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Muslim South Asian Women's Experience of Medication for Mental Health Problems

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2017

Acknowledgements

In the name of God, the most gracious and the most merciful.

I would firstly like to thank all of my participants, for their willingness to give me their time and share their personal experiences with me. Despite the challenges of having mental health problems, their will to persevere was truly inspiring and beautiful.

I want to thank my family especially my parents and all of my friends for their continual support and encouragement throughout this project.

Dinah and Dirgha, thank you both so much for always being here for me.

Kiran, Anisah and Kathleen, thank you for the many ways in which you have supported me during this project.

I would also like to thank my supervisor Mark Trueman, for supporting, encouraging and helping me throughout this project and finally a thank you to the tutors on my course for often sharing books and resources with me.

Abstract

Research has shown South Asian women to be at risk of developing mental health problems and facing barriers in accessing services. Moreover medication is one of the most widely used and quicker responses in the treatment of mental health problems. This study therefore aims to explore the experience of medication for women of the South Asian community suffering from mental health problems. To firstly explore the impact on them as an individual, in terms of what has or has not been beneficial. Additionally, to explore the impact of medication use within their community and society at large. The aim also is to understand the influence of race on their mental health.

This study was conducted using individual semi-structured interviews with four South Asian Women. Interviews were transcribed and later analysed using Thematic Analysis. Themes that emerged from the research, included medication was unhelpful, poor support from mental health services, community was unsupportive, easier to be white and mental health problems were kept private. It was anticipated through this research there would be a greater understanding in the experience of medication for this group and of wider societal and social implications as well. The hope of this research is that there will be improvement in support provided for ethnic minorities suffering with mental health problems.

Declaration: No part of the material offered in this dissertation has previously been submitted by me for a degree in this or any other University.

Contents

1. Introduction

1.1 Background

As a south Asian woman and trainee counsellor, I have been very passionate about working within the black and minority ethnic (BME) community. Upon developing my understanding of racial disparities within mental health, my interest in this area developed further.

A report by Care Quality Commission (2014e) found BME people were more likely to engage with mental health services through sectioning and medication. Alternatives like therapy and long-term care were less likely options. There is evidence showing a difference in rates of diagnosis and poorer outcomes for mental health problems amongst BME groups within the United Kingdom (Mental Health Foundation, 2016). I will explore this further in my literature review.

Fernando (2017) notes clinical psychology and psychiatry were both established "in Europe and in Europeanised America, they reflected the values of the (European) Enlightenment in general, and racism and the ideology of white supremacy attached to racism were part of that Enlightenment's values" (page 22). Fernando (2017) contends issues of racism have persistently manifested in various ways over the years.

Furthermore research in social psychology has extensively explored prejudice and stereotyping. Prejudice is defined as holding a harmful attitude towards groups/members of a group, and stereotyping is assuming characteristics are associated with groups/members of a group (Stangor, 2009). This is potentially one way in which racism may be continuing to manifest within both psychology and psychiatry, through assumptions based on physical characteristics like race or gender.

After further research it became clear, south Asian women were a vulnerable group with regards to having mental health problems. A study comparing Asian patients and British born white patients who had been admitted to hospital in Birmingham after deliberate self-poisoning. It was found Asian patients were mostly young, married and female. They were unlikely to have self-poisoned previously, or have had psychiatric involvement, diagnosis, or have personality disorder. Self-poisoning was higher in Asian females than white females, but lower in Asian males than white males (Merrill and Owens, 1986).

Furthermore, the role medication plays in mental health is crucial. Medication is one of the most quickest and easiest forms of treatment to administer for mental health problems (Mental health foundation, 2016). There has been an on-going debate over the effectiveness of medication with some studies finding there is little benefit (Kirsch et al, 2008), and other studies' finding it is beneficial (Hieronymus et al, 2017). There however is little research on the experience of medication within BME communities.

1.2 Why is this topic important?

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people..." Macpherson (1999, chapter 6 para 6:34). It can be argued services providing inadequate services to minority communities can be considered to be a form of discrimination. Therefore it is important to not further discriminate against minority communities and acknowledge their needs.

The Joint Commissioning Panel for mental health (JCP-MH) is a co-operation chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. Leading organisations come together to commission for many groups in relation to

mental health and disabilities (JCP-MH, 2014). Within the JCP-MH (2014) document, there are eight reasons listed for why mental health services for BME groups are important for commissions.

These reasons can apply to many mental health professionals and organisations. As it has been noted above there are racial disparities present in current mental health services (this will be explored further in the literature review). To begin with the demographic in the UK is continually changing and mental health services must reflect this change, secondly it is important to improve the quality of care provided, especially as mentioned above there are issues in diagnosis and outcome. Thirdly there is a responsibility to provide effective and appropriate care amongst all mental health services. Fourthly, it is noted there is a real need to reduce illness and untimely death, through providing appropriate support earlier (JCP-MH, 2014).

Other reasons provided include, the cost of mental health services. The document notes the average black service user has 58% of a higher cost than the average white user (this difference could be due to higher spending in psychiatric intensive care unit). Moreover, services have a legal obligation, under legislation in the Equality and Human Rights Act services cannot discriminate and must attend to the needs of diverse communities. Services also must be accountable in supporting and engaging BME communities, lastly it is an ethical obligation to attend to the needs of all service users correctly and provide inclusive support (JCP-MH, 2014). With regards to accountability and ethics counsellor must be accountable and work within the ethical framework with clients (BACP, 2016).

1.3 My research question

"Muslim South Asian women's experience of medication for mental health problems". I wanted to understand the experience of medication for my participants, the social implications, like how they felt within their community and in comparison to the majority community with their mental health problem and

medication use. Therefore exploring race within this context. I wanted to explore challenges and discrimination experienced by participants.

1.4. Terminology

Farooq (2012) uses the description provided by Anand and Cochrane (2005) to describe the term South Asian as being "mainly used to refer to people whose cultural or familial backgrounds originate from India, Pakistan, Bangladesh, Sri Lanka and East Africa" (page 634).

1.5. Stakeholders

I believe the stakeholders are clients, trainees and qualified counsellors, and other mental health professionals and healthcare professionals including Psychiatrists, General practitioners, social workers and support workers. I think it is important to explore the use of medication within this group and how it has impacted participants, in order to suggest ways in which support can be improved. It is also important to acknowledge the race of participant's and if this influenced the support they received and if they faced any challenges, in order to try to reduce issues from recurring. I further hope to increase the awareness and knowledge of mental health amongst general society but specifically amongst the South Asian community.

1.6. Links to Counselling

The key link to counselling is by not addressing parts of people's identity such as race, gender and sexuality can make therapy in itself can become oppressive (McKenzie-Mavinga, 2016).

As Proctor (2006) argues therapy can be of benefit to both patriarchy and capitalism because it could mask inequalities individualistically, rather than recognising wider social issues e.g. racism and homophobia. It is therefore important to be aware of such issues in order to attempt to address them within therapy.

Additionally it is important to be aware that counselling will stem from a Eurocentric model and cultural competence is crucial to continually explore and develop (Fernando, 2017).

Furthermore as medication is one of the most accessible forms of treatment (Mental Health foundation, 2016), it is crucial to be able to understand the impact of medication for BME people, individually and within their communities too. As McKenzie-Mavinga (2016) argues, that mental health problems are often concealed within BME communities to avoid gossip and caring for mental health problems can be seen as a family obligation rather than seeking professional support. Additionally there can be misconceptions about the causes of mental health problems. For example black magic or poor parenting, this can result in further isolation.

Counsellors have to be aware of such issues in order to work with them. Even if counsellors do not agree with cultural values, they should not be judgemental and be willing to explore parts of a client's identity (McKenzie-Mavinga, 2016).

2. Literature Review

2.1 Introduction

The aim of this chapter is to review the research into the experience of medication and mental health from the perspective of BME people, specifically South Asian women. This will help contribute to understanding the impact of mental health problems as well medication on a marginalised group. In the literature there will also be an exploration of social and cultural issues.

2.2 Mental health and BME People

In a survey of BME people with mental health problems from African, Caribbean, Indian and Pakistani/Bangladeshi backgrounds. It was found Asian people had depression more than black people. Indians experienced the highest rate, followed by Pakistani's/Bangladeshis then Caribbean and lastly African people. Anxiety also followed a similar pattern amongst the groups. However the reverse was seen with regards to Schizophrenia, this was highly diagnosed in Caribbean people followed by Africans, Indians and Pakistani/Bangladeshis (Rehman and Owen, 2013).

Within this sample 93% of participants experienced discrimination due to their mental health. Half the participants said this discrimination was from mental health staff members. A third described discrimination from within their communities. Around 70% described experiencing racial discrimination. Interesting a third of the Pakistani/Bangladeshi community had experienced this within the last year. This might be because of their Muslim identity, as Indians in comparison reported less. The results of these experiences of discrimination, might explain why only a minority of participants felt they could talk about their mental health with others.

It is interesting the researchers grouped Pakistanis and Bangladeshis together. It is important to acknowledge they are distinct groups. However this can also be said with regards to labelling people as African and Caribbean, both labels represent a

range of diverse groups of people and identities. This represents an even bigger issue when using terms like BME, which further clusters large groups of people together.

In a meta-analysis by Singh et al (2007) found black patients were almost four times and Asian patients almost two times more likely to be detained than white patients under the Mental Health Act 1983. The researchers argue based on previous research explanations for these findings could include racism and stereotyping and patients mistrusting in services.

However Singh et al (2007) argued these explanations might not be completely supported due to concepts like racism and stereotyping being difficult to test or publication biases only representing significant differences between groups. They argue whether racism itself was an accepted idea as a cause for detention in earlier papers as speculation, which has now been treated like factual reasoning. However despite this study itself publishing a difference between groups, and not wanting to use racism or mistrust of services as reasons for this difference. The study fails to provide explanation for the differences itself.

2.3 Differences Between Men and Women in Mental Health

According to World Health Organisation, WHO (2002), there are many differences amongst men and women in relation to mental health. It seems women tend to have higher rates of issues that present more inwardly like anxiety whereas men have more outward related issues like antisocial behaviour. With exceptions to India and China it seems men have higher rates of suicide although attempts seem more common amongst women.

Furthermore, men and women are under different gender norms and responsibilities. For example men are socialised not to express emotions and depend on women for domestic living. Within industrialised countries, studies have found women are more likely to use mental health services whereas men will delay getting support. This could be related to men's mental health problems going undetected

whereas women are more likely stereotyped for example to have depression, this stereotype could impact the diagnosis of depression (WHO, 2002).

Earlier diagnosis also means women may have learnt more skills to manage their mental health better (WHO, 2002). However despite women using mental health services more it was found by the Count me in (2010) report on inpatient and supervised community mental health patients, almost 80% of women were without access to a same sex ward. It is important to be aware of gender differences in order to understand stereotypes and issues that can cause further difficulties.

Within the South Asian community Fikree and Pasha (2004) examined the role of gender. They discussed women often find themselves inferior to men, both socially, culturally as well as being economically dependent on men. This means women are often left out of decision-making procedures and have less access to resources and limitations on mobility. Further to this women can be subjected to violence from male relatives, and with the dowry system, daughters are often perceived as a financial burden.

2.4 South Asian women and Mental Health

Initially studies showed less psychological problems amongst south Asian women, as was found in a comparison between Indian immigrants and native English by Cochrane and Stopes-Roe (1981). However later studies contradicted such findings, Anand and Cochrane (2005) discuss within some earlier studies. Less psychological problems amongst south Asian women could have been due to errors made in recording ethnicity, birthplace, excluded subgroups of south Asians and generalising findings. Furthermore Western models of mental health might have been unable to capture the experience of south Asians.

Looking at people from the Indian subcontinent and Caribbean origins. Suicide records from England and Wales between 1988-1992 showed Bangladeshi, Sri Lankan and Pakistani born men had low rates of suicide. Rates were higher for young

Indian and east African men. Amongst women, suicide frequencies were high for Indian and east African women, the ratio was low in Pakistani and Bangladeshi women largely but this rose at 15-24 years. Indians seemed to be a high-risk group. This study confirmed previous findings of high suicide rates among young Asian women, and raised rates among young Caribbean's (Raleigh, 1996).

Furthermore Raleigh and Balarajan (1992) also found suicide levels in England and Wales for 1979-1983 low among males from the Indian subcontinent and high among young Indian women. They suggested reasons for suicides included arranged marriages, submission and financial pressures by dowries. The women were also likely to be viewed by professionals stereotypically, viewing Asian cultures as repressive and therefore assuming the treatment of depression was found in the adoption of a western lifestyle. This could be a means of stripping people of their identities.

Furthermore, Bhugra et al (1999c) also found Asian women had higher suicide rates compared to white women and Asian men. These rates increased for young Asian women who were also vulnerable to self-harm. Additionally, Raleigh and Balarajan (1992) identified issues contributing to the high suicide rates in young Asian women including arranged marriages, marriage and lifestyle struggles, confined gender roles and submission to males, difficulties with in-laws, stigma and conflict with culture with regards to men and elders (these issues will be explored further below). Gary (2005) described stigma as attitudes, beliefs, and behaviours or even thoughts that are negative and cause individuals or the public to discriminate, stereotype or be prejudiced concerning those with mental health problems.

Husain et al (2006) in a review found in comparison to white women, south Asian women between 16-24 self-harmed more. Self-harm rates were lower in south Asian men, compared to south Asian women. The women were usually younger, usually married and likely to be employed and unlikely to use substances like drugs or alcohol. There generally seems to be a pattern of a risk group being young and married Asian women.

Amongst south Asian women in comparison to white women, there is an increasingly high rate of eating issues, specifically high rates of bulimia and unhealthy eating attitudes (McCourt and Waller, 1996). Bhugra and Bhui (2003), looked at teens in London within a mixed school. They found Asians more prone to think about food, to fast and eat compulsively. Also family expectations and observance to family values were part of the cause for eating distress. There may not be much research in this area, but it would be interesting to explore the relationship between fasting during Ramadan and eating disorders on Muslim people. As bloggers have described their experiences of questioning whether they are fasting for Allah or anorexia (Ali, 2015).

Nevertheless, Anand and Cochrane (2005) conclude it is difficult to be certain of mental health problems prevalence among south Asian women and it is important to recognise data can come from people already receiving support therefore may not reflect true prevalence and issues.

2.5 Subgroups

As earlier mentioned Anand and Cochrane (2005) noted there were issues with previous studies ignoring subgroups within the Asian community. It is important to acknowledge subgroups of south Asians will have their own identities, languages and cultures that differ from one another. Some research has shown differences in mental health for subgroups. Research I found mostly related to the Pakistani group.

Sonuga- Barke and Mistry (2000) for example found in three generations of Indian-Hindu and Pakistani-Muslim women, using the hospital anxiety and depression scale in English, Gujarati and Urdu. Depression and anxiety was higher among Pakistani-Muslim women. However this study focused on the association of family structure and mental health. Overall it seems mothers were adjusted better in nuclear families whilst children and grandmothers suited better in extended families. Other factors need to be taken into account, as the Muslim women were also younger than their Hindu counterparts and usually unemployed. The Hindu women also seemed less socially isolated and less part of traditional customs. Findings cannot be taken at face

value as previously mentioned, Raleigh (1996) found Indians to be a high-risk group within suicide data. Furthermore as Rehman and Owen (2013) found Indians to be at higher risk of depression followed by Pakistanis/Bangladeshis.

Nonetheless, Fazil and Cochrane (2003) found in comparison to white women, Pakistani women scored higher on depression, anxiety, sleeplessness and somatic symptoms, in Birmingham. For Pakistani women greater depression levels were associated with social troubles rather than personal. The reverse of this was for white women, for whom depression related to personal troubles.

Overall acknowledging subgroups allow an understanding of differences within the same race, rather than homogenising all under the umbrella term 'Asian'.

According to Kapadia et al (2017) Pakistani women in the UK are at high risk of mental health problems but less likely to engage with services, research can be difficult to gather due to generalisation of south Asian women being taken as referring to Pakistani women. In an analysis of 7 studies both quantitative and qualitative, Pakistani women were less likely than white British to use specialist mental health services. Though no difference was found in consulting GPs for mental health problems.

Furthermore it seemed Pakistani women's networks had more stimatising understandings of mental health problems and services, there were also disadvantages in accessing services and service usage compared to white women. Social networks could be central for a group already estranged from services. Pakistani women also had more social isolation compared to white women and were less engaged in activities outside of their communities. Kapadia et al (2017) contends that studies need to consider the level of the mental health problem when making comparisons, also socioeconomic factors and this study did not explore how social networks conceptualised negative views on mental health services.

2.6 Religion

Another factor to take into account is religion. Laird et al (2007) described Islamophobia as “forms of prejudice, exclusion and violence towards Muslims” (page 924). As mentioned above research has shown differences amongst communities based on religious groups such as Sonuga- Barke and Mistry (2000). Research on Muslims remains limited to some degree as Laird et al (2007) argues often health literature has combined the Muslim identity with an ethnic group and not distinguished between the two.

Laird et al (2007) also discusses services often may be inefficient in providing support based on religious grounds for example health services have been found to lack prayer spaces or meet dietary needs and are often stereotyping for example seeing a girl in a headscarf and thinking she is oppressed or traditional. This in itself is oppressive.

With regards to religious discrimination, Weller et al (2001) identifies multiple levels that can be experienced. This includes prejudice often resulting in exclusion or discrimination, religious hatred that is a means to rationalise violent ideology. There is then direct and indirect discrimination, direct is deliberating excluding and treating people poorly, indirectly relates to poor treatment but with a lack of acknowledgement. There are also religious disadvantages; this relates to state and institution religious privileges given to some religions over others. Lastly, institutional religionism combines all five of these and this impacts health care due to religious discrimination affecting access and quality of care. Just as the complexities of race, it is equally important to understand the complexities of religion, especially with increasingly negative stereotypes and attitudes towards Muslims (Laird et al, 2007).

2.7 Culture, shame and honour

Shame itself is associated with negative perceptions of oneself, also feelings and assumptions about how others think/feel about us (Gilbert, 1998). Within

collectivists cultures it is likely emotions are linked with how behaviours reflect on others whereas individualistic cultures regard feelings like shame to reflect yourself (Mesquita, 2001).

Gilbert et al (2004) explored the role of shame and honour with regards to subservience and entrapment for south Asian women in Britain and the impact this has on mental health and seeking support. They argue a number of aspects contribute to the concepts of shame and honour including poverty, less opportunities, dependency and racism.

Gilbert (2000) looked at associations between shame, depression and social anxiety that, using the social rank theory (Price and Sloman, 1987). According to this theory, emotions and moods are induced by perceptions of your social rank and status, and mediated by whether you feel others look you down on you.

Furthermore, shame and honour can impact one gender more, for example, shame for men can relate to seeing yourself as responsible for controlling your wife and kids. In some cultures male honour and shame are linked to the control of women's bodies and sexuality (Lindisfarne, 1998). Figueredo et al (2001) argued despite some positives of shame and honour such as resources for women, support from male relatives, social and economic status, it is an abusive and controlling patriarchal structure.

Gilbert et al (2004) carried out a focus group, and found that upholding family honour and identifying with it was tied to personal shame, leaving some south Asian women trapped in challenging relationships. Shame and the loss of honour could explain why women did not use mental health services. This study presented other issues such as needing an accompanying male relative. This in effect would limit what women can speak out about. Further issues included translators not completely capturing true meanings and raised issues around confidentiality if the translator was of the same community and the risk of information becoming exposed and the loss of shame and honour that would be tied to this. Participants

also felt clinicians did not understand izzat (honour). Gilbert et al (2004) concludes that shame and honour will create barriers in recognising problems and seeking support for mental health.

In regards to self-harm, Bhugra et al (1999c) found that in comparison to Asian women, white women attempted suicide due to mental illness whereas Asian attempters had experienced life events relating to relationships. This could relate to cultural conflict in relation to family expectations. Bhardwaj (2001) also contends that Asian women growing up in Britain may self-harm due to expectations of being part of British society but also family and community expectations. Religious and social pressure can also add to this.

Additionally, Gilbert et al (2004) argues in particular communities' mothers were less depressed in nuclear families compared to those in extended families. Some cultures place responsibilities on young mothers such as expectations to look after in laws, whilst being in subordinate positions within family hierarchies.

Additionally in Manchester a qualitative study found Asian women experienced a range of problems including social and economic pressures such as language, family problems and the concept of izzat in Asian families. However racism and stereotyping of Asian women and their communities added to further problems experiences, and self harm was seen as a coping strategy. There was a mistrust of services, with regards to confidentiality for example mental health problems being recorded and access to services was more in relation to desperation rather than seeking support prior to crisis points (Chew-Graham et al, 2002).

Culture beliefs can impact help seeking behaviours. Hatfield et al (1996) surveyed Asian people, to look at the relationship between beliefs and mental health problems and the influence on seeking help. God's will was seen as an important element in causing mental illness and prayer was a useful means of coping. Moreover within the Asian community there was a lack of knowledge regarding

services that were available. This community was also very reliant on GP services for mental health problems.

Nevertheless a study by Sheikh and Furnham (2000) using questionnaires with British Asian, Western European and Pakistani participants both males and females, found that predicting attitudes towards help seeking behaviour for mental health problems was not always mediated by culture. The Asian group for example did not have less positive attitudes in comparison to the Western group towards seeking help. They argue this could be due to sampling errors or due to the rise in the globalisation of psychology making help seeking more of a norm now.

Sheikh and Furnham (2000) continue to argue that in the British Asian community it might be preferable to discuss mental health with someone within the individual's social network or a trusted elder, instead of a professional. However British Asian community are also more likely in comparison to native Asians, to be inclined towards the culture they live in and accept services normalised in the UK like the NHS.

The study showed however that religion was a key factor in help seeking attitudes for both Asian samples, as both groups scored higher on supernatural causes and non-Western physiological causes. The researchers argue this could relate to cultural traditions and beliefs. Muslims in specific scored highest in the category of belief in supernatural causes comparative to other faith groups. The study also found that men had less positive attitudes to seeking professional help, as did participants with lower education levels.

Interestingly they also found that in regards to beliefs in supernatural causes of mental illness, young people had higher scores than older people, unlike findings of previous research. They postulate this was because young people have become increasingly dissatisfied with modern psychiatry and medication and were therefore seeking alternatives (Vincent and Furham, 1997; in Sheikh and Furnham, 2000).

Additionally Sheikh and Furnham (2000) found that Pakistanis believed in supernatural causes more than British Asians and Westerners. This could be because there is more use of supernatural explanations for daily happenings for people in Pakistan compared to people in the West. They argued more traditional beliefs which included supernatural or non-Western physiological explanations led to less positive attitudes to help seeking. Contrastingly, beliefs in western physiological led to more positive attitudes in seeking professional help and this relationship was only significant for the Pakistani group. This could be due to the British Asian sample accustomed to British culture and beliefs. This can relate to the process of acculturation, which is defined as changes that occur due to interaction with different social settings, people and groups (Gibson, 2001). It is the extent to which a minority group individual is able to engage and function in the majority group's culture (Blume, 2013).

However it is possible that it is could be more difficult for migrant community to express their beliefs using western methods and questionnaires (Sheikh and Furnham, 2000). It could be expected that when mental health is understood within a western framework, this would lead to finding resolve within western solutions, this does not necessarily mean a western model of intervention is superior.

Furthermore Anand and Cochrane (2005) in a review argued findings on acculturation remained inconclusive. This is because acculturation is complex as it can have both positive and negatives conclusions. They also acknowledge that differences can be accounted for by other reasons which include the sample's characteristics, demographics, their age and which generation they are from, in addition to faith, class and gender. They argue that some researchers may use the cultural conflict hypothesis to cover these other factors rather than address them.

In support of this Anand and Cochrane (2005) argue that in the present day more south Asian women are in higher education, employed and are succeeding regardless of males. This means the stereotype of suppressed Asian woman is becoming increasingly tiresome and might in fact be ignoring other factors that are

mentioned above.

Bowl (2007) found through focus groups and interviews with south Asian mental health service users. They often cited that socio-economic marginalisation had impacted their mental health. In addition to this there was both cultural and institutional exclusion such as a lack of understanding of religion or impact of assessments culturally on the individual, they struggled to share concerns in many service settings.

2.8 Racism and Stereotyping

Burr (2002) argued there were less rates of depression treatment in south Asian communities, despite high suicide numbers. In a small-scale study using focus groups and interviews investigating culture stereotypes in mental health, specifically stereotypes of women from south Asian communities. The focus groups included a range of mental health care professionals and interviews with psychiatrists and GPs. It seemed that mental health care professionals had unchanging views on the inferiority of the British south Asian community. This was largely based on the idea of Western supremacy, whilst viewing Eastern cultures as suppressive and patriarchal. By internalising stereotypes there is the risk of them being treated factually and causing poor diagnosis and treatment. Though the nature of this study was small scale, it indicated towards issues of a lack of acknowledgment of cultures fluidity. Additionally, viewing mental health with Eurocentric lens could pathologise assessment, diagnosis and treatment. Whereby the root of distress is perceived as the culture itself (Burr, 2002). Fernando (2017) continues training courses often assume supremacy of knowledge and work methods based with western psychology and psychiatry as opposed to non-western cultures.

It is suggested that the process of stereotyping can be unconscious and unintentional due to the stimulation of well-ingrained responses made through repeated activation in an individual's memory (Devine, 1989). However Devine (1989) argues that such automatic responses can be changed, "the attitude and

belief change process requires intention, attention and time… an individual must not only inhibit automatically activated information but also intentionally replace such activation with non prejudiced ideas and responses" (page 16). However lack of awareness of stereotyping, will not lead to change in this behaviour.

Furthermore translating emotional language from Urdu or Punjabi may lead to somatisation from an English GP. Communities can often experience the somatisation of their problems being treated as physical rather than psychological. This could be possibly due to the lack of psychological language to communicate feelings (Raleigh, 1995). Additionally an example of this is a term in Punjabi which translates as 'sinking heart' and can relate to feelings of unease and worry (Krause, 1989), though it might not clearly translate into English in the same way. As McKenzie-Mavinga (2016) argues that an everyday example of homogenising people is to assume English is an international form of communication throughout the world.

Additionally, Wilson and MacCarthy (1994) looked into five health centres in London and gave mental health patients questionnaires to see both psychiatric and other problems and understand why they wanted to see the doctor. Doctors were also asked the consultation purpose for patients. The questionnaires were then screened to find no difference in symptom presentation and non-psychiatric illness between a white and Asian sample. It was found that the Asian sample above the cut off level for psychiatric problems stated they were seeing their doctor for physical problems. The doctors also increasingly identified more psychiatric problems in white patients than in Asian patients. It is possible that the patients experience and language around their psychological distress might be going unheard due to their ethnic background and the GPs response.

Kleinman (1987) argued cross-cultural research has assumed mental health definitions are mutually exclusive and this has marginalised cultures and religious beliefs. For example, Hussain and Cochrane (2002) note in western cultures concepts like mind and body are usually perceived more distinctively than they are in Eastern.

They also argue that within some cultures alternative healers might be preferred due to their religious and spiritual understanding and herbal remedies sometimes fit with religious understanding. However the prevalence of use of these alternatives in the UK is vague. Whilst for some professionals' spirituality and religion hold no position within science. Yet this poses an issue as Asian mental health or emotions can be understood in a belief system, which includes the mind, body, soul and be heart orientated. This means the individual is surrounded by a family, culture, community that involves a spiritual world (Malik, 2000).

Furthermore Goldberg and Hodes (1992) further argued that higher levels of suicide attempts via overdosing amongst young Asian women could be related to racism. Racism could increase protective attitudes from parents, which, adolescents may then resist; this could alter the ability for girls to gain autonomy.

Additionally, Hussain and Bagguley (2007) after interviewing female students of Indian, Pakistani and Bangladeshi origins, found key concerns around their learning experiences included effects of isolation, racism and Islamophobia.

Racism can also take complex forms as McKenzie-Mavinga (2016) explains that internalised racism for example manifests in ways like skin bleaching and trying to assimilate into the majority group. This can even lead to better treatment in your own community. An example of this is colourism, which is prejudice, based on skin tone, from light brown to dark brown, "this divisive attitude was set up during slavery and maintained intergenerationally through colonialism, via apartheid, classism and assimilation" (page 84). Similar attitudes are held within the Indian caste system for example. This is only scratching the surface upon the complexities of racism, stereotyping and both internalised and institutional racism which McKenzie-Mavinga (2016) argues go hand in hand.

2.9 Medication Effectiveness

Medication is often used in treatment of mental health problems; it is quickly and easily administered, and can reduce symptoms of mental health problems and relapse (Mental health Foundation, 2016). However medication can come with some issues for example, there are side effects to consider (NHS, 2015) and problems can occur when someone stops taking medication altogether in relation to withdrawal. (Royal College of Psychiatrists, 2014).

Moncrieff (2001) however argued there has been an increase in use of antidepressants to reduce depressive symptoms. The evidence for the effectiveness of medication remains weak. Moncrieff (2001) lists a number of issues within research this includes methodological issues such as measures used often amplifying the benefits of medication, moreover a bias in the publication of results. Results have generally remained inconclusive on the effectiveness of medication with small differences found in comparison of tricyclic antidepressants and placebo. Moncrieff (2001) argues that the interests of the pharmaceutical industry and psychiatry must be taken into account as they support the use of antidepressants. Moncrieff (2001) continues, even in long-term trials there are issues of the effects of discontinuation. Moreover brief surveys in some studies do not represent a clear picture of medication outcomes in use and the lack of inclusion of some participants within analysis itself can impact the results too.

In a meta-analysis Kirsch et al (2008) found little benefits of antidepressants over placebo although this could be due to the levels of depression differing and impacting the efficacy of medication. For example it was found the initial depression scores showing severity and antidepressants efficacy was attributable to lower responsiveness to placebos amongst very depressed patients instead of increased responsiveness.

Furthermore Greenberg et al (1994) in a meta-analysis looking at fluoxetine (Prozac). As this was the most frequently prescribed drug by psychiatrists. It was found there was only a modest effect size with little different to effect sizes obtained by meta-analyses of tricyclic antidepressants.

In some controlled trials antidepressants have been found to outperform placebos, though Hieronymus et al (2017) argues this could be due to the psychological impact of an increased expectation of improvement, as patients know they are not using placebos. Hieronymus et al (2017) investigated whether adverse effects were needed for Serotonin reuptake inhibitors (SSRIs) to outperform placebos and whether the severity of negative events would impact the response in patients using SSRIs. They found that by comparison of paroxetine and citalopram, both of these drugs were superior to placebos. The study did have some limitations and this related to the data only examining paroxetine and citalopram. Additionally how patients recognise subtle negative events themselves will vary and cannot be equally represented. Therefore it can be difficult to draw conclusive results.

According to Barth et al (2016), in investigating the association of with adverse events and the effectiveness of SSRI. In a meta-analysis it was found, most patients who received SSRIs reported adverse events than those who were receiving placebos. Despite this the SSRI were still better than placebos in regards to efficacy and there has been no association made between negative events and efficacy. Therefore there is no suggestion that adverse events were an effect of SSRIs.

Moreover Leucht et al (2012) argued psychiatric drugs could improve critical episodes and prevent them from occurring in further. Upon looking at both psychiatric and general medication however they argued that scales were often criticised for being too subjective. Though debatably is it not the subjective experience that matters, as that is who the medication has the most impact on. However they continue to argue studies have shown both impact and no impact of medication might be due to large trials with lack of recruitment for severely unwell patients due to ethical issues. They suggest it is important to expand research on medication due to the impact it has on diagnosis, symptoms and side effects. They argue people might assume psychiatric disorders are purely psychological however randomized control trials have found effectiveness of medication use. Though studies still need to consider factors such as the intensity of the mental health

problem, the side effects, the course of medication and the outcomes with addition to negative life events and social values and norms.

In exploring the effectiveness of medication in comparison to general medication. Seemüller et al (2012) found in meta-analysis it has been shown there are small effect sizes and high placebo reactions within psychiatry. The authors however concluded with comparison to most medical drugs however psychiatric drugs are not much less effective. Though they contend that psychiatric patients and medication face more stigmas in comparison. However it is important to note there are fundamental differences in both physical and mental health, and it is difficult to draw a comparison of efficacy for the two in comparison to one another.

It is interesting to note however that in comparison of physical and mental health medication compliance, compliance was generally lower with patients who had psychiatric disorders (Cramer and Rosenheck, 1998). The researchers argue this could be due to multiple reasons including studies will vary on their definitions of compliance. Additionally differences could be due to the research designs and methods of studies. Therefore it cannot be said that there is a clear difference. It could be argued people generally do not comply with any medication, despite the effects of non-compliance.

It is important to consider however that in the UK the medical model is an accessible form of treatment and is free (Sheikh and Furnham, 2000). It is therefore more readily available to provide some form of support quickly. An article by Sammons and McGuinness (2015) discussed that in America most patients with mental health problems receive medication more than therapy, though most would prefer therapy. However they argue it seems preferable that patients receive both. As a combination of the two is most beneficial rather than one over the other and together can reduce costs in the long term. This could suggest the uses of more holistic treatment plans are important in providing support.

2.10 Medication and BME communities.

With regards to research on psychiatric medication and BME people, there has generally been little literature in this area, and even less was found in relation to south Asian women, it is difficult to paint a full picture.

Nye (2003) however argues that there has been an increase in medicalisation, with women, racial and sexual minorities being at the forefront of this. In an attempt to mask social issues with more individualised diagnosis.

Atdjian and Vega (2005), additionally noted biological differences to consider amongst groups, they argue "…effective use of medications with patients from racial and ethnic minority groups requires knowledge about the differences in metabolism of medications that are based on enzyme polymorphisms in different ethnic groups and knowledge about issues related to medication adherence." (Page 1601). It can be considered that ethnic minorities have different enzymes and therefore medication will impact different ethnic groups differently biologically.

Atdjian and Vega (2005) note that research of psychopharmacology for BME groups needs expansion. This includes the need to explore adherence to medication, which could be related to mistrust of services, and poor experiences with medication previously or fears around reliance and mental health stigma. They argue psychiatrists need to acknowledge their own biases and assumptions just as therapists undergo personal analysis. Psychiatrists must use self-reflection and explore their feelings around race. It is important psychiatrists do not believe that all BME members are homogeneous, rather understand differences within the group and the complexities of race and ethnicity can have a wide variance in identity and worldviews among members of the same group.

Interestingly, a study by Diaz et al (2005) found with a sample of African Americans, Hispanics and Caucasians, that African Americans and Hispanics had less adherence to psychotropic medication when factors like age, depression symptoms, disorder, psychotic symptoms, side effects and support were controlled for. This study looked

at a small sample however but it could be argued that further analysis needs to explore different types of medication, diagnosis, severity of mental illness and acculturation. However the literature was consistent with previous research in the US, this could be due to multiple factors including cultural awareness, language and beliefs.

2.11 Summary

The aim of this chapter was to review the literature relating to BME people in specific south Asian women and their experience of mental health, medication and social issues surrounding. It discussed the multiple issues and structural problems regarding race as well as difficulties within communities and mental health services too.

3. Methodology

3.1. Introduction

The purpose of this chapter is to specify the methodological approach utilised in this project. Here I will present the approach, philosophy and procedure carried out. This will include my sampling, data collection method, analysis and ethical issues.

3.2 Qualitative approach

I initially wanted to use a quantitative method. I was more comfortable with quantitative research. However a quantitative study would not have been feasible as my study was exploring experiences rather than answering something specifically or testing something. I also could not have conducted a self-study, as I have not experienced using medication for mental health problems. I also felt using an approach that entailed using interviews would be well suited with counselling research. I could use counselling skills within the interview session, however counselling is usually led by the client, whereas an interview is a lot more directive.

Qualitative research focuses on meanings and qualities of individuals. Qualitative research allows for exploration of social constructs, through an intimate relationship between researcher and participants. In order to seek answers, the researcher will explore the participant's social experience (Denzin and Lincoln, 2000). A qualitative method was useful as it allowed for more depth to be gained from the participant's experience. It gave the ability to explore beliefs and feelings, instead of a quantitative approach, which might be more numerical and structured with scales (Denzin and Lincoln, 2000). Additionally, McLeod (2001) argues using a quantitative method such as Randomised Control Trials may reinforce a medical model style methodology due to use of assessment, diagnosis or randomisation. I therefore felt in interviewing participants and using a qualitative approach I could provide an alternative exploration of the impact of medication.

3.3 Philosophy

I believe that for participants will have constructed their meaning and experiences of the world socially (Braun and Clarke, 2006). Therefore my focus would be less on the individual experience and rather I will attempt "to theorize the sociocultural contexts and structural conditions, that enable the individual accounts that are provided" (Braun and Clarke, 2006 page 85). Thematic analysis following a constructionist perspective can focus on latent themes, which are themes that examine underlying ideas or assumptions, in comparison to semantic themes, which are more explicit to what the participant has said (Braun and Clarke, 2006). Additionally the constructionist approach can be closer to deductive thematic analysis rather than inductive. This means the research is driven more by existing analytical interest and concepts, rather than through the content of the data itself (Braun and Clarke, 2006).

3.4 Bracketing Interview

As I am part of the south Asian female community, it was important to explore my own assumptions and preconceptions. I hoped this would enable me to be more reflexive in the research process. I decided to participate in a bracketing interview to recognise my own feelings and attitudes.

Bracketing interviews are a reflexive method to support research and increase the researchers understanding of the phenomena they are studying (Rolls and Relf, 2006).

I asked a colleague on my course to facilitate my bracketing interview. I gave him the interview questions I intended to ask participants. I asked him to ask me my motive behind asking each question and what answers I expected from my participants.

The bracketing interview helped me see why I wanted to research this topic and what I hoped to get from the interviews. I realised I was very focused on racial disparities and racism during my bracketing interview. This was important for me to reflect on as the participants may not have experiences that I focused on.

3.5 Research Method

Upon deciding to use a qualitative approach I chose to use thematic analysis as the method. Thematic analysis is a method for identifying, analysing and finding patterns in the data that are across all participants (Braun and Clarke, 2006). As a Braun and Clarke (2006) describe it as the foundation method of qualitative research, additionally it is free of theoretical foundations and widely applicable. In comparison to Interpretive Phenomenology Analysis (IPA), thematic analysis has a broader spectrum of philosophy; it can also be used in multiple ways and allows for patterns to be found across the participants (Braun and Clarke 2006).

Lastly Braun and Clarke (2006), provide a guide of thematic analysis, which is easy to follow and understand. Other approaches such as the grounded theory or content analysis seemed less clearly defined in comparison to thematic analysis, which had accessibility and methods of implementation clearly identifiable (Braun and Clarke, 2006).

3.6 Research Design

Semi-structured interviews were used for this study. Semi structured interviews have questions which are specified however the interviewer has the freedom to enquiry beyond the answers, and ask for clarifications and explorations (May, 2011). Semi- structured interviews are flexible, and allow the ability to explore concepts further. This can help in gaining more information from participants. Semi-structured interviews provide a balance between open and focused interviews as well. On one hand they have some structure to enable focus during the interview and on the other they permit openness and scope for exploration too (May 2011).

3.7 Questions

Each participant was presented with the same questions, relating to their experience of having a mental illness, the management of the problem and impact of

medication and then the social and societal impact and difficulties both within and outside of their community. Questions were all open, with prompts included; participants were later however asked two closed questions about their ethnicity and age.

In the interview it was important to use language that was simple, and comprehensible and appropriate for the research topic. It was also important questions were not leading (Oppenheim, 1992). Also participants were eased into questions rather than "what it is like to have a mental health problem…" instead "could you tell me a little bit about what it is like…" This could ease participants into a topic that is otherwise sensitive in nature.

Discussing mental health can be very sensitive; therefore towards the end of the interview, I tried to focus the last question on a positive area of what my participants experience could teach others.

3.8 Materials

The materials required for the interviews were my interview questions and a Dictaphone to record the interview.

3.9 Sampling and Selection

Sampling involves deciding whom the participants in your study will be to collect information from (Daniel, 2011). The method of sampling I used was snowball sampling. This is essentially recruiting participants from my own network of people that I know. This method of sampling is useful when it is difficult to access a wider population, especially a wider population specific to answering my research question (Daniel, 2011). The inclusion criterion was South Asian women, who both have mental health problems and have/had been on medication for this.

Table 1: Participant details

Participant	Ethnicity	Age
Marium	Pakistani	20
Noor	Indian-Mauritian	21
Fatima	Pakistani	22
Hannah	Pakistani	24

I tried extensively to get a wide range of participants and printed posters advertising my study and stuck them up inside community centres around Birmingham. I additionally emailed The Black, African and Asian Therapist Network requesting support in advertising my study to which they responded that they would share it in their newsletter. However it was only through my personal social media platforms that I found my participants. On my social media I advertised my study, which was then shared by my friends/acquaintances on their own accounts too, in order to assist recruitment. Four participants were recruited to take part in the study. From the table it is clear that participants were of a similar age group and mostly a similar ethnic background also. They all also identified as Muslim.

3.10 Procedure

Participants were initially emailed prior to the interview this email contained the information sheet attached. In order to carry out data collection, a Dictaphone was used in order to record the interviews. All interviews were then fully transcribed.

All participants were interviewed in interview rooms, three rooms were used, and two participants were interviewed at Keele University. Due to difficulties with travel to Keele University, locations in Birmingham were needed. One participant was interviewed in a room within the organisation Approachable Parenting and the fourth participant with Quakers organisation. Upon arrival participants were given a copy of the information sheet and a consent form to sign.

I had a semi-structured interview prepared, questions flowed one after the other. This was to assist me in advance with some structure and flow to follow as the interview went ahead**.** Furthermore the interviews were expected to last between 45 minutes and 90 minutes. At the end of the interview participants were given a debrief sheet, this sheet listed telephone numbers of supportive mental health organisations, as I was aware my topic was sensitive.

3.11 Data Analysis

The method used to analyse the data collected followed the six phases of thematic analysis by Braun and Clarke (2006). The first step is familiarisation, for this step I listened to the recordings repeated and transcribed the interviews myself. I felt this would help me immerse further into the participant's emotions and experience and really tune into their experience. I listened to recordings multiple times and read the typed up transcriptions multiple times.

For the second step I generated codes, by reading through the transcript. I did this using Microsoft word and used the comment feature to highlight interesting areas. A fully coded transcript can be found in**.**

For the third step I searched for themes. As Clarke et al (2015) describe coding is flexible and codes can be divided further or grouped. I wrote the codes out for participants on post-it notes to help me group them under themes. The fourth step was to review themes, and refine them, it was important here to ensure themes were supported by the data and some themes I found could be further divided and have subthemes to support them. The codes for each participant were put into a table and a table of codes was created to present them clearly.

The fifth stage, included defining and naming themes, Braun and Clarke (2006) describe this process as capturing the essence of the theme. I tried to name themes as to fit the codes they represented.

The sixth stage, is writing the report, which is in chapter 4.

3.12 Ethical Considerations

In order to keep my research ethical, an initial proposal was submitted to the School of Psychology Ethics Committee at Keele University, whereby approval was granted. Participants were provided consent forms and information sheets regarding information on the study and any potential harm. As part of the BACP (2016), non-maleficence is important in counselling. As counsellors it is important in research to avoid harm and be aware of the impact the study will have on participants.

Participation was completely voluntary and participants were free to withdraw, and withdraw their data within a week of the interview having taken place. In advertising for the study, I ensured participants were aware as the study was a sensitive topic, it was advised that if mental health problems had deteriorated for potential participants they should consider not taking part. Upon ensuring the consent of all participants, participants were also informed they were not obliged to answer any questions they did not feel comfortable with. The information sheet also contained a broad summary of the types of areas that would come up in the interview, the research this research was being carried out and that it would be analysed and transcribed.

Key to the BACP (2016), confidentiality was also upheld, participants were given the opportunity to choose their own pseudonyms and were aware that recordings would be destroyed upon completion of this research however transcripts would be kept. Participants were also aware of the length of time for the interview and therefore were provided times before and after the interview to ask any questions regarding the research topic.

Furthermore, initially I was only using interview rooms at Keele University and Approachable Parenting however, as one participant was unable to travel to Keele University and was familiar with the Approachable Parenting organisation, I arranged a third interview location for her. In order to prevent her being noticed as to taking part in my research in a location where she might be known. This is also a reason why I avoided undertaking interviews in interview rooms located in places such as mosques where participants may be well known to that mosque or community, so locality was also considered in upholding anonymity for participants.

All participants signed the consent form saying they were willing to take part and would have confidentiality and anonymity ensured throughout the process. As the researcher I was aware that having a mental health problem can be very difficult and I tried to be as sensitive towards participants as I could be. In one exchange, a participant began crying, to which I asked her if she wanted a break and if she was also ok to continue. Participants were also provided a debrief form at the end of the study containing organisations they could contact for further support.

4. Results

4.1 Introduction

In this chapter I will present themes that emerged from my data analysis. After completing interviews and using Braun and Clarke's (2006) six-stage analysis I identified five themes including four subthemes.

4.2 The themes

In order to find my themes, I had initially typed up codes on Microsoft word via entering comments as codes alongside the right hand side margin of the transcripts. Later I printed this and annotated the document by hand to group codes together. This process I did continually until I was able to narrow down groups of codes based on similarity.

I then wrote the codes out for each participant on post-it notes, looking for similar meanings to place them under. I came up with a theme title to capture the meaning of these codes and tried to see how they fit in the themes in comparison with the rest of the dataset (Braun and Clarke, 2006).

The main themes were as follows (with subthemes underneath the first three):

- Medication has been unhelpful
    - Alternatives to medication
    - Medication is a short-term solution
- Poor support from mental health services
    - More than one mental health problem
- Community was unsupportive
    - Family was unsupportive
- Easier to be white
- Mental health problems kept private

4.3 Theme 1: Medication has been unhelpful

All participants had negative experiences of medication. There was uncertainty over the medication and whether it had an impact. Hannah had previously taken antidepressants for 3 months and described the slowness of medications impact, "…not straight away it'll happen after a while…" (674-675). She went on to say, "…I can't analyse it because only 3 months long that I had it…" (708-709). Noor also discussed her mental health improving however said, "…I don't feel that's because of any medication… I've actually come off all medication..."

Further to this participants discussed physical and emotional problems and struggles on medication. Noor was prescribed multiple medications over the years. She described great difficulties whilst on medication such as "…developing asthma… I was overweight, I wasn't sleeping…I developed obsessive symptoms I could not function." She went on to talk about medication inducing, "…I've had about 4 suicide attempts…since I came off it I've not had a single attempt". She described psychiatrists giving medication and "…it keeps going up… to a point where you don't really feel human".

She mentioned Prozac as "…difficult coming on to it and I lost sleep". She said despite medication helping her "… it got me through my GCSEs", it seemed it eventually "…stopped working". Noor described medication saying, "I think medication numbs you… you…become a robot". The impact can even be on spirituality or religiosity.

There were also negative perceptions of medication, as Hannah described, "…I'd be emotionless…" (759). She also worried about relying on medication, "…I would've just got addicted to them" and questioned the benefit of medication saying, "…it could be a psychological thing" (941-944).

Fatima said medication helped "very little" with managing her mental health problems. She was taking medication more specifically for a symptom of her anxiety as she has struggled with insomnia**.** Although the medication helped deal with insomnia, she said, "it doesn't help as a whole…" and "…my brain would feel really

numb". She went on to say, "…you don't have the… activeness and the energy…" and described being told little about medication, "…Lack of information on the medicines". She mentioned a locum doctor tried to prescribe her antidepressants, which she felt was a "concern", "…a very visit… under 5 minutes and her conclusion was that I should take… medication for depression so I refused". She mentioned herself having a "lack of trust of medication" and believes there is reluctance in taking medication due to "being reliant on it or the side effects".

Furthermore, Marium experienced medication as helpful however she "…still had an episode" whilst on medication, though medication made it "less… intense". Marium herself has used medication on and off for some years, to help with anxiety. Marium talked about how medication can have a "placebo effect in that you become so reliant on them there not actually doing anything…"

4.3.1 Alternatives to medication

A subtheme to come from medication has been unhelpful, was the alternatives to medication; it seemed all participants wanted to seek alternatives to medication.

Hannah described her father gave her, "…vitamins that he gave me… stress relief vitamins" (918-923). Noor extensively discussed the use of alternatives. She mentioned, "…A stable relationship and a kind of healthy diet… there the two main things…" She also described her sister developing mental health problems "…at this exact same age as me she started… to get panic attacks and depressed". At this point Noor was already using alternatives to medication, so her sister also took this alternative root and Noor describes her sister after 3 years to be, "…fully recovered like she has maybe one panic attack every 6 months but her mood is quite stable…" she questioned herself, "if I had done that then would I have bipolar now".

Noor mentioned knowing a psychiatrist with a lot of bipolar patients who had not "…found one medication that has worked for life…" saying, "…you keep having to

update and change… you're never able to settle…" Noor firmly believed in a natural treatment, "…there are… physical causes which stem from the gut…"

Hannah also mentioned how medication was her last option after a friend advised her "…go through all your options…" and suggested to, "…go through the counselling… if it doesn't work… you need medication" (966- 981). Furthermore Fatima additionally described a preference towards counselling, stating "counselling and therapy in person that's far more beneficial for me".

Furthermore, Marium also mentioned using counselling to help herself with her mental health problems, she believed this would help, "figure out… underlying issues" and "…unlearning those patterns and behaviours…" She believed through counselling she would have, "better managing… strategies". Noor also mentioned she "...given it time or… proper psychological therapies… I might not have needed to go down this path…"

4.3.2 Medication is a short-term solution

A second subtheme to arise from medication being unhelpful was that it was also seen as a short-term solution.

Firstly, Hannah described wanting to avoid reliance and said she wanted "…to do this on my own without medication… imagine if it pops up again does that mean I go on medication" (960-962). Additionally Fatima similarly discussed, "I didn't want to stay on it for long… and neither did my GP want to so I didn't become reliant on it…"

Furthermore Noor talked about medication helping in the short term "…did relieve the depression long enough for me to catch up" however felt "…in the long term I don't think it's a solution for me…" Marium additionally, discussed "I don't really like to use meds I don't want to rely on them" and they were "not something I want to be on permanently…. 5-10 years from now when I'm… in a job… or have a family…"

4.4 Theme 2: Poor support from mental health services:

The second theme to emerge was poor support from services, this was found for all participants for varying reasons. Firstly, services were inadequate in providing help, Hannah, "…you should've come when you felt like something was wrong with you or when there was a change in your life or you felt like you were low" (1253- 1256). She further discussed struggling with the home therapy service she was provided which would be "15 minute" and "…every session they'd be different people… how am I gonna just… start again with you". She said, "I hated that… please don't come again" (576-603).

Services really lacked for participants as Fatima described "…you're still on a waiting list… and their like… should we be giving her medication… should we be… giving her therapy…' and "things are just getting worse and worse". For Fatima she was "relying on university… rather than professional the GP services". Fatima went say "…because the support is… delayed… you feel… there is no support there".

Additionally Noor described difficulties with mental health services, she discussed her sister being pushed by psychiatrists to take medication "…force her to take antidepressants… though she didn't want it…" She went on to describe psychiatrists making accusations against her parents, "…implying that she was not being looked… after properly…" However she said "…she was 16… so her voice mattered" and she was able to consent. Noor also went on to talk about receiving CBT from a psychiatrist however found this unhelpful; "the psychiatrist was very… cold… it didn't really help me".

Furthermore Marium described a range of issues experienced from mental health services, she described waiting "a very…long time with medical professionals to get the help I needed". She described feeling "…let down by the NHS it's been a really difficult…" She mentioned anxiety was not "picked up by medical professionals… it wasn't taken seriously until I was hospitalised..."

Marium described a mixture of experiences with White and Asian professionals (the issue with an Asian GP will be discussed later in the third theme). A white psychiatrist, she said "…laughed me out the office and was like oh no you don't meet the physical criteria… you can't have this illness" (Marium does not state what this problem is during her interview).

Due to difficulties with services Marium said she was "generally with all medical professionals I'm closed off…" and "against… counselling and medical help…" She mentioned "…even if I say something's wrong their gonna be like no you're fine". In her experience of counselling, a school counsellor told her "you know what you're doing to yourself is wrong but if you want to keep doing it then no one can stop you". She described this as "almost like getting validation for these behaviours", saying, "…From someone who's meant to be a profession… again that was… a white lady…"

In the last question asking what she would like to share with other Asian women, she said, "a lot of us will first get told by a doctor that it's not an issue" but to remain adamant is "something that you have to do to make yourself well".

4.4.1 More than one mental health problem:

A subtheme to emerge from poor support from services was more than one mental health problem.

Participants struggled with more than one mental illness. Hannah described taking antidepressants however "… in that time yeah I was suffering a lot from anxiety… like having panic attacks" (843-844). It seems services struggle further to deal with multi-layered and multiple mental health problems.

Fatima additionally described struggling with anxiety however, also waiting for confirmation on a diagnosis for Borderline Personality Disorder, saying the process of diagnosis began during the first year of university and now she is almost finishing

her degree and “still suffering with it”, “because of lack of knowledge I’m still sitting here… with… a…incomplete diagnosis”, saying “…my GP doesn’t really have a clue”.

Moreover medication became complicated due to a second mental health problem, Noor said medication “…for chronic illnesses” was “not the best solution…” she described being in school and on antidepressants, “…it was… pushing me up to a normal level but once I got to the normal level it was starting pushing me into hyper mania”, at which point she was diagnosed with Bipolar. She went on to talk about taking combinations of medication and alternating between medications as “it stopped working… I was going too high because of the antidepressant so she put me on…antipsychotic”. She described being on 3 medications at one point and “… it was… very intense… I tried to wean of 2 of them…” and described constant adjustments “…there’s a 6 week period there you adjust and then they work”. Noor went on to say she felt the medication “…changed my brain chemistry and I don’t think I naturally have bipolar I think it was induced by the medication or at least triggered severely by the medication…” she continued to say “…you’re not supposed to give antidepressants to people with bipolar… it’s kind of all mixed up…”

Furthermore there were issues finding the correct service and meeting diagnosis criteria’s. Marium discussed waiting to see specialists for an issue separate to her anxiety however due to her having more than one mental health problem, the non-anxiety specialist did not want to see her. They were “…concerned that the CBT will set me off with this other mental health issue”, so she was waiting for support for anxiety. Although the other specialists “were happy to work on… both”, however Marium said “…I’m not working on it with the correct department”. She mentioned that being “physically… recovered” also adds complications, “…just because you seem physically recovered doesn’t mean you’re mentally well”, Marium described her issues to be complex and “interlink quite a bit”, so getting help from one department only is “tricky”.

4.5 Theme 3: Community was unsupportive

A third theme to emerge was the community not being supportive with mental health problems. For example, Hannah she mentioned her best friends saying, “they weren’t like your typical Pakistanis”, in that they supported her and “didn’t regard it as nothing”(1083-1089).

In terms of Hannah’s relationship with her GP she described only opening up to her “…because she was white …if she was Pakistani… no way I would have…” Hannah said this was “… even though she’s a GP… I know what the communities like…” She said, “people judge you”, although she felt differently about a counsellor in comparison“…a Pakistani woman if she was a counsellor I’d open up to… cause she’s a counsellor if she’s a doctor… I wouldn’t… thank God she wasn’t Pakistani” (1749-1808).

She discussed that “…people think schizophrenia’s mental illness or…. bipolar… but depression isn’t a mental illness… my family friend… talking about her daughter… going through depression…saying… it would be shameful… if she had people come to their house or counsellors…embarrassing… I feel like she talks on behalf of a lot people in the community” (1333-1378).

Marium also discussed issues with her Asian GP “…my doctors were generally south Asian… they weren’t very helpful… or supportive… it was a very difficulty battle with them”, saying, “…It just felt really awkward”. Marium felt GPs could have the “same sort of stigmas”. As she described an Asian doctor who laughed at her anxiety saying “…you’re too young what do you have to be anxious about like me and your mum… now we have stuff to be anxious about”.

There was found to be a lack of space in the community for example Fatima discussed there was no service “…there’s no communication and there’s no connection”, “it makes you feel like isn’t anybody…I identify with a particular religion… if people could come at these issues from that angle… I’d feel really…secure”. She said, “…There was no one that I could tell… even a mosque… where you could go to…and talk about it…”

It was also found the community was perceived as judgemental. Noor, described "judgements that people pass" in the community. She mentioned comments from the older generation like "…she's got an illness she's on medication how'll she get married" or "…go to university". She mentioned, "There's stigma around mental illness… " Although she said "…I haven't overly suffered but I don't really get into the community that much…"

Marium also discussed in the community "…they'd be a lot of judging". She added her extended family "…take it very much as a joke… it's not something to be laughed about I was hospitalised…" and say things like "oh you can't ask someone in the shop for this haha that's so funny". She also mentioned the south Asian community focusing on religion more and advising her to "…pray more and that'll fix it".

4.5.1 Family was unsupportive

A subtheme of the Asian community not being helpful is the lack of support from families.

There was difficulty in approaching parents, and parents did not understand or support participants. Hannah described her father had told her; "…no one can help you except… your faith" could help her (145-146). He did not see counselling helpful "I was getting counselling and he didn't really think it could help me…" although she said, "I don't… think… he felt ashamed"(1516-1535). She continued, that her father did not support medication use, "… cause my father's a pharmacist… he really was against me going on medication… he was like… you know the side effects are not good…" (689-698). Hannah also struggled approaching her parents "…approaching my parents was really difficult… I didn't want to scare them… to think I was this person… out of her control… I didn't want them to… give me extra care… I just want them to treat me normal" (66-79).

She further described a family member who was Pakistani and described her views of "…depression… it's not mental illness…. She regards it as… just your mind… you don't need to see a doctor… follow your faith…" Hannah felt "…faith can help… but… it is a mental illness… people don't regard it as… mental illness…" (1012-1021).

She described her father, as "…his mentality was…more like your typical Asian person… like that family friend I was talking about…" (1227-1233). In a comparison of how she felt her parents would respond to having mental health problems compared to herself she said: "…I think they would be more secluded about it… not go… into emotionals… relying on religion…" (1307-1311).

There was also a lack of understanding, as Fatima said, "I'm in a family that doesn't really understand mental health issues… they don't have the knowledge of it…" Moreover Fatima described being able to discuss her mental health with family members who were more aware "…my… cousin… she's educated here… she doesn't have the stigma around it whereas other family members would…" however "…there are not many people from my Pakistani family that i can just say… and convey to them… you really have to put it out there… she is really unwell you have to take her really seriously…" She also questioned whether it "…could be something of the community" as she comes "…from a family that… emphasise the side effects of medication…" Although she concluded medication for her "I still don't think that's really beneficial".

Noor also struggled with her family, she did not tell her parents for a year, "…their first reaction was… no you're not cause I said I think I might have depression… they said no you don't you know were doctors we know what it is…"

Religious reliance was also seen as a means for support, Noor believed there is a "…misconception that… if you're truly… a good Muslim…you can't get depressed… because you… love God and it gives you happiness…my dad… had a slight… lent towards those views… that makes it difficult if you are a young Muslim woman or

Asian woman and you do feel depressed… you feel like it's your fault… you should be stronger in your faith or… a better person… "

Additionally there was a lack of support as Marium mentioned, "…My parents didn't want me to be on medication… their still really… against it… it took a long time to get them to… be ok with me taking it sometimes".

4.6 Theme 4: Easier to be white

The fourth theme to emerge was it was easier to be white and have a mental health problem than it is to be Asian. There were more barriers as an Asian person, as Hannah described, "…Maybe… it's… in my head that I'm Pakistani… I shouldn't talk about these things…maybe if I was a different… race… I'd be more open… or maybe I would go and see a counsellor… made decisions very early on…" its not frowned upon… but it in our community…" (1432-1458).

It was also found that the outside community was more understanding as Fatima felt that "in the non-South Asian community at least I was able to speak about it… they were more caring to understand". She also said "they realise that I don't come from a white-English family so my issues are different… they would research things…they would try to understand…"

It was believed mental health was easier to discuss with the white community than Asian. Marium believed that the white community talked more about mental health, "…just because they have a friend who's gone through it or they have a family member… and like talked about it", however in the Asian community mental health is kept "…very hush hush and not talked about...they (the white community) see it as… an actual mental health issue as opposed to… something fake…" She believed in the white community here was "…less judgement… I think it's a generational thing as well… our generation… generally… a lot easier to talk about this stuff… the older generation it's more difficult… they'd rather… shut it down… close their ears… pretend it doesn't exist".

By comparison with the Asian community she felt “a lot of similar issues within the afro… communities… the white-English community it’s not seen so much as fake illness it’s seen as real… it’s very much acknowledged… they might not like to talk about it as much but they accept that it’s real”. “Whereas within the south Asian community it’s very much oh it’s in your brain just don’t think about it… the white community… know more about resources…”

Marium believed “…there is more stigma in the south Asian community there is still a lot of stigma in the white English community… it’s just slightly less… it’s still not seen… as ok to but mentally ill… but it’s acknowledged that people are and there is help…” Marium mentioned white friends “…who’ve been on meds… their parents are really supportive and their perfectly fine like sharing it with everyone”.

Cultural differences were found to be an issue. As Fatima said she still felt “…if you’re not part of the culture the smallest… of things need to be explained.” She described an experience “I needed… a deferral for an assignment … the staff members didn’t come from my… community… they didn’t understand certain things in which my home would work… responsibilities… expectations... the culture… they were actually being quite harsh in trying to make sure that I don’t get it… another staff member had to then input and say that no you have to remember… she doesn’t have the ethnicity of other students here you’re treating her like any other student…” In response to the question regarding what would be different if her GP was a member of her community she said “things about my culture… if someone from my culture they’ll be shocked by… but they… will understand… my… GP are… not from my community… they don’t know how to… respond…you can sense… awkwardness…”

There were also issues around bullying and discrimination. Noor talked about “…being bullied for being mentally ill and for being on medication”, she mentioned her experience in school, “…no one would talk to me and people would tell me you shouldn’t be here you’re dangerous you should be locked up”. She mentioned that

teachers were part of this, "… they thought I was making it up for attention… they'd join in… laughing at me and they'd ignore me."

She mentioned a specific incident, "…French lesson… I was about to have a panic attack… the teacher stopped the lesson said oh girls look and then they turned around to me and she goes Noor there's no such things as ghosts calm down cause sometimes I would hallucinate…"

She further added, "They used to have meetings on how to handle me … if I were to have a panic attack… no one was to support me…" She went on to describe that she appeared differently to other girls, which could tie into her Muslim and Asian identities, "I was… the only girl that wore a long skirt to school cause I cover I wear a headscarf… they just…preyed on that…"

She mentioned she was "already… bullied for… being Muslim… the teachers… they weren't too fond of Muslims so in RS… when we got to Islam the first lesson on terrorism…. we got news articles about terrorism… the next lesson was on… the face covering the niqaab… which isn't even a… essential part of Islam…" and said "…I was already being isolated and teased and bullied for being… in the minority… when I got… a metal illness it became worse".

She said she felt that being mental illness was less accepted in the Asian community, "…outside my community… it's an accepted thing…in the south Asian community especially for young girls there is… enormous focus on getting married… whereas outside of the community marriage is something that… may happen may not... it's not usually arranged…" However she felt "...it's more the older generation…"

Other instances, which she felt she might have experienced some discrimination, included with paramedics and security services, "…at university an ambulance was called… and the paramedics were very… harsh… I can't tell whether it's discriminating against me being... south Asian… wearing a…head scarf… or whether it was just they would… do that to anyone… " Similarly in during an episode, a

security guard at a train station approached her and was "…not being very sensitive", he was "…quite rough handling me…"

Further to this, whilst receiving CBT with her psychiatrist, when she told her psychiatrist about how the girls in her school treated her. "…I was telling him… the girls… whisper across the classroom… the teachers they also do this… he didn't believe me…" Additionally, her psychiatrist struggled to understand the importance of Noor's faith "…he couldn't understand… my faith and how I… got comfort from God and prayer… he kind of dismissed it".

4.7 Theme 5: Mental health problems kept private

The fifth theme to emerge was mental illness kept private. All the participants had many problems, difficulties and issues with their mental health. Hannah described many struggles with her mental health saying, "…I didn't understand… what was happening to me…" and "…I didn't know I had it because I didn't speak about it to anybody…" (18-28). In addition to this Hannah described feeling afraid "…I was scared for myself… sometimes I'd wake up in the morning and it'd be like… is it gonna be today? ... Ah God (starts crying)…" (44-49). This could have further extended feelings of isolation and the impact of her mental health problems.

Fatima additionally mentioned many difficulties with her mental health "…I didn't… know… I had… mental health issues". She continued saying "…I couldn't go to university" and felt her mental health was unpredictable"…Like feeling on edge not knowing what to expect… " Complications can add to feelings of loneliness as she discussed, "…The fact you're not sleeping makes you even more anxious" and she struggled with others, such as a manager at work "…I told him… I'm suffering from anxiety and… no sleep it ended… negatively".

Furthermore Noor in describing her struggles with mental health she mentioned which could add to further isolation "…I missed about 2 years of school I was barely

there", which could add to further isolation and really pushing to get the support she needed "…I received good support… because I've asked for it".

Additionally Marium described struggling with anxiety as "…one time I had to run out of the lecture because I was about to throw up…" This has had an impact on her ability to travel as well "during holidays I get really ill flying…" which could further isolate her from others. As well as her initial denial of her anxiety "…it was very easy to deny it" though she advises other to "…keep listening to that part when you get shut down first".

All participants tried to keep their mental health problems private as Hannah said, "…I didn't want to talk about it… it was like… in your head… like nobody can understand you"(267- 269). Later adding, "…I know that my friends wouldn't understand" (1557-1559) and even keeping her medication use private "…there wasn't many people that knew I was on medication it would just be my parents" (882-883).

Fatima described feelings of loneliness saying, "…I can feel lonely… but I'm not in a lonely environment". Fatima said, "…I was more comfortable contacting someone online… I haven't met this girl in person…" However Fatima said, "…there is a lot of stigma… people don't really… stop to realise… that some people are trying to reach out…" Saying that after telling a friend "it either freaks her out or she doesn't understand it…"

An incidence she describes in particular is of an organisation called Picarus that are related to suicide prevention visiting University. She said, "…they came into my university… we had a day… about mental health and suicide… but only 3 people turned up…"

Noor described initially using the Internet as a source of support "…I joined a kind of internet forum for people with struggles who just wanna talk… there were one or

two people… they were kind of my friends… or support…" Lastly Marium kept her mental health private saying, "…I don't really tell people that I'm on medication…"

5. Discussion

5.1. Introduction

In this chapter I hope to provide an interpretation of the results that I have obtained, using relevant literature. I will then discuss how this research could have been improved and suggest further research.

5.2 Theme 1: Medication has been unhelpful

The participants had all found medication unhelpful to some degree. Hannah mentioned uncertainty over the impact of medication and negative perceptions whilst Noor described struggling with side effects. Haddad et al (2014), argues non-adherence itself to medication can happen with any chronic medical illness. However they argue it is important to note with a disorder like schizophrenia there are also factors like social isolation and stigma. Therefore improving medication adherence could mean simplifying the medical treatment and explaining it clearly with well-managed side effects and therapeutic relationship between clinicians and patients. As Fatima described concerns around being offered medication within a 5-minute encounter. It is important to also note negative perceptions could stem from stigma around psychotic medication. In regards to the uncertainty over the impact of medication as Kirsch et al (2008) found medication may not always be effective.

As Fatima described being poorly informed about medication. A study by Fleischhacker et al (1994) found with anti-psychotic medication the compliance rate improved when patients were informed of risks and side effects with addition to recognising and treating the side effects as well.

Furthermore Eisen et al (1990) found compliance to medication improves with dosage reduction; this is interesting as Noor described greater difficulties around dosages constantly changing and adjusting to this.

As previously mentioned Hispanics and African Americans had less compliance with psychotropic medicine in the US (Diaz et al, 2005). It would be interesting if there were a lower adherence amongst BME groups in general.

Furthermore Johnsen and Friborg (2015) a meta-analysis study looking at 70 studies between 1977-2014 found cognitive behavioural therapy was increasingly less affective in treating depression. Interestingly it seems women might benefit more from therapy than men, and more experienced psychologists had better outcomes than less experienced with their clients. The results could be due to the popularity of therapy, and inexperience practitioners becoming more available. Additionally it might be seen as a curative therapy and may not live up to that expectation. This raises a question of whether a placebo effect could have the same effect for talk therapy as it can for medication.

5.2.1 Alternatives to medication

Interesting all participants described wanting to use counselling. Noor and Hannah described to use more organic means of recovery such as vitamins. In a study interviewing Muslim Kashmiri women, it was found they the majority saw value in counselling, however were prevented from using counselling due to language barriers, concerns of confidentiality, cultural understanding and accessibility. It is also possible healthcare professionals may not see counselling as suitable for this group (Shoaib and Peel, 2013). It is noteworthy however that all the participants in this study were students or graduates of British universities, and despite wanting counselling, it seemed medication was the first option.

It was also found in a study interviewing 27 African, African Caribbean and south Asian women, 19 of 27 had access to therapy with mixed views on the helpfulness of therapy. However 9 had no form of intervention that was not medical. For most of the women recovery was associated with being free of the need of medication. Only some of the women, could understand their mental health within the medical model, and understand their symptoms and diagnosis. The women often saw the

side effects of medication as impacting recovery. However they were agreeable with the views and knowledge of specialists. Though it was clear that participants saw a distinction between actually recovering and using medication for stability (Kalathil, et al, 2011). This could be used to understand why participants sought alternatives to medication and even saw it as a short-term solution, as participants mentioned short-term stability but not long term.

5.2.2 Medication is a short-term solution

For all participants medication was a long-term solution. In a report exploring the barriers preventing BME people in Redbridge from seeking help from mental health services. Interviews conducted with south Asian, Jewish and black Caribbean men and women. It was found that participants felt that practitioners did not have much time for them and antidepressants often perceived as a default solution or that mental health problems were ignored. It seemed despite using medication, biological or medical causes were hardly discussed by participants (Keynejad, 2009). Similar to this my participants did not describe or talk about biological or medical issues despite the research being on medication. It is possible the lack of support or understanding around medication had led to time limited use of it.

Furthermore, Kalathil et al (2011) medication is seen more for stability than an actual means of recovery. All the participants wanted to be medication free or at least use it in urgencies only. It is clear that there are many issues in using medication, it seems that more support is wanted in a holistic sense rather than just medically.

5.3 Theme 2: Poor support from mental health services

Participants with regards to services described multiple issues. For example services telling Hannah she came for help too late and Fatima described having to wait. As Keynejad (2009) found for BME people long waiting lists made seeking help seem unnecessary.

In relation to seeking help late, this could be related to potentially seeing mental health problems as physical. A theory described by Pilkington et al (2012) called the theory of reasoned action, proposed by Fishbein and Ajzen (1975). According to this behaviour is impacted by the intention to perform that behaviour, and the intention is influenced by the individual's attitude regarding performing that behaviour with addition to what the person believes others think about the behaviour also.

Pilkington et al (2012) therefore suggests that beliefs about the causes of mental health problems affect how services are used and whether they are used. For example south Asian people are more inclined to somatise symptoms than other BME groups. Therefore they believe there is a biological/medical reason for their problems, therefore using therapy might be more difficult in comparison to using GP services.

Anand and Cochrane (2005) postulate there are differences in beliefs regarding symptoms, causes and treatment of mental health across all cultures, this will then impact both reaction and treatment. For example they argue that south Asian patients are more likely to somatise their symptoms and view it through a physical lens of physical discomfort and so a GP might see their problems as physical rather than psychological. In Marium's case her health was not taken seriously until hospitalisation.

Furthermore Marium's experience of dismissal or lack of acknowledgement of mental health problems by services has been found previously in research showing lack of acknowledgement of psychological distress for Asian women by services (Wilson and MacCarthy, 1994). However an explanation for this was due to patients' language and experience, though my participants were all British born university graduate/students. This could raise other concerns potentially like stereotyping the needs of Asian women (Burr, 2002).

As Hannah described her support was inadequate and inconsistent. Gilbert et al

(2004) also argued there was a lack of mental health awareness within the Asian community and barriers to getting help. In addition to stereotypes around Asian culture being collectivist it is possible the Asian community is becoming increasingly isolated and not noticed when they do need help.

Furthermore with Noor's experience of her sister almost being forced to take medication. Bhui et al (2002) looked at south Asian men's experience of mental health services. They found that the men often felt the assessment failed to understand them, other than language; there was a lack of structure within the assessment to fit their needs or allow them to raise concerns. The men found that treatment was authoritative and regarded religion less. Their mental health problems were also not clearly explained to them. Though this study looks at men, it represents wider issues regarding cultural sensitivity within services and authoritative use of practise. Hatfield et al (1996) argued Asian people were more reliant on GP services; it is worth noting however in Noor's example that services could be responding simply through medicalisation.

5.3.1 More than one mental health problem

There was little research on the impact of multiple mental health problems have on the experience of medication for BME groups. A lot of research looked at substance misuse in relation to having a mental health problem or physical health problems and mental health problems.

In Noor's experience, more mental health problems meant varied and higher dosages of medication. Though as previously mentioned Eisen et al (1990) found lower dosages of medication, improved compliance. Further to this issues included issues with the diagnosis criteria and services for Marium and slowing down the diagnosis process for Fatima. Hannah also described using antidepressants though suffering with anxiety and panic attacks. This represents the need for further research and development in this area.

Maj (2005) explains that comorbidity is a term used when someone has a diagnosis for a mental or physical problem and then receives an additional separate diagnosis. In the case of someone having two psychiatric diagnoses this is psychiatric comorbidity, which is becoming increasingly common (Maj, 2005).

However, Maj (2005) argued there is an issue around getting an additional diagnosis; this is because it is difficult to know whether one mental health problem could have multiple manifestations. Thereby assessment and diagnosis models might actually be failing to recognise all parts of a disorder. Maj (2005) continues that disorders can be split into many parts and this can lead to professionals focusing on different parts separately rather than holistically.

The separation of disorders within diagnosis itself can lead to more diagnosis, however practitioners might be failing to recognise that rather than what is perceived as comorbidity of multiple disorders, could rather be a transformation or adaptation of a single mental health problem. This oversimplification is not just in diagnosis but also in symptoms, and disorders may not always reflect current diagnosis criteria (Maj, 2005). The complexity of diagnosis and understanding whether there is potential over diagnosis of BME people is important. As there has been found to be overrepresentation of BME groups in mental health systems (Care Quality Commission, 2010).

5.4 Theme 3: Community was unsupportive

Noor and Marium described issues around older generations not understanding their mental health problems. Furnham and Malik (1994) found that in a comparison middle-aged Asian immigrants differed from middle-aged native British people and young Asian in their beliefs of depression. Middle-aged Asian immigrants had attitudes emphasising the importance of family over the individual.

Pilkington et al (2012) in comparing British born Asians with a migrant sample argued migrant samples might be more likely to hold different views of mental

health and this can impact help seeking behaviour. Being British born could mean that access to education and acculturation to Western culture and understanding of mental health could impact the understanding differently for younger generations of Asians.

However Pilkington et al (2012), recognises that the number of participants within the group was small, additionally migrants to Britain having higher levels of shame and izzat related to them than British born citizens could be due to differences in the understanding of mental health in Asian countries and Britain. It was also found that religiosity levels did not significantly predict intention to seek support. However the sample could have been biased, as there was little variability of religiosity within the sample anyway. Moreover it is possible British Asians might be more comfortable and familiar with using a questionnaire method compared to migrant individual's, in addition to the questionnaire being in English.

Hannah and Fatima also discussed issues like judgement from the community and stigma. As Bhardwaj (2001) found that self-harm amongst Asian women related to expectations of being part of British society and the Asian community. The conflict of the two cultures can potentially create additional complications in dealing with mental health problems.

Additionally, it was found seeking help from mental health services raised concerns around izzat and confidentiality (Gilbert et al, 2004). Interestingly Noor did discuss comments in the Asian community related to marriage, which could relate to family honour. This can relate to social rank theory in terms of wanting to uphold honour and not expose mental health problems via seeking help (Price and Sloman, 1987).

The idea of honour and shame creates nothing more than a delusion of respect and status beneath which are the women pushed into positions and roles, which are expected to uphold these concepts. And once a woman is spoiled by shame, this can stay with a family for generations (Adams, 1998). This is a representation of a patriarchal structure within another culture.

Additionally Marium and Hannah felt Asian GPs would have similar stigmas and assumptions that the community had. It would be interesting to see how the race of the GP could impact the treatment people with mental health problems receive. A study by Cooper et al (2008) found accident and emergency staff assessed south Asians more than mental health specialists did in comparison to white people. Staff also rated south Asian people to be at lower medical risk and harm to self in the future. They were more likely discharged from emergency services and this was without further referrals to other services, and referral to GPs. Whereas white people were more likely to be referred to specialist services including medical and psychiatric. South Asian women also did report more family and relationship problems in comparison to white women. It is possible also that Asian GPs might be internalising stereotypes about their own communities and basing diagnosis and treatment of that. As Burr (2002) argued internalising stereotypes impacts treatment and diagnosis for GPs in general.

Gilbert et al (2004) argues further, there is an issue with the lack of awareness of mental health services within the Asian community and barriers to services. In stereotyping collectivist cultures, and reinforcing the idea that Asian people do prefer to find support within their families. It possible then to isolate communities more and more difficult for Asian people to then access support or become more aware of services.

5.4.1 Family was unsupportive

Families were found to be unsupportive for multiple reasons. Hannah and Noor described religion being suggested as a means to help with mental health problems. Though religion can be helpful, in an interview study by Cinnirella and Loewenthal (1999), they compared White Christians, Indian Hindus, Afro Caribbean Christians and Pakistani Muslims. They found religion for the Pakistani Muslim and Afro Caribbean community impacted their ability to manage depressive and

schizophrenic symptoms. Although this can be a helpful coping means for some, it might be presumed by families to be the only means.

Furthermore, Bhui et al (2008) interviewed 116 people from six ethnic groups. It was found religion was not always a necessary coping mechanism. Though mostly Bangladeshi Muslims and African Caribbean Christians practised religious coping when it came to mental health problems. Methods of using religion to cope included talking to God and praying. The researchers found it was difficult to distinguish between cultural and spiritual practises for religious coping specifically with Muslims. It is clear that for some groups of people religion holds great significance.

Fatima described her family not understanding mental health. Keynejad (2009) found many south Asian people found talking about mental health was difficult and they felt more isolated and may even be unaware of services. They also felt they could not talk to their families or had little family support. Additionally as Fazil and Cochrane (2003) found Pakistani women had more social than personal issues, and experienced more isolation and stigma.

As Noor struggled to convince her parents she had mental health problems and Marium's parents struggled to come to terms with her problems. Gilbert et al (2004) found that upholding family honour related to personal shame for south Asian women and noted the lack of awareness of services within the community. As Kalathil et al (2011) found that BME women often found themselves unable to fulfil their social, cultural and family norms and this impacted their mental health.

5.5 Theme 4: Easier to be white

Noor described a lot of discrimination and bullying, which could have related to being Asian, Muslim and having a mental health problem. As Laird et al (2007) described that through media and within the political atmosphere, Muslims are often seen with negative stereotypes.

Keynejad (2009) contends, “The context of Islamophobia and fear of terrorism today and the heritage of colonial occupation and the slave trade must be acknowledged. There are profound reasons why ethnic minority groups will be suspicious of and reluctant to seek help from large scale institutions such as the mental health service, which are perceived to be White-dominated and therefore threatening” (page 54). Without acknowledging BME groups’ feelings and needs, further isolation and stigmatisation is created.

With regards to racism, Kalathil et al (2011) argued that internalising racism could reduce self-esteem too. With the addition of stigma in mental health, this can lead to discrimination and stereotyping, which can have negative impacts (Gary, 2005).

Cultural differences were also found to be an issue for Fatima. Bowl (2007) argues lack of culture awareness lends to problems understanding people’s words and behaviours and can lead to incorrect diagnosis or exclusion within services. Lack of cultural awareness may lead to GPs failing to recognise psychological suffering in BME clients (Bhui, Christie and Bhugra, 1995). This can lead to further issues, as Kalathil et al (2011) argues that gender based discrimination, similar to racial had a harmful effect on identity, self worth and self-confidence if this was internalised such as suppressed woman.

Conversely it was also found that all participants felt their mental health problems were easier to discuss within the majority white community in comparison to Asian. However as Furnham and Malik (1994) described this could be due to similar views between young Asian females and white females in comparison to older Asian females. It is possible there is the impact of acculturation here, in which young Asian girls may have adjusted more to the social settings and understanding of mental health within Western culture (Gibson, 2001). The community in general was found to be less understanding. This could be to do with issues around stigma and honour (Gilbert et al, 2004). Although Sheikh and Furnham (2000) found culture did not always mediate help seeking behaviours.

Bhui and Sashidharan (2003) explored whether it could be more beneficial to have separate psychiatric services for BME people. In their argument against, they contended there is a need for mainstream change rather than small incentives, and by making small incentives; this implies less importance with regards to BME group needs. Additionally they argued cultural competence was crucial across all groups rather than seeing culture as presenting issues only for minority groups. However in terms of arguments for separation they discussed continual failure of professionals in providing adequate support and assessment for minority groups, inequalities in services and growing dissatisfaction from BME groups. They argue however rather than "continuing flirtation with outdated ideas from our colonial past" (page 12). It is important to now critically reform mental health services to meet the needs of minority groups.

There is a need for greater support and reaching out earlier within BME communities. When viewing families as repressive towards a gender the family is seen as dysfunctional and the focus is the family rather than wider social issues (Bhardwaj, 2001). Additionally in categorising and defining cultures from an outside perspective instead of a self-describing way from within the communities, communities are built on an understanding from others perspectives rather than their own (Bhardwaj, 2001). As Burr (2002) notes the assumption of Western supremacy, creates more barriers for the south Asian community.

Bhardwaj (2001) argues shame and honour are based on things that are seen and not seen, so if they cannot be seen they cannot bring shame or dishonour. Both these concepts can be inclusive and isolating, and these beliefs can lead to oppression. The power dynamics based on patriarchy maintain issues like dishonour and limit expression therefore limiting service intervention.

5.6 Theme 5: Mental health problems kept private

It was important for all participants to keep their mental health private. Pilkington et al (2012) argues that in the Asian community, shame is a complex system, whereby

protecting family honour is key and maintaining a position within the community. Therefore seeking support can be influenced by what a person thinks is believed appropriate by others and there is a risk of bringing shame to families and the family status in the community otherwise.

Furthermore, Ciftci et al (2013) also discussed that group identification can be crucial in dealing with stigma. They note that some Muslim women might not share personal information or seek help because of the fear of negative consequences on potential and present marriage. They argued that additionally Muslim American college women in wearing the hijab reported concerns from both parents and society that they were visibly Muslim, there are already concerns around how they perceived. Having a mental health problem could potentially stigmatise people further.

In this review by Ciftci et al (2013), the following was said "normative cultural beliefs in the existence of jinn (evil spirits) may be confused with delusions of possession and control… may prevent patients and family members from recognizing medical or psychiatric problems (El-Islam, 2008)" (page 24). Although I agree that the idea of jinn possession can lead to failures in recognising mental health problems. There are is an error in Ciftci et al's (2013) account, jinn are defined as 'evil spirits' though from my Islamic knowledge jinn's can be both good or bad, again missing the complexities of religion. Moreover the researchers use of the term 'delusions', further stigmatises people's beliefs, whilst making 'medical' and 'psychiatric' models the western interventionist solutions that are going unrecognised. Just with the wording, research articles almost put religion or culture and mental health at odds with one another rather than reconciling these components.

Furthermore Ciftci et al (2013) argues that public stigma can lead to prejudice and discrimination which impacts access to education, housing, employment etc. There are many stereotypes around mental health problems which might lead to keeping it private. Ciftci et al (2013) also argues self-stigma, which is the internalisation of stigma can create further barriers. This can be understood in the following

components, there is the awareness of stereotypes related to mental health, this can be followed by agreement which is agreeing with the stereotypes, this is then proceeded by application regarding whether the stereotypes are believed to apply to the self, lastly there is harm, which can be on an individual's self esteem (Corrigan, Larson and Kuwahara, 2009). This could create further complexities in coming to terms with mental health problems.

All the participants described struggling with their mental health problems as well and this could be worsened by the lack of access to services. As Pilkington et al (2012) argued that within the south Asian community, Muslims are least likely to access psychological services.

Furthermore in keeping mental health private it was found by Pilkington et al (2012) for south Asians high level of shame and izzat was correlated with less intent to access services for help with mental health issues. They argued this could be due to the collectivist natural of the south Asian community. Additionally it was found that high levels of education and acculturation related positively with intent to access services, however biological beliefs about mental health problem causes, shame and izzat were negatively related in predicting the intent to access services.

Pilkington et al (2012) argues that psychoeducation is crucial in reducing stigma and shame, and addressing izzat and shame in places like therapy can help reduce issues and stigma. A further point in regards to this study is to be weary in wanting to address shame/izzat in therapy as this is pathologising and stereotyping Asian people. Additionally the study uses the terms "shame/izzat" interchangeably however by definition 'izzat' in Urdu translate to mean 'honour'. Therefore there is a lack of differentiation made between shame and honour, assuming both concepts are homogenous. Ironically this represents a continual simplification of cultures otherwise deemed as 'other'.

5.7 Limitations of the study

I will largely impact the findings of this study as the researcher, my reasons for doing this study, my data collection and analysis will all have implications on how the data was interpreted. As a young Asian Muslim woman I am influenced by my own experiences of race and religion. It is difficult to say my research can be free from bias. However as McLeod (2001) describes it is important to recognise your own assumptions and values, which I felt I tried to become more aware of through my bracketing interview and reflexive journaling.

Additionally my literature review was conducted after the analysis process which was beneficial in helping me approach my data more openly, however I cannot say my own experiences of being a Muslim, Asian and female would have no impact on how I interpreted the data.

Braun and Clarke, (2006) describe a pitfall of the broadness of qualitative research, whilst this can be an advantage, within constraints of time and word limit it can also be a disadvantage. My interview schedule could have been more specific, rather I covered a lot of areas like the Asian community, the majority community, GPs, medication, discrimination whereas these are all areas that could be focused on individually in more detail. Also with the interview schedule although the questions were open, it could have also explored more positive components of services and society. As question 4 asked discrimination and challenges, there could have been a question asking for positives.

Furthermore this was a small sample. Despite initially advertising the study for all south Asian women, the participants were recruited in the end were majority Pakistani, all participants were Muslim and within the 20-24 age bracket. Additionally my participants being students or graduates left me with a more specific image of mental health. As a less educated south Asian woman may have a completely different experience and this is an interaction I have to be aware of. As Gonzalez et al (2011) argued people with lower education levels might have less exposure to specialty mental health treatment due to economic or social restraints. Therefore other factors can also impact experiences, such as class and education.

I also recognise being a similar age, ethnic background and religion to my participants may have impacted the way or how much information they disclosed to me. I felt my participants assumed I knew what they were talking about, as they would say things like ‘our community’ or even using slang terms like ‘meds’. It felt important for me to gain clarity, rather than assume I understood. Furthermore as a trainee counsellor, this could have impacted how participants answered questions, for example potentially wanting to sound like they favoured counselling to medication in attempts to impress me. Additionally due to restraints of time and word limit on this research I was unable to explore other themes such as services being helpful or family being supportive, which could have given more insight.

6. Conclusion

6.1 Areas of learning and future research

I think this research has demonstrated a lot of issues within the Asian community. I think it would be important to explore issues within services further. To understand the difficulties BME groups are facing within services, at all levels of mental health services including diagnosis, intervention and treatment in comparison to the majority community. This is important as described in Macpherson's (1999) report that the lack of adequate services due to cultural or racial differences can be viewed as discrimination. This is an urgent and pressing concern for mental health services to provide adequate support.

Psychiatric comorbidity and the issues this causes would be important to explore, as there is little research on this area. Further exploration could include how other BME groups experience medication too. It is important to be aware of other factors. Cifti et al (2013) describes intersectionality, as the relationship between different identities and oppression such as race, sexuality and gender. Little research has explored intersectional complexities, and the interactions between race/ethnicity, gender, religion, class and health are overlooked. Intersectionality could be further explored within mental health services and treatment.

Future research could explore different interventions in depth too, for example comparisons between BME people's experience of medication and of counselling. It would also be interesting to look at larger populations of BME people not just university students/graduates, and using different designs such as mixed measure designs and quantitative methods.

6.2 Implications

There are many implications for the stakeholders mentioned in chapter 1 which included clients, trainees and qualified counsellors, also other mental health

professionals like Psychiatrists. It can be noted the study has shown a need for awareness of issues from the Asian communities. To also ensure adequate support and inclusivity, to increase the levels of access to all mental health care, including medication and therapy in BME communities. To provide safe spaces to Asian people struggling with mental health problems.

I think it is important to explore the use of medication within this group and how it has impacted participants, in order to suggest ways in which support can be improved. It is also important to acknowledge the race of participant's and if this influenced the support they received and if they faced any challenges, in order to try to reduce issues from recurring. I further hope to increase the awareness and knowledge of mental health amongst general society but also specifically amongst the South Asian community. The study has highlighted issues around medication use and support needed in taking medication, cultural differences and issues like barriers to services, racial and religious issues. For the Asian community it showed a need for acknowledgement, awareness and to address these issues and for the wider society to provide additional support to BME people that are tailored to their needs.

It is important for counselling trainers to be aware of cultural differences and understand counselling is from a Eurocentric model, which will could need expansions or adaptations when working in different communities. Counsellors and trainee counsellors must also be aware of issues around medication, as medication is one of the quickest forms of treatment provided. Therefore understanding the use of medication and how it can come into counselling or be used with counselling. Furthermore counsellors and trainee counsellors must recognise the complexities of racism as well as cultural issues.

It is important to understand there are many difficulties faced by BME people in mental health services. It is key to have a more diverse range of professionals, for professionals to be aware of their own privileges in relation to the people they work with, for there to be greater understanding of social issues and cultural differences.

However avoiding stereotypes and assumptions, which could potentially be more oppressive than helpful.

However I also believe practitioners should consider political or social engagement in ensuring that classism, racism, sexism is continually worked towards being reduced in the influence these and other issues have on mental health services. I believe it is a responsibility to engage outside of the services and socially advocate for rights, to challenge structural, institutional and systematic oppression, which will otherwise continue to infiltrate into mental health and other services.

6.3 Reflexivity

As a researcher this was my first time conducting a qualitative research study. My comfort zone was always with quantitative research. I struggled with the idea of subjectivity and really tried to mould my study into a quantitative piece of research however this was not feasible due to the research question. I began to question and challenge my need to conduct research quantitatively and really doubted how subjective quantitative research could be, as statistics can be manipulated, various factors cannot be controlled and the researcher is still part of the research despite seeming more objective from it. Eventually I felt more open and excited to pursue qualitative research and really appreciated the power it has. Through my research I gathered rich data and learned so much from my participants.

I struggled a lot with my research, outside of my dissertation I am very engaged and interested in politics and social issues I regularly read blogs and watch videos addressing a wide range of social injustices. Although this aided and motivated me to do my research it also became difficult to engage with my topic, as similar issues of social injustices such as racism, sexism, Islamophobia came up in research. I felt like this material constantly surrounded me. It was also hard to not feel frustration at the participant's experiences within the Asian community of marginalisation, in addition to wider marginalisation that some had already faced based on race and/or

religion. My own experiences of racism and Islamophobia had made it difficult at times to differentiate between participants and myself.

As a trainee counsellor this taught me a lot, I had to ensure that I was taking out enough time for my own self-care and taking breaks. It is important for me to take this into practise when I might work with clients who are similar to me, to be able to differentiate my experiences from theirs. I hoped to explore my own issues around race and Islamophobia more in therapy however I found that my white therapist had felt uncomfortable when I did mention race. Fortunately I have a supportive network around me to discuss issues with. However I think this is why it is crucial for have additional support for BME people and for the training of professionals to include awareness around race and racial issues.

My research has definitely shed light for me on my own privileges, for example being a light skin Asian woman as opposed to dark skinned has awarded me privileges as has being cisgendered, educated among with other privileges. Furthermore I can try to acknowledge power dynamics within a counselling room with a client further. As well as assumptions and stereotypes that can be made and from a further understanding now, can also be attempted to unlearn. This was an important realisation for me to have and has increased my want to understand other communities more. I also think this has given me a sense of responsibility to engage and do more within the BME community which I really look forward to.

6.4 Conclusion

In my aim to understand South Asian women's experience of medication for mental health problems, there were multiple barriers, obstacles and positives at times. On a closing note however, a theme I did not have space to mention which was found across all participants was perseverance. The will to continue despite many set backs and isolation, this will must be nurtured in people who are struggling with mental health problems.

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