yeah, we’re feeling the same; this is how we’re feeling, blah blah blah”’ (Aisha, L274–275, p.14).

A third of participants felt that professionals are unable to relate to them. Hamza described speaking to a professional as pointless due to the professional not knowing their clients on a personal basis:

> ‘…they don’t know you at all; they just know your name and your issue; they don’t really know nothing else apart from that, so it’s like it was just talking to a blank wall’ (Hamza, L95–96, p.5).

Omar referred to professionals being rich individuals that are different from him and are therefore unable to provide effective support. He further stated that a professional from a similar ethnic and educational background would be more effective in providing support:

> ‘…you can’t solve my problems; you’re different to me; you’re rich [laughs]; you’re like a rich psychiatrist…maybe having people as well as counsellors that you can talk to, who are more like mentors and like more from your background, that kind of come from the same area as you, similar to you, like had a similar type of education…’ (Omar, L300–302, p.14).

3.3 Key Findings

3.3.1 Theme 1: Defining Mental Health

- Mental health problems are hard to define as a range exists and the causal factors include biochemical imbalances and adverse life events.
- A difference exists in the perception and treatment of mental health problems as they are highly stigmatised compared to medical problems.
- Mental health problems elicit a variety of emotional responses, such as sympathy, empathy, and require an individual to be sensitive.
- Mental health understanding is derived from sources, such as the media, books, and people's personal experiences.
- Mental health services and professionals provide support for mental health problems.

3.3.2 Theme 2: General Mental Health Awareness

- Mental health awareness can be increased through the following avenues: individuals suffering with a mental health problem, authoritative figures in society, outreach programmes, mental health advertisement, and educational institutions.
- More acceptance of mental health problems is needed as individuals and society are negative, judgmental, and ignorant towards sufferers.

3.3.3 Theme 3: Cultural and Religious Stigma within the Pakistani Community

- Mental health problems are associated with demonic and superstitious factors which are beyond human control.
- Negative cultural associations within the Pakistani community exist as mental health problems are taboo, highly stigmatised, and overlooked compared to the White British community.

3.3.4 Theme 4: How Mental Illnesses are Dealt with within Pakistani Families

- More mental health awareness and openness are needed in Pakistani households as mental health problems and professional help-seeking are rarely discussed.
- Mental health problems are shameful and tarnish family reputation.
- Outside exposure and close family ties allow for mental health dialogue within the family.

3.3.5 Theme 5: Openness to Seeking Support

- GPs and the internet are good support sources for mental health problems.
- Being independent, proactive, and keeping mental health problems private is preferred.
- A generational gap exists in the understanding and acceptance of mental health problems, as the younger British Pakistani generations are more open-minded and less judgemental compared to older generations.
- Family and/or friends are preferred support systems; however, concerns about confidentiality and feelings of vulnerability still exist.

3.3.6 Theme 6: Barriers to Help-Seeking Exist

- Societal barriers such as waiting times, costs involved, and lack of knowledge regarding the available support impede professional help-seeking for mental health problems.
- Professional help-seeking can be avoided or delayed due to one's pride, concerns about how others will perceive them, and the fear of coming across as weak.

3.3.7 Theme 7: Seeking Professional Help Is Beneficial although Help-Seeking Stigma Does Exist

- Professional help-seeking stigma exists in society wherein an individual maybe viewed as being ‘abnormal’ if they are seeking professional help.
- Seeking professional help is beneficial and has advantages as it is non-judgmental and may sometimes be the only appropriate option.
- The effectiveness of professional help depends on the professionals’ approach, the individuals’ level of confidence, and comfort.

3.4 Conclusion

The analysis in this chapter has explored participants’ views around mental health problems and mental health services. Although none of the participants reported a lived experience of mental health problems, they shared insights into how they viewed mental health in general and from a cultural perspective. The analysis revealed some understanding of mental health problems and support but also a perceived lack of in-depth knowledge. Participants highlighted the prevalence of stigma around mental health and associated help-seeking in society, in addition to the need for more mental health education and awareness for young Pakistani adults to take a proactive approach to their mental well-being. Participants further highlighted the existence of particular barriers in Pakistani culture and of a generational gap around the acceptance of mental health problems, with younger generations having more of an open-minded approach to mental health due to being born and brought up in a Western country. They also outlined how mental health education and services may be able to serve the needs of young Pakistani adults better. In the next chapter, these findings will be revisited in the context of the existing literature on the topic.

Chapter Four

4. Discussion

4.1 Introduction

This chapter outlines the findings of the current study in relation to the research objectives, which were to explore how mental health and mental health services were understood by young British Pakistani adults. The chapter begins with a summary of the findings, in which all seven themes are discussed in relation to the existing literature. A critical evaluation of both the strengths and limitations of the current study is then presented, followed by a discussion of the clinical implications of the study for counselling psychology and mental health providers more generally. Suggestions for future research are then put forward, and finally the researcher's reflections regarding the overall research process are discussed (in line with the qualitative research ethos).

4.2 Key Findings with a Discussion of Previous Literature

The findings presented below demonstrate how the following research question '*How do young British Pakistani adults understand mental health and mental health services?*' was answered. The objectives of the study were:

1. To explore how mental health was understood by young British Pakistani adults.
2. To explore how mental health services were understood by young British Pakistani adults.

As previously demonstrated in chapter three and below, the findings of the study highlight how both mental health and mental health services were understood by the young British Pakistani adults that took part in the study. Several themes emerged in relation to the research question that shed light on the knowledge and understanding of mental health, mental health problems, professional help-seeking and the various associations with mental health and mental health services. Further,

the findings are discussed in relation to previous literature which highlights the similarities and differences of the present study.

4.2.1 Defining mental health

Participants articulated what they understood mental health to be, including the factors that influenced this knowledge. While participants displayed some knowledge of the most common mental health problems (i.e. anxiety and depression), they seem to lack more in-depth mental health awareness overall. This lack of mental health knowledge was similarly echoed in Ali et al.'s (2017) study, in which participants expressed feelings of frustration in regard to having minimal mental health literacy. Although participants found it difficult to define mental health problems, the majority (nine out of 12) spoke about depression followed by anxiety as the mental health problems they were most familiar with, but some spoke about this with hesitation as they seemed to be unsure as to whether depression qualified as a mental health problem. Mallison and Popay (2007) reported similar findings to the current study wherein they have suggested that South Asians, particularly Pakistanis, struggle with the identification of mental health problems, which affects their approach to help-seeking. Likewise, Bluhm et al. (2014) reported that while young adults displayed a solid understanding of mental health disorders, they struggled with knowing whether their symptoms qualified for a formal diagnosis or were normal life experiences. The awareness displayed by participants of the current study, however, may be partly a reflection of the high prevalence rates of anxiety and depression among young British adults, as highlighted by Essau (2005). It may also reflect the relatively high prevalence rates of CMDs among South Asians—particularly Pakistanis—when compared with White British individuals (Rees et al., 2016). Williams et al. (2015) highlighted the difficulty in establishing mental health prevalence rates among South Asians, given the fact that mental health conceptualisations vary from culture to culture; additionally, the complicated relationship with services means that CMDs within this group are more likely to go undetected (Prady et al., 2016). Nonetheless, explanations for the higher prevalence rates of CMDs among South Asians seem to include socio-economic factors, such as experiencing racism,

unemployment, and social exclusion (Moller et al., 2016; Sproston & Nazroo, 2002).

Some new findings of the current study were that participants also displayed some knowledge of the causal factors of mental health problems, which included biological as well as environmental factors, such as adverse life events. Further, participants spoke about the impact that a mental health problem has on a sufferer's quality of life, given that a sense of change is experienced in relation to their cognitive ability and daily functioning.

Participants highlighted the difference in how they felt mental health problems are perceived and treated when compared to medical issues. Five participants expressed feelings of frustration as they spoke about mental health problems being viewed very negatively whereas physical injuries seemed to receive more positive, solution-based attention. This finding was also in line with the findings of Bluhm et al. (2014), who found that mental health problems are judged differently to physical illnesses by friends and family. Additionally, Chen and Lawrie (2017) and Lawrie (2000) also highlighted that the media reporting of mental illness and sufferers has tended to be negative in comparison to that of physical illnesses, which are spoken about in a more positive manner. Further support of the finding in the current study comes from the fact that public stigma directed at mental health sufferers is a global phenomenon that has persisted over the past few decades (Evans-Lacko et al., 2013; Pescosolido et al., 2010; Schomerus et al., 2012), and is associated with great societal burden (Sharac, McCrone, Clement, & Thornicroft, 2010).

The various factors that facilitated participants' mental health awareness were discussed, with the media appearing to be a key source of information. Documentaries, TV shows, and the news were spoken about as educational channels for increasing mental health literacy. In support of the current study's finding, diverse forms of mass media and newspaper articles have been reported as being significant influencers in the dissemination of key ideas and concepts (Chen & Lawrie, 2017; Corrigan, Powell, & Michaels, 2013). Furthermore, the main source of contact with mental health-related issues, including where the general

public learn about mental health, has been reported as being the media, which is particularly the case for those without any personal exposure to mental health (Chen & Lawrie, 2017; Dietrich, Heider, Matschinger, & Angermeyer, 2006). The fact that half of the participants spoke about the media being a significant source of information about mental health is noteworthy given that the reporting of mental health in the media has been widely acknowledged as being negatively biased (Corrigan et al., 2005; Whitley & Berry, 2013). A new finding of the current study is that the participant's personal interest and keenness to learn more about mental health led them to educate themselves through reading relevant books and articles. Further, participants spoke about education being another influential factor, with the majority stating that the lived experience of family/friends with a mental health problem had contributed to their understanding. They felt that the absence of this exposure would have caused them to have minimal mental health understanding.

Although half of the participants spoke about mental health services providing sufferers with support for their conditions, participants were unclear about what this support entailed. It was clear that 'mental health services' is a term that participants did not come across often, which is noteworthy given that a third of young adults experience a mental health problem at a given point in their life, along with this group being at increased risk of the development of anxiety and depression (Essau, 2005; McCarthy, 2016). However, the unfamiliarity with mental health services displayed by participants of the current study is not an unusual phenomenon, as McGorry, Bates, and Birchwood (2013), Neufeld et al. (2017), and Rickwood et al. (2007) also reported young adults as being reluctant to seek professional help.

4.2.2 General mental health awareness

The diverse conduits that participants felt would assist in increasing mental health awareness were discussed. The findings of the current study demonstrated that an individual affected by a mental health problem would be able to provide valuable insight and educate others about mental health-related issues. The current study further highlighted that respected authority figures, such as religious leaders, were viewed as having a role in advocating mental health literacy. Additionally, outreach

programmes consisting of mental health campaigns and awareness classes were highlighted by participants, with half of the participants feeling that schools in the UK should incorporate mental health education into their curriculums. Similar to Neale et al.'s (2009) study, a desire for more visibility of mental health in schools among young Black and Asian adults was discussed by participants of the current study. Further to that, the majority of the participants in the present study expressed feelings of exasperation and disappointment regarding the lack of public attention given to mental health awareness. Participants affirmed that they were unable to recall any advertisements or campaigns regarding mental health, and particularly mental health services, which they felt needed addressing urgently. Similarly, the participants in Neale et al.'s (2009) study also expressed a desire for more media advertisement related to mental health, while the lack of service advertisement was further highlighted as a barrier for help-seeking among the South Asian population by Ineichen (2012). A new finding of the current study was that some participants felt that culturally appropriate advertisements targeted at increasing mental health awareness for ethnic minorities were urgently needed, so that minority groups could be better informed about mental health problems; in this sense, they felt that this would assist in the identification of mental health-related issues. This lack of awareness may provide one possible explanation for the higher number (75%) of young adults who do not receive treatment (Children's Commissioner, 2016). The DoH (2004) has previously stated that practitioners should pay increased attention to BAME groups and should ensure that service delivery is not restricted by ethnicity. More effort seems to be required by service providers, however, given the lack of familiarly with services shown by participants. The unmet needs of young adults with regard to accessibility and culturally developed mental health services are well known (McGorry et al., 2013). Minority groups have been documented as having less access to services and lower treatment rates when compared to the White population, including those with middle- and upper-level incomes (Broman, 2012; Snowden, Masland, Fawley, & Wallace, 2009).

Participants felt that mental health-related issues are perceived negatively in society, and therefore more acceptance and openness is needed. Seven participants spoke about there being a tendency to dismiss mental health problems in society as the general public do not consider it as a serious issue, whereas half of the

participants spoke about mental health sufferers being judged and made to feel like outcasts in society. This finding was in line with previous literature as both prejudice and discriminatory attitudes towards mental health sufferers have been reported as characteristic of the British public (Mehta, Kassam, Leese, Butler, & Thornicroft, 2009; Thornicroft, 2006). The current study found new evidence for the type of language used to refer to a sufferer, with participants pointing out that sufferers are mocked through the use of derogatory terms, e.g. 'retarded' or 'loopy'. Further, seven participants expressed feeling frightened by mental health problems, which they associated with violent and dangerous behaviour; participants felt that their safety would be at jeopardy when in the company of a sufferer, whereas Maya highlighted schizophrenia as a dangerous mental health problem, which is in line with the previous literature on schizophrenia (Knifton & Quinn, 2008; Schnittker, 2008). Similar to the current study, Hinshaw (2006) pointed out that sufferers are perceived as being unpredictable and harmful to themselves as well as others. Additionally, Knifton et al. (2010) found that BAME groups in Scotland also describe sufferers as dangerous. Participants views of the present study may have been strongly influenced by the media, as media coverage has been documented to negatively impact on public attitudes towards mental health problems (Angermeyer, Dietrich, Pott, & Matschinger, 2005; Thornicroft et al., 2013). Further support of the current study's findings is that the British media has repeatedly been accused of portraying mental health problems in a negative manner, overstressing the association between violent crimes with mental health problems (Foster, 2006). Furthermore, the press rarely focused on the lived experience of mental health problems by sufferers themselves prior to the launch of the national Scottish campaign 'See Me' in 2002 (Knifton & Quinn, 2008). After this, the 'Time to Change' campaign was launched in England in 2009 as an anti-discrimination programme with the aim of having a positive impact on the media (Henderson & Thornicroft, 2009). Participants also raised concerns regarding how easily a sufferer is labelled by society, sometimes on incorrect grounds. Previous literature has illustrated this in relation to the media dehumanising sufferers and reducing individuals to their diagnosis in instances when the attention is on the violent nature of sufferers (Teplin, McClelland, Abram, & Weiner, 2005). Overall, research has demonstrated that the heavily biased and negative media portrayal of mental health problems reinforces stigmatisation, distress, and social distance

among sufferers, which as discussed was also reported in the present study (Bilić & Georgaca, 2007; Chen & Lawrie, 2017).

4.2.3 Cultural and religious stigma within the Pakistani community

The emphasis that Pakistani culture places on demonic causes was identified as a significant factor associated with mental health problems in the current study. Seven participants felt that Pakistanis associate spiritual possession (Jinn) and black magic with such issues, which is a finding that was similarly reported by Ali et al. (2017), Dein and Illaiee (2013), and Nye (2012) who also found Jinn possession as being heavily associated with mental illness in Pakistani culture. The findings of the current study were also in line with those of Waqas et al. (2014), who conducted a study in Pakistan and found that students heavily associated demonic possession and black magic with mental health problems.

Half the participants of the current study spoke about mental health problems being a God-given punishment, which was in line with the findings of Rethink (2010) and Waqas et al. (2014). This finding was also supported by Garrett et al. (2012) who also found mental health problems to be associated with supernatural factors and a punishment from God and that South Asians favour religious interventions such as prayer; as a consequence, religious leaders and faith healers are preferred over professional help-seeking, which echoes the findings of Ali et al. (2017), Khalifa et al. (2011), Khalifa et al. (2012), Rassool (2015), and Uvais (2017).

All of the participants of the present study bar one spoke about the cultural stigma that exists within the Pakistani community, in which mental health problems and sufferers are frowned upon. Participants felt that this negative attitude was almost by default, as the culture heavily stigmatises such issues. Similar to the current study, high levels of mental health stigma by family members of a sufferer were also found by Kapadia et al. (2017), while Moller et al. (2016) and Soorkia et al. (2011) highlighted cultural stigma within the Pakistani community as a key barrier to help-seeking. The stigma and shame associated with marrying a sufferer reported by Knifton et al. (2010) and Rethink (2010) was echoed by a third of the participants in the current study. Furthermore, the negative cultural impacts were

discussed by nine participants, who felt that cultural influences lead to a limited understanding and narrow-minded approach to mental health problems. This finding is in line with those in Tabassum et al. (2000), who suggested that cultural values serve as a barrier to help-seeking for first- and second-generation Pakistani women. The direct link between mental health understanding and cultural and religious values as seen in the present study has also previously been highlighted by Bansal et al. (2014), McGrother et al. (2002), Moller et al. (2016), and Shefer et al. (2013). A new finding of the current study is that Pakistani culture adopts a dismissive attitude, in which mental health problems are trivialised and overlooked, according to participants. In contrast, the participants felt that Western culture adopts a more compassionate and empathic approach as mental health problems carry less stigma within Western society. Consequently, a third of participants maintained that mental health exposure is greater in the UK when compared to South Asian cultures and that this open culture has contributed to their mental health understanding. These findings were also illustrated by Pilkington et al. (2012), who found that British South Asians with higher acculturation levels to Western culture had greater help-seeking intentions when compared to participants with lower acculturation levels. It is noteworthy that Western culture is individualistic when compared to the Pakistani culture, which is collectivistic. Greater emphasis is therefore placed on how others perceive individuals within this community, which may hinder the development of an open culture towards mental health problems (as is seen in Western societies). Members of this community who experience mental health problems are therefore faced with a twofold challenge in relation to how they would be perceived by their immediate family and by the community as a whole.

4.2.4 How mental illnesses are dealt with within Pakistani families

The present study found new evidence for the lack of mental health dialogue in Pakistani households which was articulated by seven participants. This was identified as another contributing factor to the lack of awareness and acceptance for such issues by this community. The desire for Pakistani families to take a more open approach to mental health problems was expressed by five participants. Additionally, half of the participants conveyed that Pakistani families are in need of

mental health education, which was similar to the findings of Ali et al. (2017), wherein participants also felt that the Pakistani community needed a better understanding of mental health problems and the associated symptomology. The need for information that is more readily available to improve mental health literacy was suggested by participants in Ali et al. (2017). Three participants spoke about the lack of mental health literacy within Pakistani families; this was further described as having harmful and adverse effects on a sufferer, which was a new finding of the present study, as participants felt unable to be adequately supported by their family.

Upholding family reputation and honour are strongly emphasised in South Asian cultures (Knifton et al., 2010; Moller et al., 2016). Half the participants of the current study mirrored this concept in indicating that mental health problems are shameful and tarnish family pride. This finding is in line with the studies of Rethink (2010) and Pilkington et al. (2012), who found that shame and izzat (honour) predicted lower help-seeking intentions among British South Asian adults. Similar to the present study, Soorkia et al. (2011) highlighted that family honour and shame being compromised were key barriers to help-seeking within the Pakistani community, particularly women. Gilbert et al. (2004) reported similar findings, with the addition that South Asian women emphasise their role as the carrier of family honour. The preservation of family honour, irrespective of the hardships experienced within Pakistani families, was also highlighted by Tabassum et al. (2000), who again found that this served as a key barrier to help-seeking. Furthermore, eight participants expressed their feelings about how judgmental they felt Pakistani families are, and as a result, how much they feared the judgement they would receive if they were to disclose experiencing a mental health problem. However, difficulties surrounding mental health conversations within families may not be specific to Pakistani families but may be representative of the concern of young adults in general; in this regard, the young adults in the study of Bluhm et al (2014) stated that they felt uncomfortable disclosing a mental health problem to family due to the feared judgement.

A new finding of the current study is that some participants felt that good family ties and outside exposure may pave the way for mental health dialogue to take place in Pakistani families.

4.2.5 Openness to seeking support

Most the participants of the present study displayed awareness of GPs being the first point of contact for mental health-related issues. They expressed feeling comfortable with seeking advice from this source, which is supported by previous studies showing that British South Asians utilise GP services more frequently than their White counterparts but underutilise specialist and community outreach services (Bansal et al., 2014; Moller et al., 2016). That being said, Anand and Cochrane (2005) highlighted the fact that mental health-related symptoms commonly go undetected by GPs within this group, whereas Ali et al. (2017) also found that while young British Pakistani adults were familiar with GPs as a support source for such issues, local CAMHS were unknown.

Additionally, some participants stated that they would consult the internet for mental health knowledge and support, which was similarly echoed by the participants in the study of Ali et al. (2017), as the internet was seen as the primary source of mental health information. Marcus et al. (2012) also reported a similar finding to the current study as young adults have been shown to commonly resort to the internet for health-related information. A systematic review by Yonker, Zan, Scirica, Jethwani, and Kinane (2015) illustrated that young adults contributed to the high number of mental health-related information on social media sites. User-generated health-related information around CMDs has multiplied since the emergence of social media. A qualitative study conducted by Fergie, Hilton, and Hunt (2015) explored the experiences of engaging with health information online among young adults, and their findings demonstrated that the internet was the primary source for accessing health information regarding CMDs, which is representative of young adults' daily online activity. Fact-finding and gaining insight into others' experiences was the priority for participants, which was also highlighted by Giles and Newbold (2013). These findings are in support of the current study.

Independence and being active were common themes discussed by participants of the present study in relation to recovery from emotional difficulties, which was also reported by participants in Neale et al. (2009) and in Kumari (2004), where South Asian women shared similar views. Keeping matters private was also discussed by participants, as they felt that sharing their difficulties with others could have potential negative consequences. This finding was similarly reported by Garrett et al. (2012) who found that keeping personal matters private was shown to be a South Asian cultural practice. Moreover, this was also the case for Bluhm et al. (2014), who found that young British adults emphasised the importance of keeping mental health issues private. Further evidence for the finding of the current study comes from Kapadia et al. (2017) who found that Pakistani women were particularly concerned about their mental health-related issues being disclosed to others by health professionals of the same ethnicity. Gilbert et al. (2004) reported the same concern existing among South Asian women.

Participants of the present study spoke about a generational shift in acceptance towards mental health problems, as they highlighted the fact that older-generation Pakistanis are more judgmental and less accepting of such issues when compared to the younger generation. McClelland, Khanam, and Furnham (2014) reported similar findings among British Bangladeshis, as they found that more positive attitudes towards depression were adopted by the younger generation when compared to older British Bangladeshis. Although this particular finding came from a Bangladeshi sample, the findings of the current study support it.

Participants identified family and friends as providing a preferred support system for mental health difficulties, in addition to feeling that the strong Pakistani family unit ensured that they would be better supported with a mental health problem when compared to other cultures. This finding was supported by Kapadia et al. (2017), who found that the family was the most prominent support system for Pakistani women when compared to White women. Similarly, previous studies by Karasz et al. (2016), Kumari (2004), Moller et al. (2016), and Neale et al. (2009) also found evidence in support of South Asians preferring to seek support from family and friends (as seen in the present study). More generally, help-seeking has

been described by Pescosolido and Boyer (1999) as a contextual process in which social networks provide support as an alternative to utilising services (Holman, 2014). Some participants of the current study preferred to seek support from friends as they were seen as less judgmental than family. Similarly, Kapadia et al. (2017) found that Pakistani women reported higher levels of help-seeking stigma demonstrated by family members when compared to friends. Participants of the current study further felt that friends are more open and relatable as they are not heavily influenced by cultural viewpoints. However, disclosure to friends raised concerns about confidentiality.

4.2.6 Barriers to help-seeking exist

The time-consuming process of professional help-seeking was described as a barrier to accessing support due to lengthy waiting lists (DoH, 2004), and the travelling time involved in the present study. Ineichen (2012) similarly highlighted time and location as barriers to help-seeking. Allocating time for therapy sessions and the cost implications of private therapy were discussed as further barriers by participants of the current study, while the lack of knowledge regarding available services served as an additional barrier. Likewise, Cooper et al. (2013) highlighted that British Pakistanis and South Asians as a whole seem to underutilise mental health services when compared to the White community. As seen in the present study, delayed help-seeking and challenges to accessing support for this group have also been reported by Bansal et al. (2014) and Sashidharan (2003). Further support for the finding of the current study was demonstrated by Moller et al. (2016) who found that minimal knowledge about counselling served as a barrier to help-seeking among British South Asian women. Minimal awareness of services among young adults was also highlighted by Marcus et al. (2012), who suggested that raising awareness about the available support may improve help-seeking within this group. Similarly, Ali et al. (2017) also found that young British Pakistani adults lacked awareness of available services as they had not heard of CBT before and were unfamiliar with local CAMHS. In addition, Neale et al. (2009) highlighted that young adults lacked knowledge of available services and were uncertain about whether the support received would improve their mental health.

Personal barriers that can prevent one from seeking help were additionally discussed by participants of the present study, consisting of how others would perceive them, being reluctant to confide in others, and feeling ashamed. This finding was in line with previous literature on shame contributing to lower help-seeking intentions among South Asians as demonstrated by Gilbert et al. (2004), Pilkington et al. (2012), and Waqas et al. (2014). Similar to the present study, Marcus et al. (2012) found that, rather than seeking help, young adults reported feeling ashamed and worried about what others would think with respect to their mental health problems. Pride and the fear of being perceived as weak were highlighted by participants of the current study as barriers to professional help-seeking. Studies by Khalifa et al. (2011), Khalifa et al. (2012), Rassool, (2015), and Uvais, (2017) similarly found help-seeking to symbolise weakness among South Asians, making them more likely to reach crisis point. As demonstrated by the participants of the present study, Gilbert et al. (2004) found that fear of losing izzat (honour) by professional help-seeking was also a concern among South Asian women.

4.2.7 Seeking professional help is beneficial although help-seeking stigma does exist

The stigma surrounding both mental health problems and help-seeking was discussed by participants of the current study as a contributing factor to the underutilisation of services. Stigma can be understood as a cultural phenomenon that is prominent within the social networks of minority groups and that ultimately hinders help-seeking (Corrigan & Rüsch, 2002; Gary, 2005; Holman, 2014). Similar to the present study, Hinshaw (2006) acknowledged mental health stigma as a barrier to help-seeking and recovery, which can also result in self-stigmatisation as sufferers are made to feel that they are unable to form normal relations (Mehta et al., 2009; Ritsher & Phelan, 2004). Furthermore, mental health stigma and discrimination have been highlighted as substantial public health issues (Knifton & Quinn, 2008). Further evidence for the finding of the current study was illustrated by Kapadia et al. (2017), who found that Pakistani women reported family members of a sufferer displaying higher levels of mental health and help-seeking stigma when compared to their White counterparts. Similarly, Soorkia et

al. (2011) found that mental health stigma served as a key barrier to help-seeking among the Pakistani community, particular Pakistani women. Similar to the present study, cultural values and mental health stigma were also shown to reduce help-seeking behaviour among both British South Asian women by Moller et al. (2016) and young British Pakistani adults by Ali et al. (2017). Furthermore, Waqas et al. (2014) claim that treatment rates among South Asians may be low due to the associated public stigma and shame despite services being available. Additionally, Schomerus and Angermeyer (2008) found that self- and anticipated discrimination were shown to minimise help-seeking. Professional help was seen as a last resort in instances where symptoms had deteriorated and there was no other option by participants of the present study. This finding is in line with previous literature (Anand & Cochrane, 2005; Karasz et al., 2016; Moller et al., 2016) that shows mental health services to be viewed as a last resort by British South Asians. A similar finding to the present study was also reported by Neale et al. (2009), who found that young British Black and Asian adults felt reluctant to contact the Samaritans and viewed this as a last resort as they preferred to be independent in their recovery. Further evidence of the current study's finding comes from Tabassum et al. (2000) who found that Pakistani men and women viewed help-seeking as a last resort as family members were expected to provide the necessary support. A new finding of the current study is that if professional help is sought, participant would view others (including themselves) as 'abnormal' and 'crazy' as help-seeking is associated with a problem that is severe in nature.

Irrespective of the stigma associated with mental health and help-seeking, majority of the participants of the present study believed that undertaking counselling is helpful. Furthermore, some participants felt that in instances where an individual is unable to manage their symptoms, professional help is the most appropriate solution. A similar finding was reported by Ali et al. (2017) who found that young British Pakistani adults were open to counselling, with a preference for one-to-one therapy rather than family CBT due to not being able to fully express themselves in front of parents. However, Soorkia et al. (2011) found that female South Asian students displayed more positive attitudes towards help-seeking when compared to male students, along with Indian students illustrating slightly more favourable attitudes when compared to Pakistanis. A new finding of the present study is that

participants viewed professional help as being non-judgmental and providing a safe and comforting space. Although participants did not have any previous experience of counselling, they did not seem to hold the view that racial discrimination exists in mental health services. In contrast, Burr (2002) reported that the negative cultural stereotypes that some practitioners may uphold, such as viewing Pakistani culture as inferior, can discourage South Asians from seeking help.

Participants of the present study spoke about certain conditions that are necessary in order for professional help to be effective. A friendly and relaxed approach was deemed important, in line with the findings of Marcus et al. (2012), who suggested that help-seeking may be improved among young adults by providing more friendly environments. A new finding of the current study is that participants favoured counselling over medication as they considered the latter to be a negative form of treatment due to symptoms being alleviated on a short-term basis only. Confidence, courage, and level of comfort were directly correlated with help-seeking (both professionally and family/friends), as participants of the present study felt that these qualities are essential for facilitating help-seeking behaviour. This echoed Neale et al.'s (2009) findings that confidence in services and self-confidence were key predictors of help-seeking. However, some participants of the current study viewed professionals as strangers that are unrelatable and unable to help an individual work through their difficulties as they do not know him/her on a personal level. Ethnicity, education, and class were highlighted (by participants of the present study) as differences that would exist between the individual and the professional and were considered to hinder the development of a positive rapport. This finding was supported by Sue and Sue (2012), who claimed that individuals from lower socio-economic backgrounds struggle to explore their inner worlds with a middle-class therapist, as such therapists have difficulty in relating to the challenges of poverty. As a result, matching a therapist and client in class and ethnicity can positively affect clients' levels of self-exploration in initial clinical interviews (Carkhuff & Pierce, 1967; Holman, 2014). Likewise, Ali et al. (2017) found that White counsellors lacked cultural understanding and that participants therefore expressed a desire for more Pakistani counsellors. Further evidence for the finding of the present study was demonstrated by Moller et al. (2016) who

found that South Asian women perceived White counsellors to be ignorant, whereas South Asian counsellors were viewed as being gossipy but important.

4.3 Strengths and Limitations of the Research Study

4.3.1 Strengths

The purpose of this study was to obtain a deeper insight into young British Pakistani adults' understanding of mental health and mental health services. Existing literature exploring the understanding of mental health and mental health services among young British Pakistani adults is largely lacking, with previous research mostly grouping South Asians together, and thus minimal literature exists that has exclusively focused on this group. This is especially problematic given the growing British Pakistani population in the UK (ONS, 2013) and the existence of significant inequalities within BAME communities in regard to accessing mental health services (Bansal et al., 2014; Bauldry & Szaflarski, 2017; HMG/DH, 2011). Only one study—conducted by Ali et al. (2017)—explored UK Pakistani young people's views on mental health and mental health services, but they focused on 11–19-year-olds (16 female; 17 male) living in Peterborough. Therefore, a strength of the current study is that it offers novel insight, as the participants consisted of 18–24-year-olds living in London.

From a methodological standpoint, the various criteria identified by Braun and Clarke (2006) and Yardley (2000) that constitute rigorous qualitative research were paid close attention to. The researcher displayed sensitivity to context and the cultural element given that they are of the same ethnicity as the participants. This helped to create a trusting environment as the researcher adopted a sensitive approach when engaging with participants due to their enhanced understanding of the subject matter. The researcher was mindful of the diverse pressures that participants may have experienced and was able to analyse certain aspects such as family dynamics and supernatural factors with particular sensitivity. Additionally, the cultural match may have minimised cultural barriers that may be experienced when the researcher's ethnicity differs from the participant group, as highlighted by Tabassum et al. (2000). The researcher was able to engage with culture in the sense

that their knowledge about and understanding of the cultural perspective on mental health allowed for participants to speak freely without feeling judged. Furthermore, participants felt comfortable speaking honestly about religious beliefs, parents, and family dynamics, which they may have felt shy and embarrassed about doing with a researcher of a different ethnicity. The researcher was further able to bring out and emphasise the importance of supernatural factors, religious explanations/remedies, and prayer despite how stigmatising mental health problems are from a cultural perspective.

In addition, the study employed a good sample size with an even gender split; as a result, both genders were well represented. A further strength relates to the transferability of the study's findings, as some of the insights gained could resonate with other people in the Pakistani population and those working with them therapeutically. An additional strength relates to the transparency of the data analysis as the data collection process was conducted in a thorough manner and clearly detailed, which is a criteria of rigorous qualitative research, as outlined by Yardley (2000). Furthermore, the analytical process was also clearly defined and the analytical claims were supported by data extracts that represented the patterns identified.

Finally, the current study was in line with the aims of BPS governance research, as the findings contribute to maintaining an evidence base for therapeutic work, which is a core element of professional practice. Furthermore, as mentioned in Chapter One, it is essential that Counselling Psychologists recognise the ethnic differences that exist among BAME communities (BPS, 2017b), which the current study set out to do. The study findings provide professionals with useful information about how to improve and increase mental health awareness among both young Pakistani adults and the Pakistani community as a whole. Thus, as an additional strength of qualitative research (Yardley, 2000), the current study offers a close link between research and clinical practice. Further to this, working with culturally and linguistically diverse groups is highly encouraged as a part of the professional development of counselling psychologists (BPS, 2017a).

4.3.2 Limitations

There were various limitations of this qualitative research study, which must be commented on. For example, the sample was not large enough to be representative of young British Pakistani adults as a whole, and thus the findings are not generalisable. All of the participants lived in London and were in full-time education. Therefore, the study findings may not represent the views of young British Pakistani adults who do not have a similar level of education and/or live in other parts of the UK.

Due to time constraints, the themes that emerged were not checked with the participants. As suggested by Yardley (2000), this would have increased both the rigour and credibility of the research while truly upholding the position of participants as experts. However, the rigour and validity of the findings were discussed in depth with the research supervisor, thus providing an element of triangulation. The recruitment process consisted of purposive sampling, which was fairly slow and time consuming. A potential explanation for this may be that mental health is a culturally sensitive topic within the Pakistani community. Participants were recruited from Pakistani community centres, local libraries, and through word of mouth; therefore, the sample was limited to those who responded to and were aware of the advertisement. Thus, future research may consider broadening the recruitment to include other sources such as social media, given that such platforms are commonly used by young adults.

Another potential limitation of the study may have related to the researcher's role as a trainee counselling psychologist, as participants may have felt obliged to speak about mental health and help-seeking in a positive light. This, however, did not seem to be the case as participants were vocal about the negative connotations related to both mental health problems and help-seeking. Finally, the researcher's personal views and understanding of how mental health problems are seen from a cultural standpoint must be acknowledged, which is inevitable when conducting qualitative research. However, this was managed through the researcher being as reflexive as possible, along with capturing any preconceptions in a reflective diary.

4.4 Clinical Implications

The study findings have significant implications for clinical practice. More specifically, they highlight a number of issues that mental health professionals and service providers attempting to provide support to young British Pakistani adults should seek to address in order deliver services that are both sensitive and appropriate to the needs of this group:

1. There is an urgent need to improve mental health awareness and knowledge of the available services within this population, which may be achieved by incorporating mental health literacy in school curriculums, including more open dialogue at college and university levels. Furthermore, universities and student counselling services should disseminate mental health information more regularly, which is currently being tackled through the launch of a new University Mental Health Charter in 2018 (DoH & Department for Education [DfE], 2018). In support of this, the UK government outlined a set of proposals to provide support networks between children and young adults and educational institutions for the early intervention and prevention of mental health problems among this group (DoH & DoE, 2017). The Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: a Green Paper and Next Steps (2018) reported that 'Designated Senior Leads for mental health in schools and colleges', 'Mental Health Support Teams' (to produce an evidence-based curriculum), and 'Piloting a four week waiting time standard' will be implemented in approximately a fifth of the country by 2022/23 (DoH & DoE, 2018).
2. Mental health awareness interventions that are culturally appropriate targeted at both young British Pakistani adults and the older generation of Pakistanis is greatly needed, which will help combat the cultural stigma and shame associated with both mental health problems and help-seeking. This could take the form of more advertisements talking about mental health problems (including the services available) across a number of South Asian community radio stations, such as the BBC Asian Network, Lyca Dilse, and Sunrise Radio. Organisations could also join forces with the Pakistani film

industry, Bollywood, and South Asian music icons, who would feature in mental health campaigns through their social media and more generally in society. Mental health information could also be disseminated by religious leaders, given that they hold significant authority within this community. Additionally, outreach programmes delivering awareness workshops in Pakistani communities and local mosques could prove to be effective interventions. Mass awareness programmes that are delivered in all countries to raise awareness and reduce mental health stigma have been recommended by the WHO (WHO, 2001).

3. As well as culturally appropriate advertisements, there is a great need for more mental health campaigns and promotional advertisements in society at large. Given that young adults heavily utilise social media, services may seek to provide information regarding mental health problems and the services available using such platforms.
4. Organisations should mobilise within the local communities populated by young British Pakistani adults in an effort to raise awareness of available services, build trust among this group, and reduce the shame/embarrassment associated with help-seeking. If organisations are to provide effective services, then establishing visibility is a must.
5. Service providers should undertake training to ensure that adequate Pakistani cultural literacy is woven into clinical practice, which has also been flagged by the BPS (2017a), and they should build and maintain relationships within the local community to reduce the stigma associated with mental health problems.
6. Service utilisation could further be improved by providing clearer information on referral pathways, which has been an aim of Delivering Race Equality in Mental Health Care targeted at BAME groups (DoH, 2005). Employing more Pakistani and South Asian mental health professionals to work with this group may also increase help-seeking. Furthermore, mental health representatives acting as a link between services, schools, and community-based groups may assist in building support networks amongst this group.
7. A mental health approach that is holistic in nature and takes on board (and is open to) help-seekers' beliefs in supernatural explanations is needed. This

would make mental health services more approachable and establish a more sensitive way of working that addresses the cultural needs of this group.

8. To increase help-seeking among this group and for more timely interventions, the lengthy waiting lists must be tackled. Assigning a mental health representative or providing clients with a support line during the waiting period may minimise the feelings of isolation, loneliness, and despair experienced by clients. Alternatively, GPs could provide more regular updates with regard to clients' positions in the waiting list to ensure that they are kept in the loop and do not feel ignored.
9. Professionals working with this group must be aware of/consider the generational dynamics at play and how they influence help-seeking and mental health perceptions among young British Pakistani adults. Immediate family dynamics should further be considered, along with professionals remaining mindful of families being seen as the first port of call by this population, although they can also act as a barrier to help-seeking.

Table 1

Key Themes Related to Clinical Implications

Clinical Implication	Theme
1	Defining Mental Health
	General Mental Health Awareness
	How Mental Illnesses are Dealt with within Pakistani Families
	Barriers to Help-Seeking Exist
2	General Mental Health Awareness
	Cultural and Religious Stigma within the Pakistani Community
	Openness to Seeking Support
3	General Mental Health Awareness
4	Defining Mental Health
	Barriers to Help-Seeking Exist
	Seeking Professional Help Is Beneficial although Help-Seeking Stigma Does Exist
5	Cultural and Religious Stigma within the Pakistani Community
	How Mental Illnesses are Dealt with within Pakistani Families
	Seeking Professional Help Is Beneficial although Help-Seeking Stigma Does Exist
6	General Mental Health Awareness
	Barriers to Help-Seeking Exist
7	Cultural and Religious Stigma within the Pakistani Community
8	Barriers to Help-Seeking Exist
9	How Mental Illnesses are Dealt with within Pakistani Families
	Openness to Seeking Support

4.5 Recommendations for Future Research

This section will outline some potential directions for future research into mental health understanding among young British Pakistani adults. First, the sampling limitations of the current study could be addressed by recruiting participants who are non-university/college students and thus have a different educational level to those of the current study. It would also be interesting to recruit participants from outside London, given that it is a unique city due to its multiculturalism. Young British Pakistani adults living in different geographical locations—with a higher/lower Pakistani ethnic density—may have perceptions and understandings of mental health that differ to those of young adults living in London. Second, a mixed-methods study could use focus groups to explore specific initiatives and suggestions from participants related to what steps could be taken to improve mental health awareness and help-seeking among this group; in addition, administering questionnaires that consist of the key findings from the focus groups would increase the sample size and improve the generalisability of findings. Third, replicating the current study with the parents/guardians of these young adults, and then comparing the two groups, may highlight potential ways to overcome the cultural stigma associated with mental health and contribute to a better understanding of the family dynamics at play around mental health difficulties and help-seeking. Lastly, replicating the current study with a researcher from a different ethnic background may produce diverse narratives, as participants may feel more or less open to vocalising their mental health understandings, including the role of culture.

4.6 Overall Reflections and Challenges of the Research Process

This study was a personal project, as I felt strongly about conducting research that was important to me. For many years, I have witnessed the significant need for mental health perceptions and understanding to be addressed and openly talked about within the Pakistani population. The further I delved into this project, the more I realised there was a great need for literature to be published on this topic. Although the current study only provides a small contribution to the literature on

the mental health understanding of young British Pakistani adults, the findings nonetheless provide clinicians with useful insights.

The reaction of other professionals and trainees to my research has been extremely encouraging, as they have displayed a great interest in my work. I felt particularly proud and honoured to provide young British Pakistani adults with a platform to share their understandings, which were both open and honest. Engaging with my participants through the interview process and witnessing how each unique narrative unfolded while collectively similar views were shared was an exciting process. My knowledge regarding how best to improve mental health literacy and awareness among this population has grown significantly. What stood out for me was the desire expressed by participants for more mental health awareness and acceptance among young British Pakistani adults and the Pakistani community overall. I understood the importance of taking generational dynamics, the immediate family system, and superstition into consideration, in addition to other factors that have previously been mentioned when working with this group. A very particular way of working, with a sensitive approach, is essential for encouraging this group to engage with mental health services and to reduce the shame and stigma associated with mental health. The fact that I am a female trainee counselling psychologist from the same ethnicity as my participants would have inevitably impacted on participants. I initially had some reservations as to whether participants would feel comfortable enough to truly open up and be honest. However, I feel that they benefited from my understanding of Pakistani culture, as it overcame potential cultural barriers.

Upon reflection, I feel that the overall research process was smooth and educative despite the challenge of finding relevant literature and previous research that solely focused on mental health understanding among young British Pakistani adults. From my learning of the research process, it would have been very interesting and insightful to interview the parents/guardians of the young adults that participated in the study, as this would have shed further light on the family dynamics and the impact they have on mental health understandings. I am particularly proud of conducting research that has significant value to counselling psychology, as the current study focused on illuminating mental health understanding among a

specific ethnic group, which is highly encouraged by the BPS (2017b). Consequently, approaches sensitive to the needs and understanding of young British Pakistani adults were developed. Giving a voice to their views and being able to disseminate this valuable information among various mental health professionals through platforms such as BPS conferences and in colleges/universities populated by young British Pakistani adults will be extremely gratifying. For these reasons, this doctoral thesis primarily focussed on the Pakistani population with some comparison to other ethnic groups to avoid cultural essentialism. For time and space purposes ethnic group comparisons was done to a small degree. However, this is something that could be elaborated on in future work in this area.

4.7 Conclusion

Many of the themes identified in relation to participants' mental health understanding and barriers to help-seeking were supported by the previous literature published on this group. The current study, however, highlighted certain areas of emphasis, such as the importance of generational dynamics and the immediate family system, with regard to mental health acceptance and help-seeking. The role of culture, supernatural explanations, religious remedies, and the urgent need for mental health advertisement to reduce barriers to help-seeking related to pride, shame, and culture were all prominent aspects of the findings. Although participants in the present study lacked awareness of mental health problems and the available services, they expressed a strong desire to improve their mental health literacy. Additionally, participants showed their openness to seeking help, something which they spoke about in a positive manner regardless of cultural stigma and family discomfort.

The current study contributes to the advancement of knowledge into and the literature on the mental health understanding among this group in the field of counselling psychology. This study was in line with therapeutic work and process (Morrow, 2007) as the mental health understanding of young British Pakistani adults was explored, which mirrors the therapeutic work that counselling psychologists engage in. Thus, the study findings provide an evidence base for

professionals who are working with this group therapeutically, including recommendations for increasing mental health awareness. In order to develop mental health services that are culturally appropriate and easily accessible for young British Pakistani adults, the mental health literacy and service knowledge of this group must be understood (Neale et al., 2009). Given the well documented health inequalities that exist among South Asians and the growing British Pakistani population in the UK (ONS, 2013), this study has particular relevance to counselling psychology. In this regard, counselling psychologists should endeavour to reduce such health inequalities through evidence-based research, which will facilitate mental health professionals to be culturally sensitive and appropriate when working with this population. Additionally, the BPS (2017a) has identified the need for more psychological therapies that are culturally sensitive and appropriate for BAME groups in the UK. Overall, it is hoped that the findings of the current study will have useful clinical implications for mental health professionals and services, helping to reduce the gaps that exist in mental health understanding among this group and enabling more young British Pakistani adults to access counselling psychology and other forms of psychotherapeutic support.

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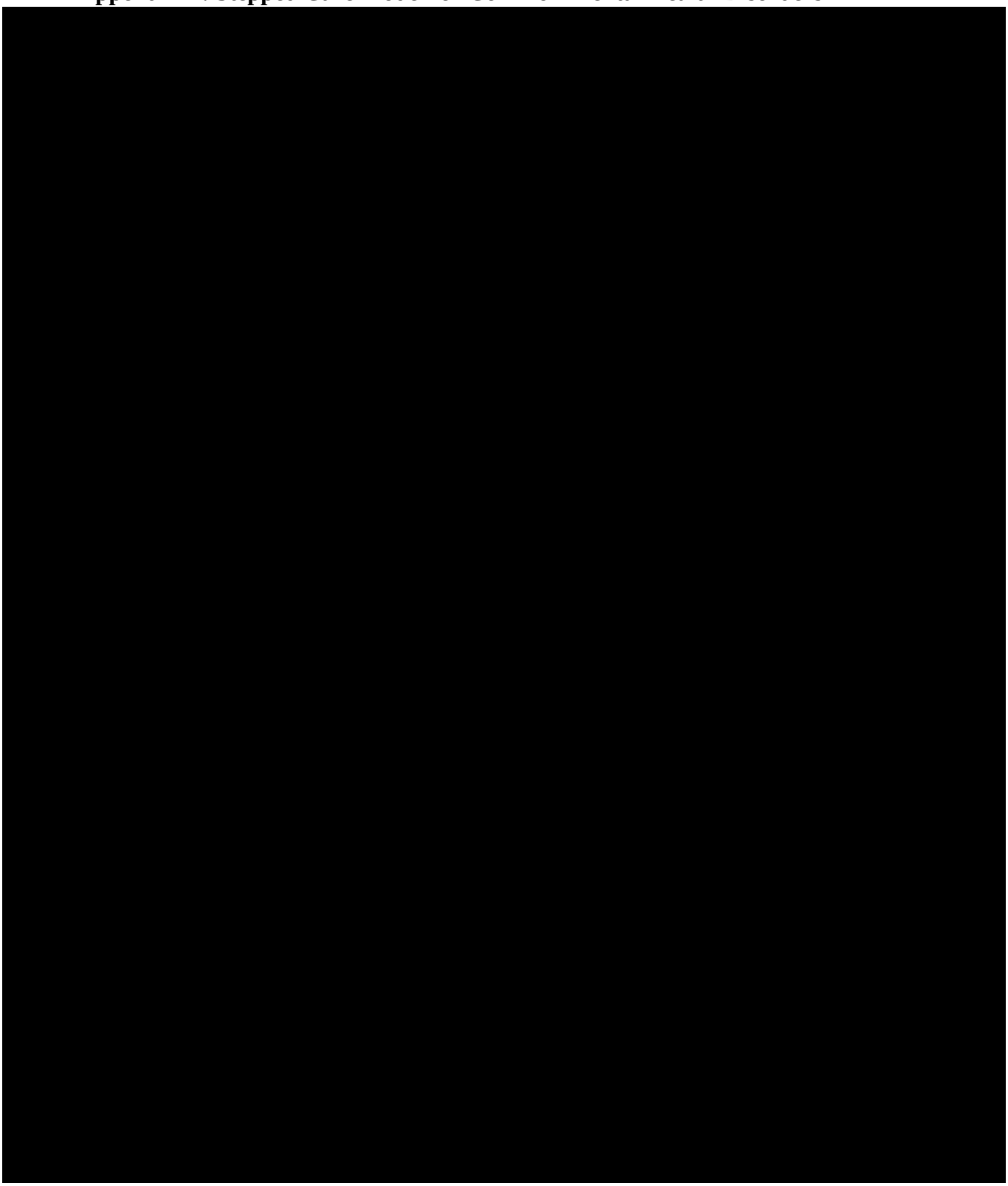
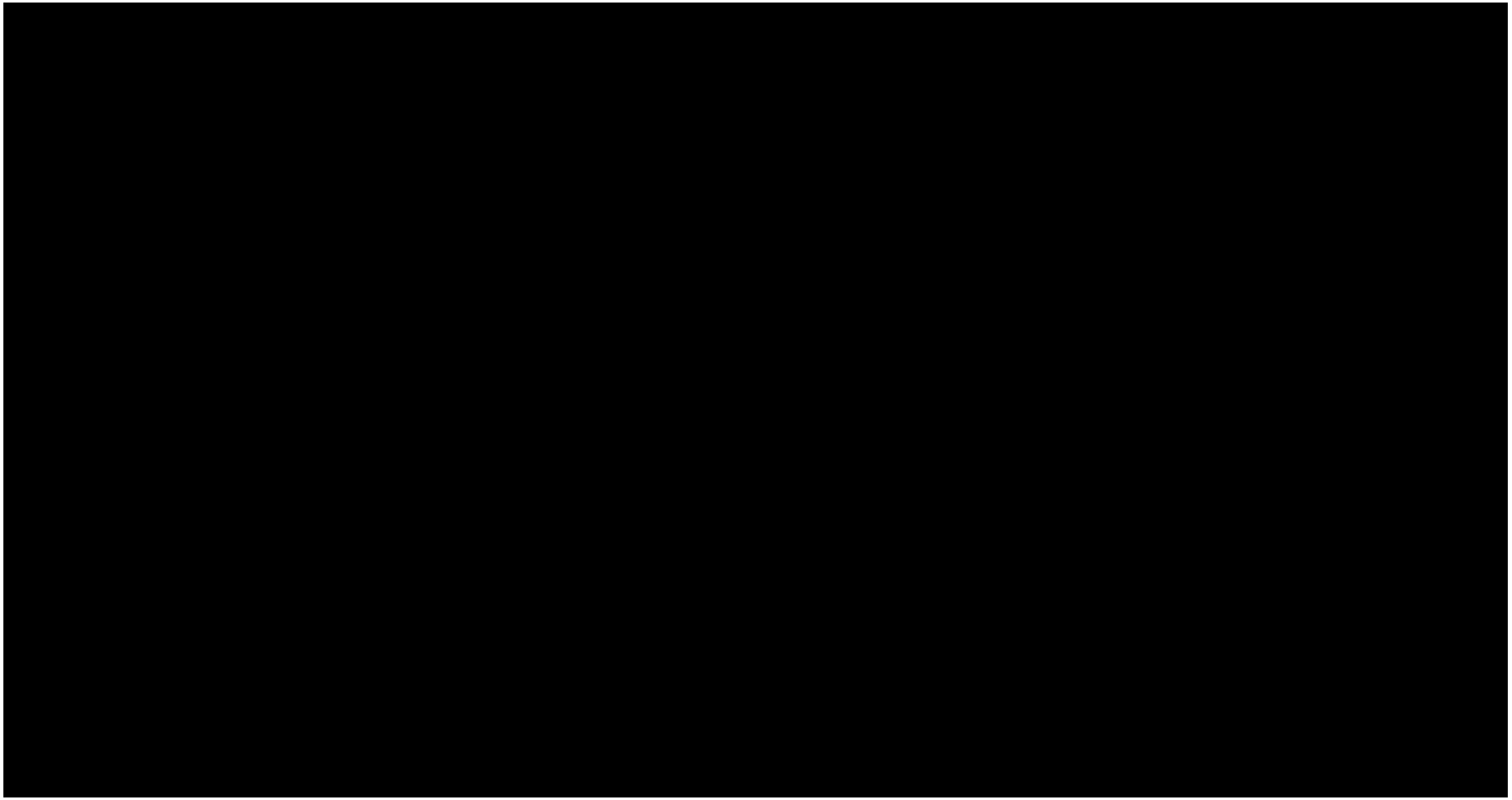
Appendices

Appendix A: Stepped Care Model for Common Mental Health Disorders



Appendix B: Mental Health Care Pathway Maps in England



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Appendix C: Ethical Approval

Psychology Research Ethics Committee
School of Social Sciences
City University London
London EC1R 0JD

26th May 2015

Dear Sana Ahmed

Reference: PSYCH (P/F) 14/15 159
Project title: An Exploration of Mental Health Understanding among Pakistani Young People

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

[redacted]

Departmental Administrator [redacted]

Chair [redacted]

Appendix D: Recruitment Advert

CITY UNIVERSITY LONDON

Department of Psychology

City University London

PARTICIPANTS NEEDED FOR RESEARCH IN COUNSELLING PSYCHOLOGY

We are looking for volunteers to take part in a study on:

An Exploration of Mental Health Understanding among Young British Pakistani Adults

You are invited to participate in an interview lasting approximately 60 minutes

In appreciation for your time, you will be entered into a raffle for a £20 John Lewis Voucher

For more information about this study, or to take part, please contact:

Sana Ahmed
Psychology Department
[redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City, University of London [PSYCH (P/F) 14/15 159].

If you would like to raise any queries about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee [redacted]

Appendix E: Interview Guide

1. How do you understand the phrase 'mental health problems'?
2. Can you elaborate on how you developed this understanding?
3. What are your views on mental health problems?
    a) What influenced your views?
4. How do you understand the term 'counselling'?
5. What comes to mind when the term 'mental health services' is used?
6. Are mental health and mental health difficulties discussed in your family?
7. If so, how are mental health and mental health difficulties discussed in your family?
    a) Can you provide any examples?
    b) Is this the same for your extended family?
    c) Would you feel comfortable discussing mental health issues with members of your family? Which?
    d) Would you feel more or less comfortable discussing mental health issue with your friends? Why is that?
8. Can you think of a time when you felt you needed mental health support or counselling?
    a) If yes, how was that experience for you?
9. Can you think of a time when a family member needed professional help for any mental health issues?
    a) How was that experience for you?
    b) Is there any family history of mental health conditions you are aware of?
10. Do you know anybody who has used mental health services?
    a) Can you give any examples of their experience?
    b) How did you perceive them seeking help?
11. What advice, if any, would you have for someone suffering from a mental health problem?
    a) How would you advise the family/carer of that individual?
12. What obstacles, if any, do you feel exist with seeking professional help?

13. How would you feel about talking to someone with a mental health condition?

    a) Would you have any concerns?

14. Do you feel there is a difference in the ways in which mental health is discussed in White/White British communities compared to Pakistani?

    a) Can you describe your feeling on this?

15. Who would provide the support network for you if it was required?

    a) How would you feel asking for support?

16. How would you describe the approach of mainstream mental health services towards minority groups?

    a) Can you elaborate?

    a) What changes, if any, do you think are needed?

Appendix F: Screening Questionnaire

Purpose of screening questionnaire: to check that you meet the criteria for participating in the study and to ensure that you are not at risk of experiencing psychological distress as a result of being interviewed.

1. How old are you?

2. What is your occupation?

3. Have you ever experienced mental health difficulties?

4. Are you currently engaged with mental health services?

5. Can you tell me more about this?

Appendix G: Resource sheet for individuals that did not meet the inclusion criteria

Thank you for taking the time to participate in the screening questionnaire. As some of your responses indicate you may be experiencing some level of psychological distress, I regret to inform you that you will not be able to participate in this study. This is due to the sensitive nature of the study in which discussion of sensitive topics will be taking place. For this reason, precautionary measures such as this screening questionnaire are put in place to minimize participant distress as much as possible.

Please see below reference to some mental health support services that may be of use to you.

- South London and Maudsley- Patient Advice and Liaison (PALS)
  Number: 0800 731 2864
  Website:http://www.slam.nhs.uk/about-us/contact-us
- Newham Talking Therapies
  Number: 0208475808
  Website: https://www.newhamtalkingtherapies.nhs.uk/ 02084758080
- Rethink Mental Illness
  Number:0300 5000 927
  Website: http://www.rethink.org/
- Mind
  Number:0208519222
  Website: http://mindinlondon.org.uk/
- Samaritans
  Number: 08457 90 90 90 (24 hours)
  Website: http://www.samaritans.org/

Thank you again for your time and participation in the screening process.

Appendix H: Information sheet

CITY UNIVERSITY LONDON

Title of study An Exploration of Mental Health Understanding among Young British Pakistani Adults

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being conducted and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask me if there is anything that is unclear or if you would like more information.

What is the purpose of this study?

Previous research has indicated the significant levels of stigma and barriers faced by ethnic minorities, when seeking professional help for mental health problems. South Asians are a group that have received little research attention, despite the high rates of mental health problems experienced, in particular depression. This study aims to qualitatively explore the way in which young British Pakistani adults understand mental health and mental health services. The study duration is approximately two years as it is being taken as part of the Counselling Psychology Doctorate Programme.

Why have I been invited?

You have been invited to take part in a semi-structured interview as the study aims to understand how young British Pakistanis make sense of mental health difficulties and services. Participants being recruited are both male and female British Pakistanis, aged between18 to 24. A total of twelve participants will be recruited to take part in the study. Recruitment is on a voluntary basis and participants will be selected on the basis of being of Pakistani descent and aged between18 to 24.

Do I have to take part?

Participation in the project is voluntary, and you can decide to withdraw your participant from the study at any point. If you do decide to take part you will be asked to sign a consent form. But you can withdraw at any stage of the project without being penalised or disadvantaged in any way. Participants can avoid answering questions which are felt to be too personal or intrusive.

What will happen if I take part?

- You will be involved in an interview lasting approximately one hour
- The interview will consist of open-ended questions on your experience of mental health problems and mental health services
- The interview will take place in either a community centre, library or University
- The research study will last approximately two years
- You will have a three-month time period to change your mind if you do not wish for your data to be included in the publication of the study

Expenses and Payments (if applicable)

- All twelve participants will be entered into a raffle for a £20 John Lewis voucher

What do I have to do?

You will have to sign the informed consent sheet before the interview begins. During the interview you will have to answer questions as openly as possible. However you do have the right of refusing to answer any questions, and to withdraw at any point.

What are the possible disadvantages and risks of taking part?

Due to the sensitive nature of the research topic and questions you may feel distressed during or after the interview. If you do feel distressed the interview can be put on hold or terminated, and as a trainee Counselling Psychologist I can offer some emotional support if necessary. The names and contact details of local services will also be provided should you wish to receive additional support after we complete the interview.

What are the possible benefits of taking part?

The benefits of taking part include contributing towards knowledge of how young British Pakistanis make sense of mental health and mental health services. You will also be providing practitioners with an insight of the barriers faced by young British Pakistani adults in relation to accessing services.

What will happen when the research study stops?

When the study has been completed, all identifying information will be safely destroyed. If the study is stopped prematurely participant information and data will also safely be destroyed.

Will my taking part in the study be kept confidential?

- I the researcher will have access to the data before and after it has been anonymized. My research supervisor will have access to the data once it has been anonymized. If research is published, the wider public will only see the anonymized data.
- All audio recordings will be kept confidential
- All data will be safely destroyed after the study is completed

What will happen to the results of the research study?

The results of the study will be used in my thesis. These findings may also be included in future journal publications where anonymity will still be maintained. If you wish to receive a copy of the publication or a summary of the results, a copy can be emailed to you.

What will happen if I don't want to carry on with the study?

You will be free to withdraw from the study without giving an explanation or incurring a penalty at any time. However once the interview has been carried out you will have three months to ask that your data be withdrawn (beyond that date the data will have been analysed and aggregated).

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: An Exploration of Mental Health Understanding among Young British Pakistani Adults

You could also write to the Secretary at:

[redacted]
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London

Northampton Square
London
EC1V 0HB
[redacted]

City, University of London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City, University of London Psychology Department Research Ethics Committee, [PSYCH (P/F) 14/15 159].

Further information and contact details

[redacted]

[redacted]

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

Appendix I: Informed Consent Sheet

CITY UNIVERSITY LONDON

Title of Study: An Exploration of Mental Health Understanding among Young British Pakistani Adults

Ethics approval code: *PSYCH (P/F) 14/15 159*

Please initial box

1.	I agree to take part in the above City, University of London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): • data analysis • report of findings • potential publication of data findings I understand that confidentiality will be ensured through anonymity of participant details. Data protection will consist of placing participant names in a separate drawer to the transcripts. The data will be securely stored in a locked drawer. Any identifying details will be altered, and the recordings and transcripts are to be safely destroyed once research objectives have been met. This will all be done to protect my identity from being made public. AND I understand that I have given approval for the name of my village/community, to be used in the final report of the project, and future publications. AND I consent to the interview transcript being viewed by other professional researchers.	

3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. I understand that I will have three months from the date of the interview to ask that my data be withdrawn from the project.	
4.	I agree to City, University of London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date

_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix J: Debrief sheet

CITY UNIVERSITY LONDON

An Exploration of Mental Health Understanding among Young British Pakistani Adults

DEBRIEF INFORMATION

Thank you for taking part in this study! Now that the interview is finished we would like to further explain the rationale behind the work, and to give you a chance to share any question or concern you may have.

Previous research has indicated the significant levels of stigma and barriers faced by ethnic minorities when seeking professional help for mental health problems. The South Asian minority group is one on which little research attention has been given, despite the high rates of mental health problems experienced by its members, in particular depression. This study aims to qualitatively explore the way in which young British Pakistanis make sense of mental health and mental health services. You were asked to participate in this interview as the study aimed to gain a rich insight into the way in which mental health difficulties and services are understood by a young British Pakistani Adult. The research may show that there are potential barriers faced by young British Pakistanis, hindering help-seeking. Research may also indicate that there is high levels of stigma associated with mental health within the young British Pakistani community.

If the interview has raised any concerns or distress, do not hesitate to contact one of the support services listed below:

- Rethink Mental Illness http://www.rethink.org/ 0300 5000 927
- Mind http://mindinlondon.org.uk/
- Samaritans http://www.samaritans.org/ 08457 90 90 90 (24 hours)
- Sane http://www.sane.org.uk/what_we_do/support 0845 767 8000

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact me at the following address:

[redacted]

You can also contact Dr Daphne Josselin, who is supervising the research, at:

[redacted]

Ethics approval code: *PSYCH (P/F) 14/15 159*

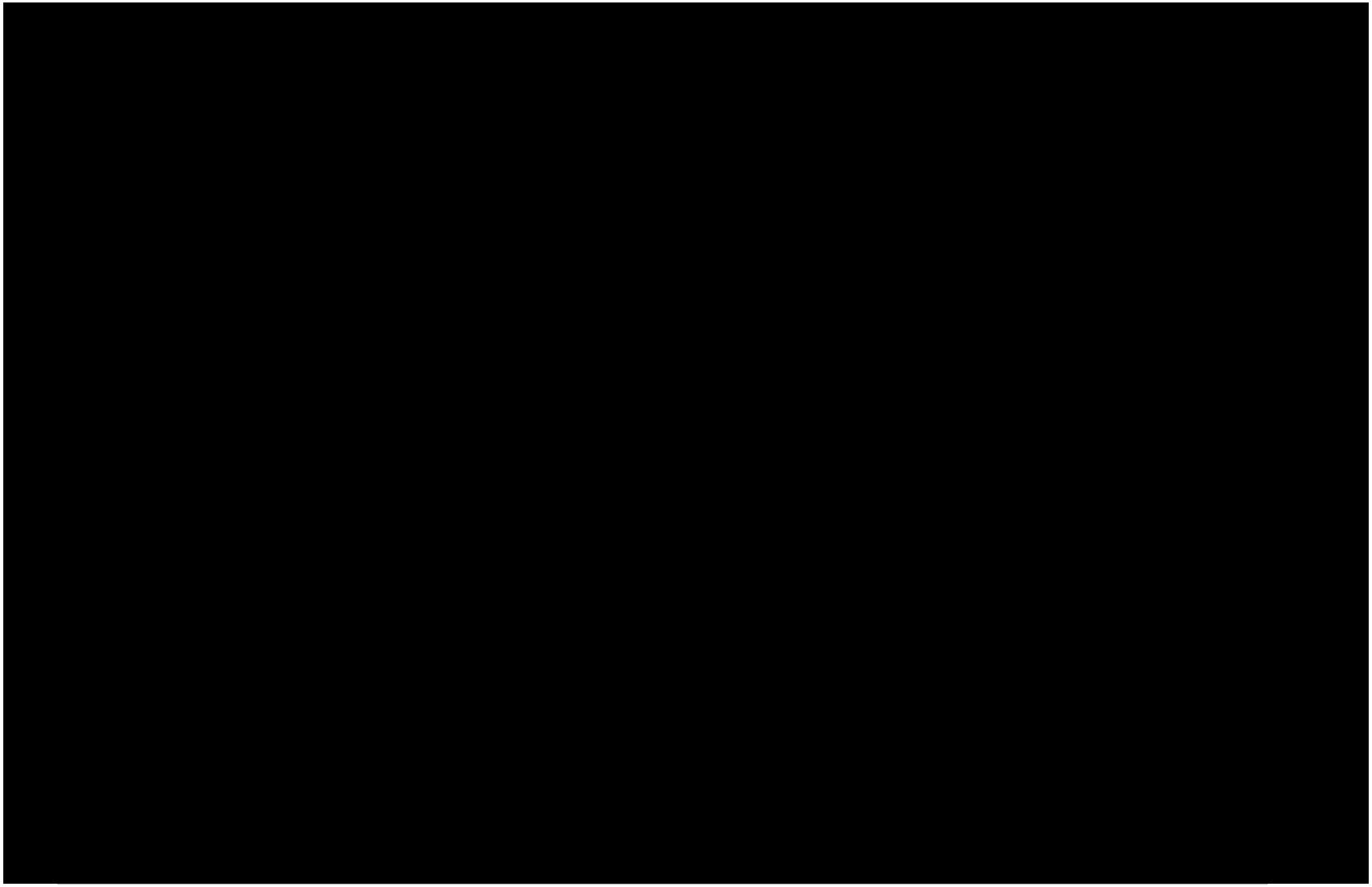
Appendix K: Participant Pseudonyms Table

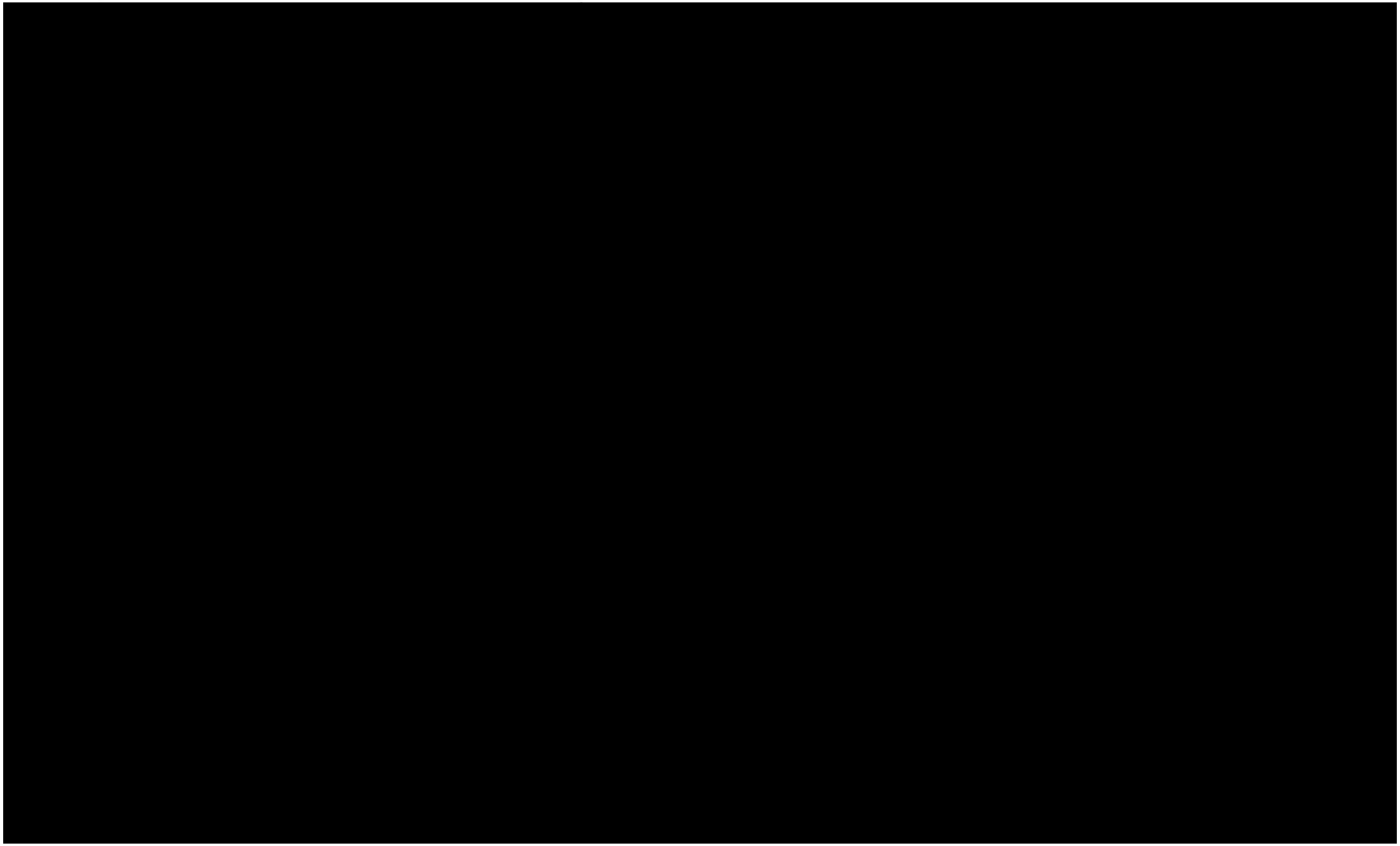
Table 2

Participant Gender and Pseudonym

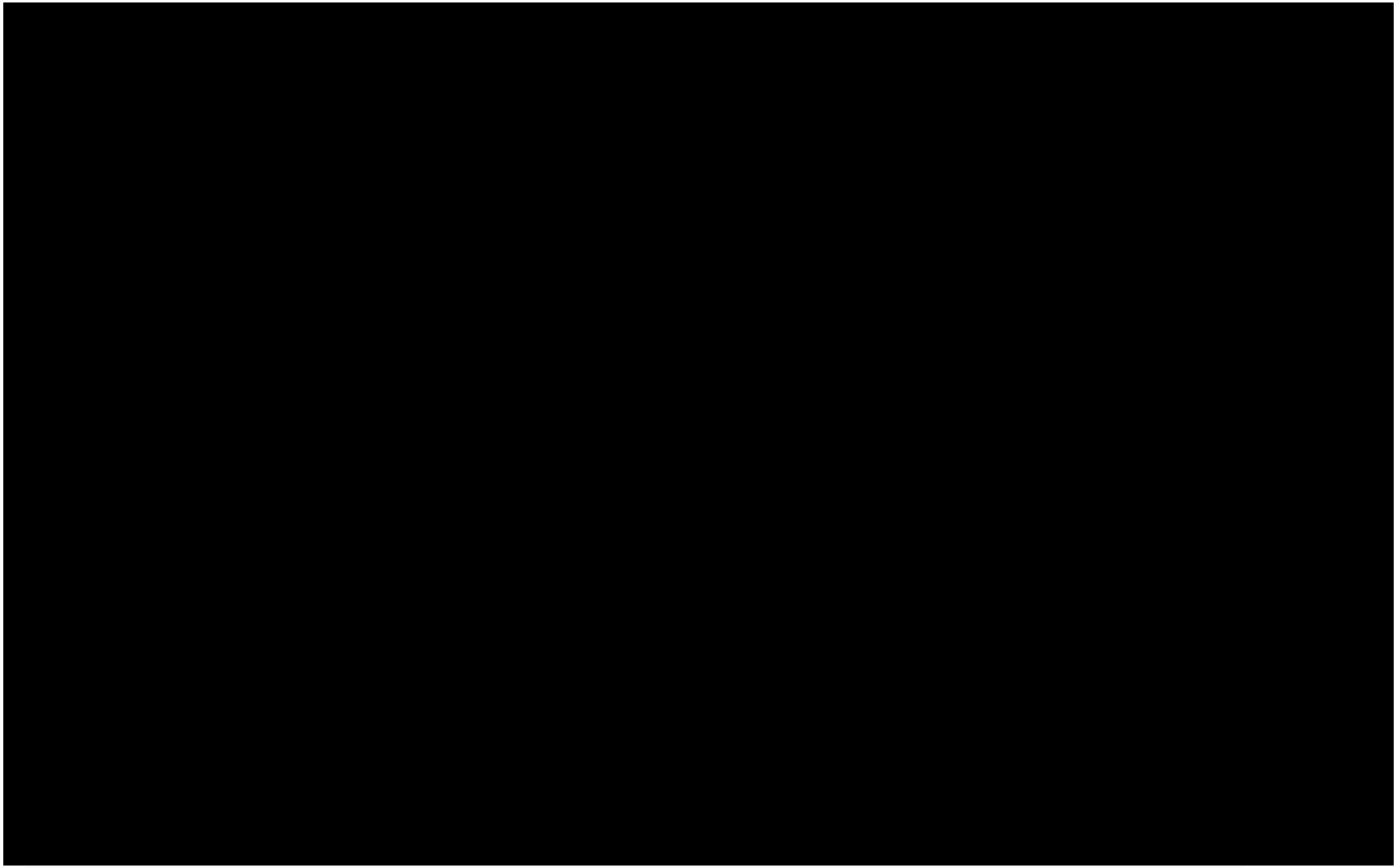
Participant Number	Gender	Pseudonym
P1	Male	Abdul
P2	Male	Omar
P3	Female	Forida
P4	Female	Maliha
P5	Female	Aisha
P6	Female	Aaliya
P7	Female	Hina
P8	Male	Hamza
P9	Male	Noman
P10	Male	Riaz
P11	Male	Yusef
P12	Female	Maya

Appendix L: Transcript Example with Initial Codes





[209]



[210]

Appendix M: Identified Codes Across the Entire Data Set

Table 3

Identified Codes Across all Seven Overarching Themes

Overarching Theme	Codes
Defining Mental Health	A range of mental health problems exist
	Mental health problems that young British Pakistanis are most familiar with
	Scientific factors contribute to mental health issues
	Mental health issues can develop due to negative life experiences
	Mental health issues make you feel isolated
	Impaired daily functioning
	Impaired mental ability
	People suffering with a mental health problem would be unware of it
	Mental health problems cause behaviour that is abnormal to society norms
	Mental health problems may cause eternal damage and may not be reversible
	Mental illness is treated differently to physical illnesses
	Mental health issues cause sympathy
	Sensitive approach needed with mental health sufferers
	Your choise of words are important when interacting with mental health sufferers as they may cause unintentional harm
	Mental health problems are unfairly inflicted upon you which cannot be controlled
	Media has influenced understanding
General Mental Health Awareness	Mental health awareness influenced by personal interest – books
	My education has increased my mental health awareness
	Mental health awareness influenced by friends/family experience
	Mental health services and professionals
	Mental health sufferers provide mental health education
	Respected authoritative figures have a responsibility
	Outreach programmes needed to encourage community conversations
	More mental health advertisement needed to increase awareness in society
	Schools should promote mental health awareness and education

	Ethnic minorities require specific mental health targeting
	Mental health should be taken more serious as it does actually exist
	Limited education contribute to a distorted understanding of mental health problems
	More understanding and openness towards mental health problems comes with more education
	People in society are very ignorant towards mental health
	Society is judgemental towards mental health problems
	Derogatory terms are associated with mental health problems
	Society attaches negative labels to mental health
	Mental health issues are dangerous and frightening
	Society should not marginalise mental health sufferers and view them as outcasts
	Demonic factors associated with mental health
	Cultural and religious remedies preferred over help-seeking
	Beyond human control
Cultural and Religious Stigma within the Pakistani Community	White British are more empathic and understanding of mental health problems compared to British Pakistanis
	Mental health exposure exists more in Western societies
	Marrying a mental health sufferer is unacceptable
	Cultural stigma surrounds mental health problems
	Pakistani culture is narrow minded towards mental health problems
	Pakistani culture overlooks mental health
	Limited dialogue in Pakistani household exists
	More openness needed in Pakistani families
	Pakistani families require mental health education
How Mental Illnesses are Dealt with within Pakistani Families	It is harmful that families lack awareness
	Pakistani families are judgemental
	Mental health issues are shameful and tarnish family pride
	Pakistani families blame themselves if the child is a sufferer
	Open dialogue related to good family ties
	Outside exposure leads to family discussion
	GPs provide mental health support
	Resort to internet for mental health information
	You play an active role in your recovery
	Prefer to independently solve the problem
Openness to Seeking Support	Prefer to keep mental health issues private
	Minimal acceptance and understanding by older generation Pakistanis
	Younger British Pakistanis are understanding and open-minded to mental health problems

	More mental health awareness and acceptance exists in society nowadays
	Support for mental health problem(s) will be provided due to the strong Pakistani family unit
	Family is a valued support system because they know you the best
	More open to friends than family
	Friends are relatable and of similar mentality
	Feel vulnerable to trust friends as they may disclose my issues with others
	Disclosure raises concerns about confidentiality
	Time consuming process is a barrier to help-seeking
	Recovery is a time consuming process
	Cost factor is a barrier to help-seeking
Barriers to Help-Seeking Exist	Minimal understanding and awareness of available support services
	We prevent ourselves from seeking help
	Help-seeking can damage pride and make you look weak
	Mental health stigma exists
	Help-seeking stigma
	Professional help is typically the last resort
	Seeking help means you are mad and abnormal
	Counselling is helpful so people should seek professional help
Seeking Professional Help Is Beneficial although Help-Seeking Stigma Does Exist	In some situations professional help is the most appropriate option
	Professional help is non-judgemental
	Racial discrimination does not exist in services
	Approach determines uptake of treatment
	Medication is a negative treatment option
	Professional help-seeking requires confidence
	Effectiveness of support depends on level of comfort
	Professionals are strangers that cannot relate to you

Appendix N: Initial Thematic Map

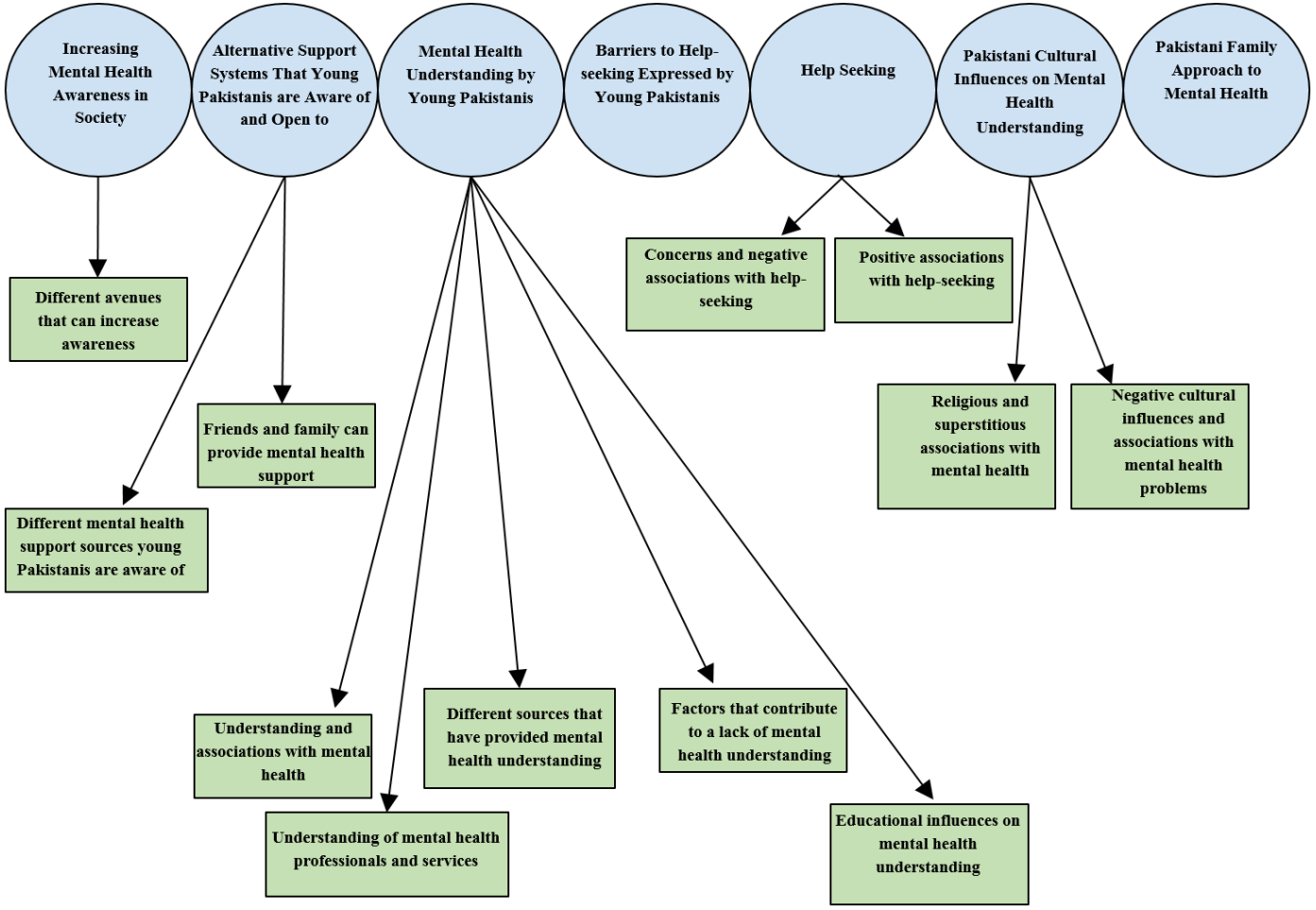


Figure 2. Initial thematic map of overarching themes and sub-themes

= Overarching Theme

= Sub-Theme

Appendix O: Final Thematic Map

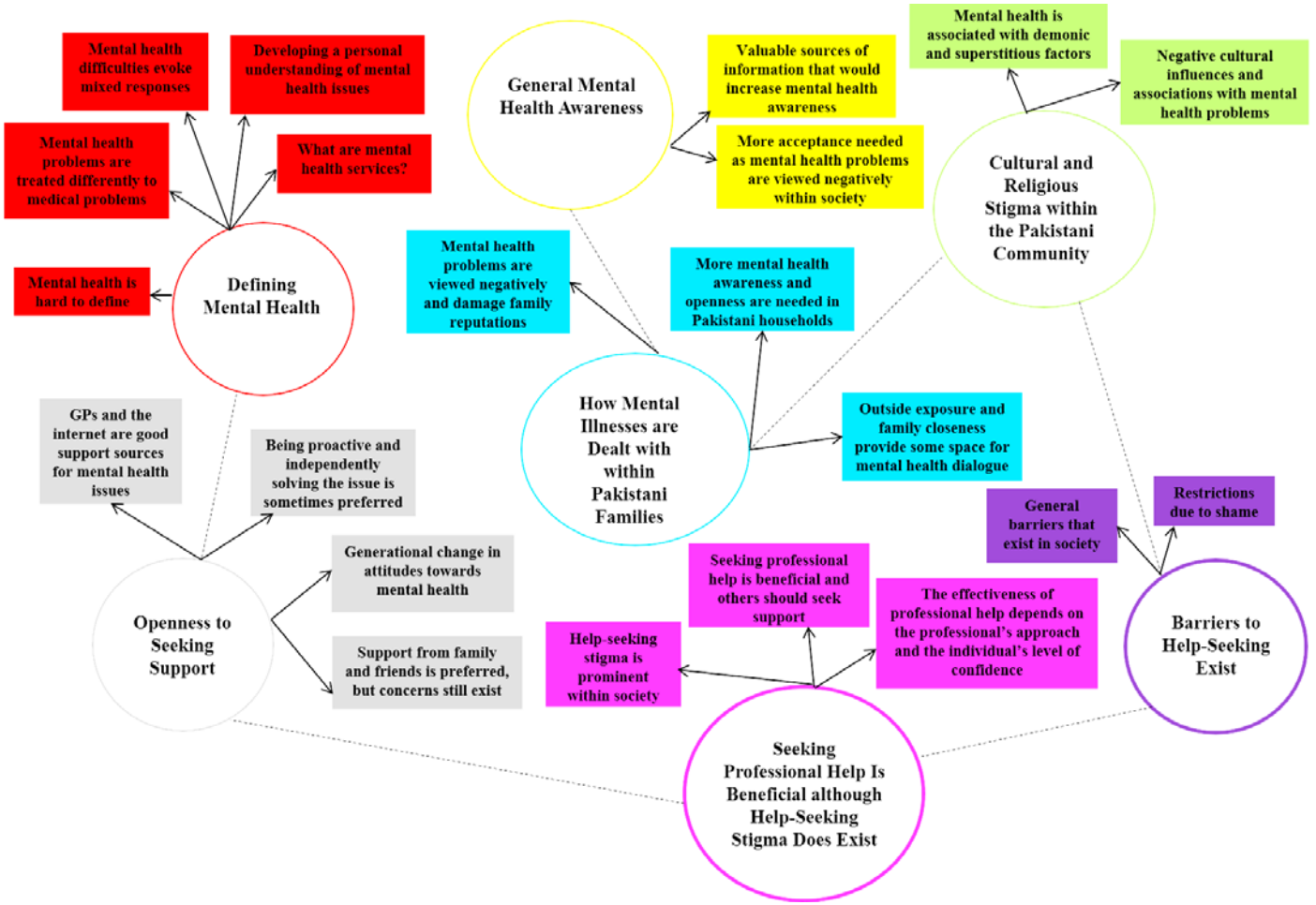


Figure 1. Final thematic map of overarching themes and sub-themes

○ = Overarching Theme

▭ = Sub-Theme

------ = This was used to represent the link and overlap between the overarching themes

Appendix P: Examples of Collated Codes with Data Extracts

Table 4

Examples of Collated Codes and Data Extracts for each Overarching Theme

Overarching Theme	Code Names with Related Data Extracts	
Theme 1	Mental health problems that young British Pakistanis are most familiar with - *Hamza:* '…mental health issues like depression…' - *Maya:* 'I think there's lots of things to do with mental health; I think depression comes in there as well, which is very, very common these days' - *Aisha:* 'I think depression is really common nowadays'	Mental illness is treated differently to physical illness - *Hina:* 'It's like I think it should be treated a lot more like we treat physical illnesses because you break a leg, like, the doctor will fix it straight away and everyone around you will be supportive' - *Yusef:* '…doctor for example, you know, if you've broken a leg or something you don't pull up a book and start fixing your own leg, you go to somebody who's studied it' - *Riaz:* 'I think illness for some cultures only go to the extent of physical illnesses, I don't think they regard an illness to a mental extent'
Theme 2	More mental health advertisement needed to increase awareness in	Mental health issues are dangerous and frightening

	<u>society</u> - *Omar:* 'I one hundred percent think mental health awareness is not advertised as much as it should be at all, because even looking now, when you asked me that, I was thinking: "Okay, what advertising can I think of? What campaigns can I think of that target mental health, not just mental health within the Pakistani community or the Black community or whatever erm or ethnic minorities…"' - *Aisha:* 'I think there needs to be more awareness; there is very less awareness; I don't see any leaflets about mental awareness; I see leaflets about sex education' - *Aaliya:* '…if the media, like not just documentaries, but the news, they talk about mental health services where to go, erm, that's basically how it could be brought more into the limelight, the services basically'	- *Omar:* 'I think, with mental health problems, it scares a lot of people, I don't know why' - *Hamza:* 'You don't do things the way you normally would do, so it's a bit scary I'd say' - *Aisha:* 'She would actually beat people up and stuff like that, beat herself up, they put her in prison'
Theme 3	<u>Demonic factors associated with mental health</u> - *Noman:* '…they tend to believe that it was Jinns or stuff like that, so they always bring in their own culture' - *Aaliya:* 'Somebody has black magic that's why they have become like this, rather than saying it's mental health' - *Abdul:* 'Sometimes they class that as mental health because	<u>Pakistani culture overlooks mental health</u> - *Abdul:* 'For example, if somebody were to take therapy for like depression or something, it would be very unusual. Like, "Can't you just talk to us? What's wrong with you? Why don't you smile? I mean, we're having so much fun, you're just staying to the side", but they

	that person is not who they are you know, how they used to be and so on or like back in the day he probably had a Jinn in him or something like that'	don't understand that there is this actual issue that requires certain ways to tackle it' - *Yusef:* '[pause], erm, in a Pakistani family, no way! Again, I think they really lack the understanding of it; I think, er, they think it's a non-existent problem to be honest' - *Hamza:* 'Pakistani people, I mean if you're traditional then you're not going to see it as a mental health issue'
Theme 4	<u>Limited dialogue in Pakistani household exists</u> - *Noman:* '... mental health problems—we don't tend to discuss that at home' - *Forida:* 'Yeah, I think it's, I think in Pakistani families, it's very, erm, there's a lack of conversation about it. It's not discussed as much in Pakistani families as it would be, for example, in a modern Western family' - *Maliha:* 'Mental health is discussed however, erm, it's not something that we commonly discuss'	<u>Pakistani families are judgemental</u> - *Aisha:* '…again, as I said, you don't know how everyone's going to take it, and, erm, what if I am acting normal but they start judging me that I'm not acting normal' - *Maliha:* 'Because, obviously, when you talk about your 'whatever', you feel, erm, weird with your parents and stuff; they I don't know, you want that open-mind that the psychologist gives' - *Forida:* 'Probably my best friend first, erm, then if I had the guts to open up to my family [laughs]'
Theme 5	<u>Resort to internet for mental health information</u>	<u>Younger British Pakistanis are understanding and open-minded to mental health problems</u>

	- *Riaz:* '…I'll just read stuff on the internet that will give a broader or wider knowledge' - *Noman:* 'I would just Google it, erm, I would literally Google it'	- *Maya:* 'I think, when it comes to newer generation, they are a lot more understanding, a lot more open-minded, and we have a bit of Western cultural understanding…' - *Riaz:* 'I feel like the youngsters nowadays actually know or they actually like to give you more options, and they like to think outside the box and think actually maybe this can be the cause' - *Aaliya:* 'So my friends obviously, I would be more comfortable because they know, they'll be on the same page as me basically in terms of like you know accepting mental health and people with mental health'
Theme 6	<u>Time consuming process is a barrier to help-seeking</u> - *Omar:* '…you go and ask for help, and then they tell you, "Oh, sorry, like, you know, there's a list", like you would have to wait, like three months, then you would maybe like, "Okay, forget it then". Do you know what I mean?' - *Maya:* '…if I have to go travel really far for a counsellor being depressed as it is, I'd be like, "Forget it" [laughs]; you know, if you're feeling shit as it is and then you have to go travel an hour somewhere, because maybe that's where the counsellor is if they are not that widespread, I think that would	<u>Help-seeking can damage pride and make you look weak</u> - *Hamza:* '…well, erm, ego perhaps: "Nah, I don't want to seek professional help", you know? So, people have massive egos…' - *Hina:* 'I'd say pride, but that's I've explained that before, people wouldn't want to go get help because then they're seen as a weaker person and they want to be a stronger person, which I think is complete nonsense; there's no such thing as a weak or strong person…'

	be a problem…' - *Aisha:* '…then when you try to seek help, erm, GPs are really booked and you basically wait a month or two to get an appointment'	
Theme 7	<u>Seeking help means you are mad and abnormal</u> - *Yusef:* '…but, you know, counselling or whatever, when you're going through all this kind of stuff, I think it will make matters worse because you're thinking now really you're a nutcase, not a nutcase but you're going through something that you're requiring all this help…' - *Hina:* 'People take it as a really big thing like, if I need counselling, I'm like a lost soul or I'm a broken person and stuff like that' - *Forida:* '…a lot of people who have it kind of feel like, they refrain from seeking help because they don't want to be seen as like, erm, not normal I guess or abnormal'	<u>Professional support is non-judgemental</u> - *Maliha:* 'I feel like their approach is nicer; you can ramble on and you can keep on talking and there's no judgement' - *Abdul:* '[sigh] counselling to me, when it comes into my mind is somebody who requires an unbiased opinion, or an unbiased speaker who would kind of listen to their problems and somebody who you're not afraid to talk to'